

**Investigation into the circumstances surrounding the
death of a resident at
an Approved Premises,
Cheshire Probation Trust, in September 2010**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

November 2011

This is the report of an investigation into the circumstances surrounding the death of a man in September 2010. He was 48 years old. He was found hanging by a ligature in his room at an approved premises in Cheshire. The man had been remanded to HMP Altcourse since 12 May, before being bailed to live at the approved premises on 15 September.

I extend my sincere condolences to the man's family and friends for their loss. I apologise for the delay issuing my report and for any additional distress which this may have caused.

The investigation was carried out on my behalf by two of my colleagues. I would like to express my thanks to the Chief Executive of Cheshire Probation Trust and the staff and residents at the approved premises for their full cooperation during the investigation. In addition, I would like to thank staff at HMP Altcourse for participating in the investigation and providing all relevant documentation regarding the man's time at the prison. I am also grateful to Cheshire Constabulary for their liaison and input into this investigation.

Cheshire and Wirral Partnership NHS Foundation Trust completed a review which investigated the care that the man received from the Adult Mental Health Services, prior to his time in prison and the approved premises. I am grateful to the clinical service manager for her assistance.

The man had only lived at the approved premises for two weeks before he took his life. He admitted to staff when he arrived there that he had thought about ending his life and repeated this on more than one occasion though without making any attempt to do so. He was also anxious about his health and medication. The staff considered whether to monitor the man under the suicide and self-harm policy but decided against it and initially advised him to discuss his feelings of depression with his community doctor.

I am concerned about the staff reticence and apparent lack of confidence in applying the suicide prevention measures, as well as the absence of documentary evidence regarding the rationale for their decisions. This is particularly disappointing given the recommendations on such measures made by my predecessor following a previous death at the approved premises. I therefore repeat a recommendation regarding the review of training and support for staff in these procedures. I also make a further six recommendations, one of which is a national recommendation relating to bail referral procedures, first aid training, communication in an emergency, confidential access to the Samaritans, notification of deaths to off duty staff and anti-ligature knives.

The recommendation in the draft report which referred to financial assistance for funeral arrangements has been withdrawn, as there was no provision for approved premises to contribute towards funeral expenses at the time of this man's death.

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.

Thea Walton
Acting Deputy Ombudsman

November 2011

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SUMMARY

1. The man was arrested and remanded to HMP Altcourse on 12 May 2010. He had sustained some injuries during his arrest. When he arrived at Altcourse he was treated for his injuries and he also told staff that he suffered from epilepsy. He said that he had previously had contact with Cheshire and Wirral Mental Health Services. He was not thought to be at risk of harming himself whilst he was in prison.
2. Whilst he was in Altcourse, there was some investigation into the seizures and the medication that the man had been prescribed, although he was not allowed to keep the medication in his cell. He was not happy about this and failed to attend some appointments with healthcare staff but he eventually agreed to a referral to an outside hospital's neurology department.
3. Unfortunately, before this appointment took place, the man was bailed to live at an approved premises. No information about his medical history was passed to staff at the approved premises. However an appointment was made for him to attend the local doctor's surgery.
4. The man eventually reached the approved premises at 10.57pm on 15 September, which is considerably later than he was expected to arrive. He staggered up the steps and said that he had got lost on the way. At his induction the following day, he told staff that he wanted to end his life and repeated this subsequently. Although staff discussed his comments with the manager of the hostel, they decided not to put in place the Probation Trust's suicide and self-harm prevention measures. On various occasions in the next two weeks, he expressed feelings of depression, concern about his treatment and said that he wanted to keep his own medication rather than leaving it with staff. Whilst members of staff had a lot of contact with the man and recorded how he felt, no one considered that the suicide monitoring procedure was necessary.
5. The man's doctor had prescribed clobazam. On one occasion, the pharmacist gave him clonazepam, by mistake. The man took only one of the incorrect tablets, on the day before he died. The pharmacist explained the side effects of the tablet as dizziness, drowsiness and light headedness.
6. On late September, a member of staff checked the man's room because he had not been for his evening meal. The staff member found him hanging by a ligature made with a belt. An ambulance was called and staff attempted resuscitation. Paramedics arrived and pronounced that the man had died.
7. I make a number of recommendations, the most significant of which relate to training in the suicide and self-harm prevention procedures as well as the use of mobile telephones or radios to be used in an emergency and the need for robust risk assessments on bailees referred from prison. I also draw attention to the use of anti-ligature knives, first aid training for all staff, informing off duty staff of a death at the premises and confidential access to the Samaritans.

