Investigation into the circumstances surrounding the death of a man, a resident at an Approved Premises in January 2008

Report by the Prisons and Probation Ombudsman for England and Wales

October 2008

This is the report of an investigation into the circumstances of the death on 15 January 2008 of a resident at an Approved Premises. The man's death was caused by a head injury sustained when he was struck by a train. He had suffered from depression for many years.

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

My colleagues conducted this investigation. I am grateful for the assistance they received from staff in the local probation areas.

The man who is the subject of this report had a history both of offending and of contact with mental health services for treatment of anxiety and depression. He was also well known to the local probation area and local police's Public Protection Unit (PPU). In the six months to January 2008, he had been on remand at HMP Holme House before being given a six month custodial sentence suspended for 18 months with an 18 months supervision order. Although there was no court order instructing him to reside at an Approved Premises, the man and the PPU agreed that this would be the best place for him. The local probation area first arranged for him to stay at a different Approved Premises. However, because of concerns for his safety in light of local media coverage of his court case, he was relocated to this Approved Premises.

On what was to be his penultimate day at the Approved Premises, the man spoke to a member of staff and expressed thoughts of self harm and re-offending. The following day, he left the hostel and failed to return. During the evening, the police contacted the Approved Premises to say that the man's body had been found on a railway.

I make two recommendations. The first relates to the assigning of a key worker at the Approved Premises. The second refers to information sharing that occurred in the transfer of information relating to the man (in light of this recommendation, a copy of my report will be shared with the local probation area). In spite of this, I do not believe that his death could reasonably have been predicted.

In this version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and residents involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2008**

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SUMMARY

The man who died had suffered from depression and anxiety from a very young age. This included periods in hospital for treatment as well as contact with mental health services in the community. He was being prescribed a number of medications. He had also attempted to self harm on many occasions by taking overdoses of prescribed medication.

In 1996, he was sentenced to ten years imprisonment for six sexual offences. He was released on licence in December 2002 but recalled five weeks later for breaching his licence conditions. He then served the remainder of his sentence until his release in April 2006.

He was considered a very high risk offender and was monitored at Multi Agency Public Protection Arrangements (MAPPA) level three. Prior to 7 January 2008, he had been on remand in HMP Holme House for six months. On that date, he was given a six month custodial sentence, suspended for 18 months, and an 18 months supervision order, at the local Crown Court. This sentence was to run alongside an existing Community Order to allow him to undertake the local Sex Offender Groupwork programme.

As the man's release from custody was unexpected, provision had to be quickly made by the local probation area for him to stay at the first Approved Premises on a voluntary basis. However, after only two days, he had to be relocated as a result of local media coverage of his case in which he was clearly identified. The decision was made to move him for his own safety to another probation area on an emergency respite basis.

He transferred to the Approved Premises, but concerns were raised very soon after his arrival. He showed signs of anxiety and soon alerted staff to thoughts of self harm and re-offending. The staff were also concerned that they did not have all the necessary information relating to his offending history. His probation officer was away from her office during his time at the Approved Premises and so there was a delay in sending information about him. However, the local police's Public Protection Unit (PPU) kept in regular contact with the Approved Premises.

Because he was a quiet individual, the staff did not really get to know the man well during his short time there. Much of his time was spent away from the hostel. Nevertheless, I believe the staff did everything possible to offer him support. He had told staff he felt there was a high risk of him re-offending.

On the morning of his fifth day at the Approved Premises (14 January 2008), the man told a member of staff that he hated himself. The following day he left the hostel and failed to return for the evening curfew.

The police later contacted the Approved Premises and informed them that the man had apparently committed suicide by throwing himself in front of a train.

My report includes two recommendations.

CONDUCT OF THE INVESTIGATION

1. The investigation was conducted by two of my investigating officers. I am grateful for the assistance they received from the local probation areas, especially from the deputy manager at the Approved Premises. Although those interviewed were themselves coming to terms with the man's death, they made facilities available and participated fully in the investigation.

2. My investigators visited the Approved Premises and the local probation area Headquarters office. They studied records, and interviews were conducted with staff at the Approved Premises and the local probation. Ms A, a residential worker who had significant contact with the man who died, was unavailable at the time of the investigation. However, my investigator was given a copy of her notes detailing the contact she had with him. None of the residents of the Approved Premises came forward to offer any information regarding the man, although given the short time that he spent there this was not surprising.

3. One of my Family Liaison Officers contacted the man's mother and explained the investigation process to her. She was invited to raise any concerns or questions for the investigation to consider. His mother asked if my investigation could look into the three matters listed below, and I hope this report addresses them appropriately:

   - The police had told the man's mother that he had mentioned taking his life to someone in the hostel. She is not sure who he had spoken to or when, and would like further information on this.

   - She would like to know his whereabouts in the days leading up to his death.

   - His mother would like to know what medication he was receiving at the time of his death and whether he had any contact with a doctor.

APPROVED PREMISES

4. Approved Premises (APs), formerly known as Probation and Bail Hostels, are approved by the Secretary of State under Section 9 of the Criminal Justice and Court Services Act 2000. They provide accommodation for people granted bail in criminal proceedings and also supervision and rehabilitation for those convicted of offences. APs provide a supportive, structured environment in the community for high risk and difficult to manage offenders.

5. The purpose of the period of residence is to ensure that individuals are subject to close oversight. Supervision within APs is governed by the National Offender Management Service's (NOMS's) Standards for the Supervision of Offenders. NOMS issues Probation Circulars which set standards for the work of staff in probation areas, including those working in APs.

6. APs are a resource for managing high risk of harm offenders who have either been released from prison on licence or bailed from court. In the case of former prisoners, conditions are attached to each licence and a breach of these conditions means that recall to prison can be considered. Recall is normally proposed by the probation officer, and involves an application being made to the Ministry of Justice.

The Approved Premises

7. The Approved Premises is purpose built, built around 12 years ago. It has 24 single rooms. Referrals for a place are made by the field probation officer, normally within the local area. The AP manager (or deputy) then checks the individual's probation records and reports, OASys (see definition below), and the bed capacity to decide whether the referral can be accepted. Occasionally, referrals are made from probation officers out of the area when accommodation is required quickly for individuals who are deemed a medium or high risk. Such referrals go through the Assistant Chief Officer (ACO) of each area, as well as being endorsed at a multi-agency public protection meeting.

8. At the time of this investigation, the Approved Premises was unable to offer residents any educational programmes due to reduced staff numbers. However, residents have a progress to work class which takes place once a week where they are assisted to gain employment, as well as given employment training.

9. A community psychiatric nurse (CPN) is assigned to the Approved Premises. The CPN attends weekly, but also attends if there is a specific need on the part of a resident. The CPN conducts assessments and checks individuals for any history of mental health problems. When necessary, the CPN will then try and obtain past medical records.

10. All residents have to register with the AP doctor who holds a weekly surgery at the premises, usually on a Wednesday. If a resident has any medical problems the doctor sees them and prescribes the necessary medication. All prescriptions are handed to staff at the end of the surgery who take them to the pharmacy for collection. Staff must be notified when medication is prescribed to a resident, and the medication is securely stored in the main office.

11. The Approved Premises also has an addiction therapist who works as part of the local care share scheme. The therapist is funded by the local Safer Cities and four of the APs in the local area. The addiction therapist spends a day in each AP, assesses the residents and makes recommendations to the doctor for detoxification.

12. Every resident receives an induction into the AP, which should be completed on the day of arrival. This allows staff an opportunity to assess any difficulties or concerns and show newcomers around. The induction also ensures that residents know the rules of the AP.

13. Residents are allocated a member of staff as their key worker whom they meet on a regular basis for support, to discuss their well-being, and to assist with any offence-related work. Attendance at key worker sessions is part of the resident's contract and failure to attend can be considered a breach of rules.

14. Breakfast and dinner are provided each day. Unless a resident is subject to individual curfew arrangements imposed by a court, they must be on the premises between the hours of 11.00pm and 6.00am. A residents meeting is held once a month.

15. Residents have keys to their rooms, which they hand into the office when they go out and collect on their return. They are not allowed to bring friends into the AP without prior permission. Routine room searches are carried out. All concerns about residents must be recorded in the house log and the resident's personal file. Issues must be shared with the resident by the key worker and the discussion recorded.