THE INVESTIGATION PROCESS

8. The man died in September 2010. I appointed one of my investigators to investigate the circumstances surrounding his death. She visited the approved premises on 5 October and obtained copies of the man's probation records. She also contacted HMP Altcourse, who provided copies of the man's clinical and prison records.
9. The approved premises issued notices to staff and residents informing them of the investigation and inviting anyone who had relevant information to contact the investigator. In response to the notices, several residents contacted my investigator and she arranged to interview them when she returned to the approved premises. My investigator and her colleague returned to the approved premises on 22 and 23 November 2010. During the visit they interviewed six members of staff and two residents. A staff member who helped to administer cardio pulmonary resuscitation (CPR) said that he would rather not explain the events again and so his police statement was used in respect of the events when the man was found in his room.
10. My investigator also contacted Central Macclesfield Mental Health Team and was given a copy of their review of the man's treatment whilst he was in the community, completed by Cheshire and Wirral Partnership NHS Foundation Trust. It is the policy to carry out a review whenever anyone dies within a year of treatment. My investigator also liaised with a detective sergeant from Cheshire Police and was given access to police statements and reports, in accordance with the Memorandum of Understanding between my office and the Association of Chief Police Officers.
11. My Senior Family Liaison Officer contacted the man's family to inform them about the investigation process and to invite them to ask any questions or raise any concerns about the care he was given. His daughter explained she was very concerned and disappointed with the care her father received at the approved premises. She knew that he spoke with staff and told them that he was depressed, suicidal and concerned about his debts. She asked the following questions about her father's care:
 - Why staff did not do anything about her father's disclosure of suicidal thoughts and undertake closer monitoring?
 - Following his disclosure that he felt suicidal, why was he allowed to have belts in his room?
12. The man's daughter responded to the draft report and said that she thought it was a thorough report and the investigation had been carried out properly. However, she said that she remained angry with the Probation Service because she felt nothing had been done to help with her father's depression. She also expressed concern that all staff were not first aid trained.

HMP ALTCOURSE

13. HMP Altcourse is a category B local prison, near Liverpool. It is contracted by the National Offender Management Service (NOMS) and run by G4S, a private company. It serves the courts from Merseyside, Cheshire and North Wales, and holds sentenced and unsentenced adults and young offenders. There are seven house blocks divided into individual units. The units hold between 60 and 95 prisoners and are named after fences on the Grand National steeplechase course. Each unit is also colour coded to ease identification. The prison is divided down its centre by buildings containing the support services, such as the healthcare centre, resettlement unit, sports centre, education department, segregation unit and first night centre.

Independent Monitoring Board (IMB)

14. The IMB is a body of people appointed to each prison by the Secretary of State for Justice to be independent watchdogs of the public interest. They are not members of the Prison Service, nor are they part of the management team. They are required to produce an annual report to the Secretary of State on the prison, highlighting good practice and flagging up areas of concern.
15. The most recent Independent Monitoring Board report is dated July 2009 – June 2010. The IMB described the prison as follows:

“The maxim that 80% of the time is spent on 20% of the people could not be more apt than in a prison situation, where an extraordinary amount of time and care is spent on particularly vulnerable groups of prisoners. It is therefore of particular note that there has been no incidence of self inflicted death during this reporting year. And, that diversity issues, including foreign nationals, have been dealt with both well and empathetically.”