16. The possession or use of alcohol, solvents and controlled substances is not allowed either on the premises or within the grounds of the Approved Premises.

17. A minimum of two curfew checks must be carried out daily in the AP, usually at 11.00pm and 6.00am. All curfew requirements are monitored by staff. Additional curfew checks on specific residents are carried out when necessary. In addition, all communal areas, including bathrooms, showers and toilets, are checked regularly and these checks are recorded in the house log. The Approved Premises also has a number of CCTV cameras installed in communal areas which are monitored by staff from the main office.

18. The night time hours are normally supervised by one night supervisor (the assistant residential officer). The night staff start their duty at 10.00pm and they are required to stay awake until 9.30am the following morning. At least one of the staff in the hostel at night is first aid trained. The staff are given a handover by the day staff when they begin their shift. A sleeping residential officer is also on duty during the night, although they will go to bed at midnight and resume duty at 7.00am the next morning. The night staff keep order and look after residents' welfare, issue medication and patrol the premises. Any issues that occur during the night are recorded in the house log.

Multi Agency Public Protection Arrangements (MAPPA)

19. The MAPPA is a formal partnership between police, probation, prisons and other statutory and non-statutory agencies which assesses and manages offenders in order to minimise the risk of serious harm they may pose to the public.

20. Offenders who come within the MAPPA remit are classified according to the nature of the risk and its management. The higher the risk and level of resources required to manage 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 all the MAPPA agencies and level three offenders are managed by the Multi-Agency Public Protection Panel (MAPPP) made up of senior managers from the MAPPA agencies.

Public Protection Unit (PPU)

21. The local police's Public Protection Unit is a specialist unit of highly trained officers responsible for the prevention and investigation of crimes involving adult abuse, child abuse, and domestic violence, and for the management and support of sexual and other dangerous offenders and vulnerable and intimidated witnesses. The PPU work jointly with the local probation service. Police and probation staff are co-located in the same (probation) office and work together in the same geographical clusters, conduct visits together and share the responsibilities of high risk offenders who are subject to supervision.

OASys

22. The Offender Assessment System (OASys) is a standardised process for the assessment of offenders developed by the National Offender Management Service. It assesses an offender's likelihood of re-offending and risk of harm.

KEY FINDINGS

Prior to the man's release from prison

23. The man who died had a record of sexual offending. In 1996, he was sentenced to ten years imprisonment for a number of serious offences. He was released on licence in December 2002, but was recalled five weeks later for breach of his licence conditions. He then served the remainder of his sentence until his release in April 2006. As a result of his offences he was required to sign the Sex Offender Register and was dealt with as a very high risk offender, subject to MAPPA level three.

24. He appeared at the local Magistrates Court on 8 August 2006. He was made subject to a community order with a two year supervision requirement for breaching an Interim Sexual Offences Prevention Order (SOPO) for an offence carried out in June 2006.

25. On 29 September, he was sentenced to a Community Order with a three year supervision requirement. This included a requirement to attend the local Sex Offender Groupwork programme for a breach of his SOPO.

26. On 25 June 2007, he was remanded into the custody of HMP Holme House in respect of three breaches of the SOPO and was due to be sentenced on 30 July. Sentencing was later deferred due to other charges also being considered by the police. On 19 November, he was placed on basic regime (under the prison's Incentives and Earned Privileges Scheme) following a period of poor behaviour.

27. A MAPPA review took place on 27 November. Representatives from the prison, probation and police attended. The review found that the man's level of risk to the public remained high. It was noted that in prison he kept himself to himself and remained unemployed.

28. The prison probation officer, Ms B, informed the meeting that the man had been displaying some bizarre behaviour in prison. At times he appeared to be speaking a different language and was uncommunicative. He had been assessed by the mental healthcare team but they did not consider that he needed to be under their care. He was, however, prescribed venlafaxin (an antidepressant). He was also being monitored under the Care Plan Approach (CPA) to assess his well-being. However, there were no self harm issues noted whilst he was in custody. Ms B spoke with the man after the MAPPA meeting and he engaged her in conversation regarding his future plans, one of which was to live with his girlfriend.

29. Ms C was the man's probation officer. She had taken on this role at the end of October 2007 from another probation officer whose duties had been reassigned. When interviewed by my investigators, Ms C said that she only saw him once while he was in custody (on 6 December 2007).

This was an introductory meeting following the MAPPA meeting on 27 November.

30. Ms C said that the purpose of meeting the man was to build up a rapport prior to his court hearing which was scheduled for 7 January 2008. She talked to him about his behaviour in prison, as reported by Ms B. He said it was his way of rebelling against the prison system. He said he was taking antidepressant medication. Ms C said that he talked constructively and any concerns she had about him soon faded. It was agreed Ms C would return to the prison to see him once he had been sentenced.

31. During December, no concerns were raised about the man. His behaviour on the wing had improved and he was returned to the standard regime on 19 December. He also participated on the Sex Offender Groupwork programme.

32. On Monday 7 January 2008, the man appeared at the local Crown Court and pleaded guilty to charges of attempted fraud and breach of his SOPO. Ms C, along with other members of the MAPPA panel, considered that it was unlikely that he would escape a custodial sentence. Their expectation was that the judge would adjourn the case, and request a pre-sentence report from the probation service.

33. However, at around 4.00pm, having taken into account the period of time the man had already spent on remand, the judge sentenced him to a six month sentence suspended for 18 months with an 18 months supervision order. In addition, he was ordered to attend relevant sex offender treatment programmes (SOTPs) within the community.

After the man's release from prison

34. Following sentencing, the court clerk telephoned Ms C to inform her that the man was being released, and asked where he would be staying. He had lost the tenancy on his flat and was therefore of no fixed abode. A pre-sentence report had not been requested and there was no requirement for him to reside at an AP.

35. Both the local police PPU and the local probation area staff were present at the court hearing. (Following receipt of this draft report the Director of Public Protection for the local area confirmed that the PPU and the local probation worked as a joint unit and on cases where there were high risk factors). The man was fully aware of his high risk status. He wanted to stay at his girlfriend's flat but was dissuaded by the PPU because it was deemed an unsuitable area. Ms C had recently carried out a home visit to the flat and confirmed that the area was unsuitable. It was also anticipated that his case would attract local media coverage and that he might be recognised.

36. The man who died cooperated with the PPU and probation service. He understood the risk he posed and was aware that the court had made no requirement for him to reside at an AP. He was surprised, but happy, at regaining his freedom. He agreed to stay at an AP on a voluntary basis in order to demonstrate his motivation to address his offending behaviour.

37. In the light of the man's situation, Ms C consulted Ms D, a Senior Probation Officer (SPO). Ms C telephoned a couple of the APs in the area and at 4.30pm was able to secure accommodation for the man at an AP. She informed the court and the man was then escorted by the PPU to the first AP. Ms C told the man that it was in his best interests that he reside at an AP, given the media interest he could attract.

The man's arrival at the first Approved Premises

38. The man arrived at the first Approved Premises at around 6.30pm on Monday 7 January. He received an induction into the AP and all the rules were explained to him. He was allocated a room and signed the required compacts to confirm that he understood and would abide by the rules. Given his previous offences, staff completed a notification of admission pro-forma to be sent to the police. It was also confirmed to him that a meeting with Ms C had been arranged for 11.00am the following morning.

39. The man told staff that he had previously been prescribed venlafaxine (an antidepressant) and olanzapine (anti-psychotic medication) as he experienced anxiety and depression. He also disclosed that he had had several admissions into hospital for these conditions. Because of his appearance in court, he had arrived at the hostel with no medication and staff made arrangements to contact his doctor to request his medical history. A referral was also made for him to see the community psychiatric nurse (CPN), community drugs team (CDT) and doctor for a mental health assessment and the prescribing of any necessary medication.

Tuesday 8 January

40. An emergency MAPPA level three meeting was called on Tuesday 8 January 2008 at the Teesside Probation Headquarters. This was as a result of the man's unexpected release. He was considered to pose a very high risk and the decision was made to apply to the courts for a retrospective residency order requirement. This would mean that he could continue to be managed at MAPPA level three, and be required to live at an AP. Ms C confirmed at the meeting that the man was under a court order to attend the Sex Offender Groupwork Programme, and would be recalled to custody if he did not comply.

41. Ms C said that she had spoken with the local CPN who confirmed that he was not currently under the care of the Community Mental Health Team.