Her Majesty’s Chief Inspector of Prisons

16. The last inspection report covers a full, unannounced inspection in January 2010. In the section on healthcare, inspectors noted that:

“Health services were provided by an in-house team, most employed by G4S. A health needs assessment had been completed and was regularly updated. A range of health services was available. There had been a lack of senior management due to the long-term absence of the healthcare manager. Primary care was basic, with little chronic disease management. GP [general practitioner] provision was comprehensive, but waiting times were too long. Dental services were very good and a full range of treatment was offered. Pharmacy services were satisfactory, but some attention to medicine management and administration was needed. Mental health services were good, with some very good joint working between primary and secondary services. Inpatient services were only basic. There was no day centre.”

THE APPROVED PREMISES

17. Approved premises are approved by the Secretary for State for Justice within section 9 of the Criminal Justice Act and Court Services Act 2000. They provide a structured, supportive environment in the community for high risk offenders, many of whom have been released from prison as part of their supervision plan, agreed with the offender's offender manager (formerly probation officer). Occasionally, as in this man's case, places are offered to unsentenced people who are on bail, but this is becoming increasingly rare. Although administered locally, each approved premises must comply with the National Offender Management Service's Standards for Probation Hostels and operates a curfew for residents.
18. The approved premises which is the subject of this report is one of two approved premises in the Cheshire area. Both approved premises provide a resource to the Cheshire Courts and have the following aims:
 - i. protect the public
 - ii. prevent re-offending
 - iii. provide residents with an opportunity to address their problems in a safe, stable environment
 - iv. enable residents to face up to their offending behaviour
 - v. complete the conditions of their order or licence
 - vi. facilitate their resettlement into the community.
19. The approved premises which is the subject of this report is a 22 bed unit, and has been all-male accommodation since April 2005. Residents are over 18 and the majority have been sentenced and are under licence supervision, unlike this man who was on bail and awaiting sentence. The approved premises has a closed circuit television monitor which shows all the corridors and doors of rooms. If a staff member goes to check on a resident, or do room checks they are told to stay on camera at all times and not to close the room doors. 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 within the building.
20. Each of the two approved premises in Cheshire generally has a deputy manager. At the time of the man's death, owing to long term sickness, one person was covering both hostels. That person explained that, although his title was deputy manager, he was actually the person who provided operational management cover and was in essence the manager of the approved premises.
21. When residents arrive at the approved premises, they take part in an induction process in which they are required to read, agree and sign the Cheshire Probation Area 'Approved Premises Conditions of Acceptance' document. By signing the document, residents confirm that they understand the rules and agree to abide by them. Failure to comply with any of the rules

means that the resident can be returned to the court for a possible breach of their licence conditions, which could result in a return to prison. Every resident is allocated a key worker with whom the resident meets to discuss their progress, well being, participation in the activities and group work.

22. All approved premises have strict rules regarding alcohol and illegal drugs. The possession of alcohol, solvents and controlled drugs is not allowed. This is reinforced by random but regular room searches. Prescribed medication must be handed to staff for safe storage who closely monitor whether the resident takes their medication. New residents are advised about a local surgery who will accept registration to a general practitioner (GP). It is the resident's responsibility, however, to register with the practice. The information between GP and patient remains confidential and staff at the approved premises do not have access to it.
23. Cheshire Probation Trust uses the Assessment, Care and Teamwork (ACT) procedure which is designed to help staff support and monitor residents who are thought to be at risk of self-harm and suicide. ACT was introduced in 2006 and is similar but not identical to the ACCT (Assessment, Care in Custody and Teamwork) procedures used by the Prison Service. (ACCT is used in prisons to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner will be subject to regular case reviews that will direct observations/conversations to be carried out at intervals determined by their perceived level of risk. The observations continue during the day and the night.) This adapted document and procedure has been put in practice across the North West probation region, but it is not a national probation policy.