They had not treated him for a least a year. The CPN described his bizarre behaviour as a smoke screen for his offending behaviour.

42. The MAPPA meeting concluded that the man should continue to be monitored. The staff at the first AP should meet him regularly and record his movements and details of those he associated with. His room was to be searched frequently on a random basis. If staff had any concerns about his behaviour or discovered something which they believed was inappropriate, the PPU was to be contacted immediately.

43. Following the MAPPA meeting, Ms C and the PPU met with the man. He was advised not to visit his girlfriend at her flat to reduce the risk of breaching his SOPO. He was also reminded that, as there was a press representative at court when he was sentenced, it was likely there could be local coverage of his case. It was explained that he could potentially be at risk of harm if seen in the vicinity of his girlfriend's flat. He told Ms C and the PPU that, on a scale of one to ten, he assessed his risk of re-offending as six or seven. This was the last contact Ms C had with the man.

44. No issues or concerns were raised by staff following the man's second night at the first Approved Premises.

45. The following morning (Wednesday 9 January), he was prescribed venlafaxine and olanzapine by the doctor. Later in the day, his photograph was published in the local Evening Gazette together with headlines detailing his release and the nature of his offence. Having seen the paper, Ms E (ACO) and the SPO, Ms D, along with the input from the PPU decided that the man should be relocated outside the area for his own safety.

46. When interviewed by my investigators, Ms D said that, as Ms C was away from the office, she took responsibility for finding suitable accommodation for the man who died. Across the probation areas, there is an agreement to try to accommodate each other's offenders when the occasion arises. However on this particular day, neither of the other areas was able to accommodate the man. The search was therefore extended.

47. The second Approved Premises was one of the only APs with a vacant bed. His transfer was considered to be a temporary measure, as the bed was only available for a maximum of three weeks. The local probation area would continue to be responsible for him.

48. Arrangements were made for the man to leave the first Approved Premises. At the time that the newspaper article was published, he was out shopping with his girlfriend. He was telephoned by the PPU and asked to come into their office where the situation was explained to him. He was reluctant to go to but, following a discussion with Ms D, he understood that it was for his own safety. A member of the PPU also

spoke with the man and he was shown the newspaper. He was later escorted by Mr F (a member of staff from the first Approved Premises) and a PPU officer to the new Approved Premises. Ms D informed Mr F that all paperwork relating to the man would be faxed through to the Approved Premises prior to their arrival.

49. Mr F noted in the escort travel log that there were no concerns raised on their car journey to the Approved Premises. He also noted that he had been given no documentation for the man to be handed over to staff on their arrival.

The man's arrival at the Approved Premises on 9 January

50. On Wednesday 9 January the Approved Premises deputy manager, and Mr G, residential officer, were on duty. At interview, the deputy manager told my investigators that she received a telephone call from the local probation ACO who had liaised with the other ACO. It was agreed that the Approved Premises would offer accommodation to the man as an emergency respite for a few days because of the local press coverage of his case. The deputy manager agreed to this and informed the area managers that she would need the bed back by 29 January at the latest.

51. Mr G told my investigators at interview that on this day (9 January) he was on a 'sleep in' shift and his duty would have lasted over 24 hours from 1.00pm to 1.30pm the following day. The man arrived at the Approved Premises in the middle of the evening. On arrival he was met by the deputy manager and was taken to the office for her to obtain some preliminary details. The deputy manager told my investigators that she had received no documentation for the man. Mr F informed her that she should contact Ms D first thing in the morning.

52. The deputy manager said that she asked Mr F if the man was taking any medication. Mr F explained that the man had been prescribed some medication by the doctor that morning, but the prescription had not been delivered to the previous Approved Premises. The man therefore arrived at the new Approved Premises with no medicines. Mr F provided the deputy manager with the name and address of the doctor who prescribed the medication so that she could pass it on to their doctor.

53. Ms D faxed information relating to the man to the Approved Premises later that evening. The man was described as a very high risk offender and his triggers for re-offending were identified. He was to adhere to the AP's rules and his SOPO conditions, and be monitored closely. If he failed to return to the AP after curfew time, the police should be informed immediately together with the man's probation officer. Ms D also e-mailed the MAPPA minutes for 18 July 2007 to the deputy manager.

54. Ms D said that, in the meantime, the local probation would try and find alternative accommodation for the man nearer home, possibly in a bed and breakfast premises. She suggested to the AP that they access the

man's records on OASys. To do this, a probation area must seek electronic transfer of, or access to, the document. Although this was deemed a simple task, staff at the AP gave no indication as to how long it would take.

55. Mr G confirmed that they received some information from Ms D about the man's offending history and medication, and that he had a previous self harm history. He also telephoned the previous AP to try and gain further detailed information.

56. Mr G said that the man was initially anxious and withdrawn. He attempted to deliver the man's induction and obtain some basic information from him. However, he did not fully engage with the process. He said that he last self harmed approximately three years earlier, but now felt fine and had no current thoughts of self harm. He confirmed that he was prescribed medication, but had none with him. Mr G therefore made a referral for him to be seen by the local doctor the following day.

57. As he appeared quite distant during their first meeting, Mr G said they would resume the induction the following morning. He later ate a sandwich and watched television in the communal room. Shortly afterwards, he went out for some fresh air. When he returned, Mr G showed him to his room where he settled for the night.

Thursday 10 January

58. The following morning (Thursday 10 January), Mr G sent an e-mail to Ms C. He explained that when the man had arrived at the Approved Premises he was very anxious and withdrawn. However, he seemed in a better mood in the morning. Mr G confirmed that the man had arrived with no medication and requested further information from Ms C relating to his mental health, court reports and up-to-date MAPPA notes. Following sight of this draft report, the Approved Premises confirmed that they received Ms C's fax (sent the previous evening), which contained further information about the man, on this day.

59. Mr G then telephoned the doctor and explained the man's circumstances, giving the name and address of the doctor who had recently prescribed his medication. Following confirmation, the doctor arranged for a prescription to be issued, and this was later collected and taken to the pharmacy by the deputy manager.

60. Mr G completed the man's induction before lunchtime. He told my investigators that his demeanour had settled. He was happy to finish his induction and sign the appropriate compacts to confirm he understood what was expected of him. Given the information they had received about his medical history, Mr G made a referral for him to be seen by the local community psychiatric nurse (CPN) who visited each Friday.

61. The man left the AP after his induction and returned later for his tea. He went to the office at around 4.50pm to collect his dose of venlafaxine and olanzapine for the day. Whilst there, staff reminded him of an appointment made to see the CPN the following day. Mr G completed the Child and Public Protection Unit (CPPU) pro-forma and sent it to the local police station to notify them of the man's residency at the Approved Premises.

Friday 11 January

62. On the morning of Friday 11 January, the man collected his medication from the office. Soon afterwards, he attended his appointment with the CPN, registered mental health Nurse H, who carried out an assessment. Nurse H noted that the man was very reluctant to discuss any issues, "displayed avoidant behaviour", was mildly anxious and appeared unhappy. Nurse H recommended that the man be monitored for suicidal behaviour by searching his room for any medication or other items. He noted that they were awaiting the man's previous community mental health reports and suggested that he be referred to the local community mental health team (CMHT) should he remain at the Approved Premises.

63. The house log sheet recorded that the man's room was searched by staff during the day. They found items identified as likely triggers for his re-offending.

Saturday 12 January

64. On Saturday 12 January, the man left the hostel at 11.40am returning around 10.40pm. At 4.00am the following morning, he came to the office to tell the staff that he had been trying to contact a member of the police team in the CPPU to inform them that his girlfriend would be visiting him. The night duty staff told him that he should contact the CPPU unit during office hours.

Sunday 13 January

65. On Sunday 13 January, the man spent the majority of the day away from the AP. Ms A (residential officer) sent an e-mail to Ms D, the deputy manager, Ms C and the local police the following day regarding the man's behaviour over the weekend. In the e-mail, Ms A said that she had spent some time with him on Sunday because he was anxious and upset. He told her that he was suicidal and had thought about lying on a railway line. He had bought a railway ticket and travelled to a town where he purchased more items identified as triggers for re-offending. He later threw them away. While shopping, he said that he thought that his risk of re-offending was very high.