Previous deaths at the approved premises

24. There have been three previous deaths at the approved premises since the Ombudsman was given responsibility for investigating all deaths in approved premises, which was in April 2004. Two of the previous deaths were self-inflicted and the other followed a drug overdose. There are some common issues in respect of this man's death, in particular with regards to the use of the ACT procedure and notifying staff of a death at the hostel. In respect of the death at the approved premises in 2006, the Ombudsman made a number of recommendations regarding the ACT suicide and self-harm prevention policy and procedures. This included reviewing the training policy and appropriate provision of training, as well as ensuring that the training is "sufficient to equip staff to assess residents and make informed decisions".

KEY EVENTS

25. The man was born in Cheshire in June 1962 and lived in the north west before he went into prison. He was arrested following an alleged offence and appeared at a magistrates' court on 12 May 2010, when he was remanded in custody at HMP Altcourse. On 8 June, the case was committed to a crown court for trial and the man remained in custody on remand.
26. Prior to the man's arrest and imprisonment in respect of the alleged offences, he was being treated by Cheshire and Wirral Partnership Mental Health Team. They were trying to find out why he was suffering from seizures and whether they were epileptic or caused by another condition. He had been diagnosed with Dissociative Disorder and referred to a specialist organisation which helps people with complex needs, including epilepsy and learning difficulties. (Dissociative disorders are conditions that involve disruptions or breakdowns of memory, awareness, identity and/or perception.)

Previous mental health treatment and diagnosis

27. The man had attended the accident and emergency (A&E) Department on 1 May 2010, when he told staff that he was having hallucinations. He left before being examined and the hospital staff alerted the police because they were concerned that he was at risk. The police went to the man's home the following day and encouraged him to return to A&E, which he did. A senior house officer assessed him and noted that he had an eight year history of seizures. The man was recorded as saying that his life was not worth living as a result of his visions and seizures, although at that time he did not say he wanted to end his life.
28. In the man's medical notes, it is recorded that Central Macclesfield Community Mental Health Team (CMHT) confirmed that he had been diagnosed with organic delusional disorder secondary to a post-ictal state. Organic delusional disorder is a group of symptoms which collectively indicate a psychological disorder or other abnormal condition. A post-ictal state is the altered state of consciousness that a person enters after experiencing a seizure. It usually lasts between five and 30 minutes, but sometimes longer in the case of larger or more severe seizures and is characterized by drowsiness, confusion, high blood pressure, headache or migraine and other disorienting symptoms. Additionally, when a person is going through this period they can often have memory loss or other memory problems. It is during this period that the brain recovers from the trauma of the seizure. This diagnosis was made following a one-day admission to a ward, on 8 February 2010, following admission under Section 136 Mental Health Act, after he displayed "bizarre" behaviour. Staff concluded that the man's symptoms were caused by lack of sleep, seizures and by taking zopiclone, which is a drug prescribed to help sleep problems.
29. A plan was made to send the man home and stop the zopiclone prescription, replacing it with temazepam, which is a sedative medication. He was supposed to take this for three days and review its effectiveness with his

general practitioner (GP). The review completed after his death also states that there was conflicting information about the nature of the man's seizures and it was unclear whether they were caused by epilepsy or another disorder. Staff therefore decided to refer the man to the epilepsy specialist at the specialist organisation which helps people with complex needs. The man did not attend Cheshire and Wirral Mental Health services again following this assessment.

Remand to HMP Altcourse

30. A number of health concerns were identified whilst the man was at Altcourse. At his healthscreen when he first went into Altcourse, he told staff that he suffered from epilepsy and was allergic to penicillin. He said that he had been prescribed clobazam and temazepam for his epilepsy. (Clobazam belongs to a group of drugs called benzodiazepines and is used to treat seizures and anxiety. Temazepam is also a benzodiazepine and is normally prescribed to treat anxiety and sleeplessness.) Benzodiazepines are generally discouraged in prison because they are addictive and can also be easily misused. A referral was made to the prison doctor to review his medication.
31. There was also a record of injuries that he had sustained when he was arrested. They consisted of black eyes, damage to his nose, stitches to the back of his head, cuts to his hands and knees and bruising to his arms and chest. This was apparently due to him being struck by a police vehicle when he was arrested. The man said that he had never been prescribed medication for any mental health conditions and had no previous contact with the mental health services. In response to routine questions, he told staff that he had no thoughts of harming himself. He was then transferred to Furlong wing, the prison's induction unit.
32. The day after his reception into Altcourse a mental health nurse assessed the man. He told her about his problems sleeping and said he was generally worried about his health. He also explained that, contrary to what he had said the day before, he had previously been detained under the Mental Health Act for 72 hours. He said that this was because he had a seizure which left him confused. However, he denied any mental ill health. He also told the nurse that he was suffering from pain from his bruising, for which he was subsequently given ibuprofen, an anti inflammatory and painkilling medication.
33. Healthcare staff made enquiries with the man's community GP to clarify his medication. The response was received at the prison on 18 May. The surgery confirmed that he had been prescribed temazepam, co-codamol (a painkiller), and clobazam, to be taken when he thought a seizure was starting.
34. Staff interviewed the man again on 18 May, when he transferred to Beechers Unit at the prison. During this meeting, the man said that he did not feel suicidal or that he would harm himself and was aware of how to get support in the prison if he needed it. He also said that he was concerned that, eight days after coming into prison, he had still had not been given his medication for his epilepsy. An appointment was made two days later and a doctor

recorded that he was currently reviewing the man's medication. Two days after his review, he prescribed clobazam to the man. He was also prescribed paracetamol and diclofenac (painkillers and anti inflammatory drugs) for the pain he said he was having from the bruising to his chest. He also said that he was coughing up blood.

35. Healthcare staff made enquiries with a doctor at the specialist organisation which helps people with complex needs. On 11 June, the doctor told prison healthcare staff that the man's diagnosis of epilepsy was uncertain. However, he advised them to continue prescribing clobazam, unless the man was seen having a seizure. If this happened, he should then be prescribed Keppra. (Keppra is the trade name of an anti convulsant medication prescribed to stop seizures.)
36. The doctor from the specialist organisation which helps people with complex needs contacted the prison healthcare department again on 14 June. He said that a diagnosis of epilepsy was dubious and he thought the man might be suffering from "psychogenic non epileptic attack disorder" which might be part of a "conversion disorder". Before the man went into prison, he had been meant to attend the specialist organisation which helps people with complex needs for further assessment. However, the doctor there said that the man was reluctant to try different medication to clobazam because of the side effects. He said he had previously suffered from pancreatitis when he had been taking Keppra.
37. The man had asked to keep the clobazam in his possession (meaning that it would be kept in his cell) rather than have to collect it from the healthcare centre (HCC) because he said that he had previously been told that he should take it when he got an aura. (An aura is specific to each person with epilepsy and may be a smell, visual disturbance, as well as hearing and/or balance problems. It usually indicates that a seizure will follow.) As clobazam is from the family of benzodiazepines, the man was not allowed to keep it in his possession but had to ask healthcare staff for it if he felt that an aura was happening. This is the prison's policy for this type of medication because of its potential for misuse.
38. The doctor from the specialist organisation advised that, whilst he was in prison, the man should be prescribed Keppra but should not be allowed to have the clobazam in his possession. The man was not happy about this and made a complaint. A doctor from Altcourse subsequently suggested a referral to an outside hospital neurology department to the man, but he refused to go to the appointment.
39. On 25 July, the man told staff that he had not had his medication for two nights and said he had started to have hallucinations. Later that day, staff from the unit said that he had been vomiting and having hallucinations. He was given his medication and a further appointment was made for him to see the doctor, which the man failed to attend.