Monday 14 January

66. The CMHT report was received at the AP on Monday 14 January. The report had been written on 12 December 2006 and confirmed that the man had a history of sexual offending and a long history of contact with mental health services for depression and anxiety. The report concluded that he did not require any mental health services intervention at that time. It also said that any mental health service offered to him would not reduce his risk of re-offending.

67. Ms A talked to the man about how he was feeling. She asked him to rate his suicidal thoughts on a scale of one to ten, ten being the highest. He said he rated himself as a two and was too scared actually to take his own life. He said that he had had an argument with his mother on the phone which had upset him. He later apologised to her but had cried afterwards. (After reading the draft report, his mother confirmed that their telephone conversation was not an argument but a discussion about an argument he had had with his girlfriend. The end of their conversation was therefore amicable). The man said he was unsure whether he should visit his girlfriend today. She had been staying in a local hotel and they had been going through a rough patch in their relationship. During their conversation, he also told Ms A he was hearing voices in his head. He then left the hostel at around 3.20pm, saying he was going to see his girlfriend. Ms A conducted a search of the man's room and found further items which were identified as triggers for his re-offending.

68. The man returned at around 8.50pm. He told Ms A that he had gone to see his girlfriend but she was not at the hotel. The man believed she had gone off with another man. He decided to go for a drink before returning.

69. Ms A told the man of the items confiscated from his room following the search. He replied that he had bought further items of clothing but later discarded them. Ms A asked him how he was feeling, to which he responded that he felt better than earlier, but "the facts hadn't changed and he hated the skin he was in".

Tuesday 15 January

70. The following morning (Tuesday 15 January), the man was up by 6.30am and collected his medication from the office. Ms A spoke to him for a while and asked if he slept well. The man said he did but nothing had changed about how he was feeling. Ms A offered the man support should he wish to talk about anything. He later left the AP. Ms A informed the local probation and the police PPU of his recent behaviour.

71. That afternoon, the deputy manager sent an e-mail to the local ACO. She explained that so far she had had very limited contact from the probation area regarding his move. This was in contrast to the contact

she had received from the police officers at the previous police PPU. They had told her that the man was due to reappear in court on 5 February and it was likely that this attendance would attract further media attention. The PPU believed that he would probably remain at the Approved Premises until 29 January.

72. The deputy manager reminded the ACO that the man was there on a voluntary basis. He had no licence conditions and could come and go as he pleased. She raised her concern about the recent find of clothing items in his room, and also his admittance of inappropriate thoughts about re-offending.

73. As it was thought that he would only be at the Approved Premises for a short period, he had not been assigned a key worker. The deputy manager raised her concern about the level of risk the man posed and suggested that he should be assigned a probation officer the previous area to provide further supervision. The ACO said he would contact the local probation area to get an update on the man's circumstances.

74. Mr G said that staff constantly tried to get in touch with the man's probation officer and the senior probation officer. They found that, after time, their contact just seemed to diminish. The PPU actively communicated with the Approved Premises, and frequently asked for updates about the man's movements and behaviour. Ms C told my investigators that it was unfortunate that she was unable to respond directly and immediately to correspondence received from the Approved Premises because of her absence from the office.

75. Around 9.45pm that evening the night duty officer received a telephone call from the police. They asked if the man was a resident there, and she confirmed that he was. The police informed the night duty officer that a man had apparently committed suicide by throwing himself in front of a train and that they suspected that it was the man. An official identification would take place and confirmation would be given as soon as possible.

76. At 10.20pm, the police contacted the Approved Premises and requested next of kin details so that they could inform them what had happened. The night duty officer told the deputy manager and other necessary agencies of the events of the evening. The night duty officer later checked the man's room to see if he had left a note, but nothing was found.

After the man's death

77. The man's room was sealed by staff to await the arrival of the police. All staff were informed of the events relating to his death. The deputy manager took the decision to delay informing other residents. He had kept a very low profile during his short stay and knew very few residents.

78. The deputy manager referred to probation procedures regarding the death of a resident and ensured all the appropriate authorities were informed of his death.

79. A team meeting was held and the wellbeing of all staff was checked. Staff were reminded of the services of the probation counselling service. The ACO also made a personal visit to offer support to staff. The CPN was on duty the following day and made himself available to any member of staff who needed support.