40. The man failed to attend various appointments over the next few weeks. The medical records show that he had disagreed with a prison doctor over his epilepsy medication and would not attend appointments with him. However, he went to see a further prison doctor on 13 August. He told him that he was frequently experiencing auras and still wanted to keep his clobazam in his cell. He was again told that this was not possible because of the restrictions on having benzodiazepines on the wing. However, at that appointment, the man agreed to being referred to an outside hospital neurology department. The prison doctor subsequently made a referral to outside hospital on 13 August. However, the man failed to attend further appointments with the doctor on 10 and 13 September. My investigator made enquiries but no reasons were given.
41. The man was not considered at risk of suicide or self-harm whilst he was at Altcourse. Therefore staff did not put in place monitoring under the ACCT suicide prevention and self-harm management procedures.
42. The man was due to attend a crown court on 15 September for a bail hearing. Prior to this, the Bail Information Officer at Altcourse interviewed him in respect of his application for bail. The Bail Information Officer was interviewed by my investigators. She said that she had completed bail and legal service training. She used a North West Approved Premises Referral Form – Bail Cases. The form was not dated and so it is not clear exactly when the assessment was made. The form asks about the prisoner's physical and mental health, alleged offences, accommodation, education, drug and alcohol misuse, lifestyle and associates, thinking and behaviour and attitudes. There are four questions relating to risk information. These ask if the offender has assaulted or threatened others, been violent to a member of his family, committed a serious offence whilst on bail and whether they have displayed obsessive behaviour. The information is then used to make a risk assessment, which is subsequently used to help the court decide whether bail into the community should be allowed.
43. The information contained in the man's assessment is brief. The Bail Information Officer explained that little was known about him, as he had no recent involvement with the Prison or Probation Services. She added that gaining information regarding a prisoner's health was historically very difficult because of medical confidentiality policies. The Bail Information Officer said that when a prisoner has not yet been convicted there is little information from previous risk assessments, so the information that she obtained was from the man himself.
44. The Bail Information Officer also explained that most of the assessments she made were of convicted prisoners who were coming to the end of their sentence. She said, she had only completed two assessments on people on bail, including that of this man's, in the whole of the year. After completing the assessment, she telephoned the approved premises to see if they had a bed and could take the man. My investigator asked her what forms or information the hostel staff normally required at this stage. She replied that they normally ask for the name and age of the referee and information about the alleged

offence. The deputy manager told my investigator that he agreed that the man could go to the approved premises, based on the information given by the Bail Information Officer. However he did not ask for a risk screen to be completed.

45. Subsequently, on 15 September, the man's bail application was granted and he was released from Altcourse, on conditional bail, and told to report to the approved premises. The conditions of his bail licence were that he should reside at the approved premises and was not to contact any of the prosecution witnesses, or enter the area of Macclesfield and he should abide by the rules of the approved premises.

Residence at the approved premises

46. The man arrived at the approved premises at 10.57pm and staff noted in the log that he staggered up the steps. The supervisor explained that he looked as though he had been drinking alcohol but, when he came into the hostel, she was not sure. The man told her that he had not eaten all day and had been lost since he left court. She did not interview him at the time but gave him a meal and showed him to his room. He was given a double room at this time because it was empty. Staff noted in the log that the man told them he had epilepsy.
47. The following day, a relief supervisor completed the man's induction with him. He signed the rules, regulations and other disclaimers relating to his stay and staff helped him try to process his benefits claim. The relief supervisor made an appointment with the local doctor's surgery because he said that he did not have any epilepsy medication. At his induction, the man told the relief supervisor that, despite never having harmed himself previously, he felt very low and wanted to end his life, although he did not tell her how he planned to do so. He also explained that he had been diagnosed with disassociative disorder which could cause him to forget where he lived. He said that he should not go out alone because he could get lost, particularly as he was living in a new area. The relief supervisor advised him to discuss his feelings of depression with the doctor at his appointment.
48. At interview, the relief supervisor explained that because the man had told her that he might end his life, in line with the normal approved premises procedure she subsequently reported this to a full-time member of staff who was a Probation Service Officer. She told my investigator that after discussing what the man had said about ending his life, she telephoned the deputy manager of the approved premises.
49. At the time of the telephone call the deputy manager was at the other Cheshire approved premises. He explained that due to staffing shortages he was managing the two premises. The deputy manager said that he discussed the man with the Probation Service Officer and "the consensus is we are not concerned enough to open a [ACT] concern form". He made the point that this was the view of several staff. He said that he was relying on the staff at the approved premises to decide whether to open a concern form because