80. Ms E (local ACO) told my investigators that they were informed officially of the man's death by the PPU. The PPU had broken the news to his mother and girlfriend. Ms E then went about informing her staff, including Ms C, who was on leave at the time. The local probation area also has a counselling service as well as offering support from line managers. Staff were reminded of the support that was available through these avenues.

Post Mortem Result

81. The post mortem report confirmed that the man's death was caused by a head injury sustained when he was struck by a train. The man had not taken any alcohol or consumed any unprescribed drugs.

ISSUES RAISED IN THE INVESTIGATION

Allocation of a key worker at the Approved Premises

82. The Approved Premises agreed to accommodate the man for a few days to a week, with an absolute maximum of three weeks, to alleviate immediate risks for him and issues for the previous Approved Premises, relating to media attention. Of the six nights that he did reside at the new Approved Premises, his probation officer was absent for two days due to sick leave and a further day which was one of her non-working days. A further two nights out of the six also fell over the weekend. It was therefore unlikely and would have been difficult for the man to have received a visit from her during this period.

83. He was not allocated a key worker because his stay was expected to be short. Key workers play a fundamental role in offering support to residents in APs. This is not to undermine the work that other staff do, but key worker contact is regular and structured. This would certainly assist when a resident has no licence restrictions and can come and go as they please.

84. I am pleased to note that, although the man was not assigned a key worker, he was monitored and received care and support as far as possible from the staff at the Approved Premises. However, I suggest that a key worker is assigned to all residents irrespective of their duration of stay.

    The manager of the Approved Premises should ensure that all new residents are assigned a key worker on arrival at the AP.

Communication between the local probation area and the Approved Premises

85. I commend the speed with which the local probation area and the PPU acted to ensure the man's move after they judged it might not be safe for him to remain in the area he was in. He ultimately remained under their supervision, although his probation officer last had contact with him at the first Approved Premises a week prior to his death.

86. During that week, the Approved Premises staff felt anxious about the placement because of the lack of offending and health history information received from the local probation. Ms C was unfortunately away from the office and, although a duty probation officer usually covers staff absences, for what ever reason this did not seem to occur. After Ms D provided the initial basic information to the Approved Premises, no further contact was made from the probation service.

87. I am pleased to note that the police's PPU were pro-active with their communication with the Approved Premises. Given their joint working relationship with the local probation service, they would have had full

knowledge of the man's case. This working relationship however, seems not to have been understood by, or promulgated to, the Approved Premises staff. I do not conclude, however, that if further information had been shared his death could have been avoided.

88. The Probation Service has a national procedure (PC25/2007) entitled "Case Transfers" which refers to the minimum standard of contact and information which should be shared between probation areas. It is especially important when, as in this case, there is a high risk of re-offending. It covers information relating to any offending history and other background material which should be quickly made available to assist decision making and planning. No doubt, this would include imparting information to those who would need it, explaining the PPU's role on particular cases.

The Chief Officer of the local probation area should remind staff of the content of PC25/2007 and ensure that these principles are adhered to when transferring cases between probation areas.

CONCLUSION

89. The man who died had been a high risk offender for a number of years and was well known to the probation service. He also had a history of mental health problems and self harm. He arrived at the Approved Premises unhappy at having to be relocated. Nonetheless, staff welcomed him and helped him to settle. As a voluntary resident, the man had no licence restrictions and was free to come and go within the confines of the AP curfew times.

90. There is no doubt that the staff at the Approved Premises were concerned that he might re-offend or self harm and these fears were addressed with him and passed to the local probation area and to the police.

91. There is no knowing what was going through the man's mind on the evening of 15 January. However, he had alluded to disliking himself the evening before. Whether this related to his past offending behaviour, current thoughts of wanting to re-offend or to some other factor can only be speculated upon.

92. Notwithstanding that he exhibited a number of risk factors, I do not believe that the death of the man could reasonably have been anticipated by those responsible for his care. Nor do I think there were actions they could have taken that would have prevented it from occurring.

RECOMMENDATIONS

1. The manager of the Approved Premises should ensure that all new residents are assigned a key worker on arrival at the AP.

2. The Chief Officer for the local probation area should remind staff of the content of PC25/2007 and ensure that these principles are adhered to when transferring cases between probation areas.