they were with the man at the time and he believed that they were in the best place to make that decision. The deputy manager said that the plan was to wait for the outcome of the doctor's appointment and subsequently "keep an eye" on the situation.

50. My investigator asked where the decision making process whether to open a concern form would be recorded. The deputy manager replied "It doesn't look like I recorded that process at all". He clarified that it should have been recorded on the man's resident's log.
51. My investigator asked staff what training they had on the suicide prevention and self-harm management process. The deputy manager explained that he was the only person at the approved premises who had been trained as an ACT assessor. The full-time member of staff who had informed the deputy manager earlier that the man had said he might end his life and who is also a Probation Service Officer, had received the basic ACT training, which teaches how and when to open a concern form and the subsequent ACT procedure.
52. The relief supervisor explained to my investigator that as she was a relief supervisor, she had only had a short, one to one, training with the deputy manager and had not undertaken the full training. She also said that the short training which she had undertaken had been about the old procedure and not the one that was now in place. She felt that it would have been useful to have completed the full training. Both she and the Probation Service Officer said that, if they were in a similar situation now, they would complete an ACT concern form and then pass it to the manager for consideration.
53. The man attended his GP appointment on 16 September. He was only prescribed one clobazam tablet because the doctor wanted to verify his condition with the man's previous GP. He was asked to return the following day to collect further medication once it had been verified. When he returned he was given three more tablets.
54. It is the approved premises's policy to take all medication from the residents and keep it in a locked cabinet. My investigator was told that although there was a new policy which said residents should keep their own medication as long as there are no risks, they had not yet changed their procedures. However, they were looking to change the procedure imminently. At the time of this investigation my investigator was told that the residents tell staff when they require their medication. It is then dispensed privately in a small treatment room. On 20 September, the man was prescribed ten tablets of clobazam 10mg, one to be taken at night for his epilepsy. He was also prescribed Lansoprazole tablets, for stomach upsets which can be caused by clobazam. He gave the tablets to staff, as per the policy at that time
55. The following day, 21 September, the man was moved from room 18a to room 15. He was not happy about the move and asked to move to a different room because he said that he could not breathe in room 15 and felt that the walls "were closing in" on him. Staff explained the next day, 22 September, that he would not be allowed to change room again. He complained about his room

again on 24 September, saying that there was a funny smell. He later decided to wash the curtains in the laundry room which may have been an attempt to get rid of the smell he was experiencing.

56. My investigator asked the deputy manager why the man had been asked to change rooms. He explained that room 18a was a double room and was the only one available when the man arrived. He said that the man had asked to move from that room on 21 September as he did not like being in the double room because of its large size. He wanted to move away from the open landing area outside his room into a quieter part of the hostel. He was then given room 15 because all the other single rooms in the hostel were occupied. He could not move again because all the rooms were occupied, including the double room that he had previously lived in.
57. The contact log indicates that later the same evening, the man told a female member of staff that he felt very low and isolated and did not have anyone to talk to. One of the rules at the approved premises is that residents should not go into each other's rooms. The man had been told to leave another resident's room around the same time as this record was noted in the contact log. The record states that he was reassured that he could talk to any member of staff if he needed to and particularly if he felt in a low mood. The man said that he did not feel comfortable talking to male staff and had not discussed his feelings with his keyworker or the GP because they were men. It is noted that he felt more settled after their conversation.
58. On 25 September, the man spent much of the day in his room, but later joined other residents and went out for the evening, after having his dinner. He asked for his clobazam medication at 11.45pm, as he said he was experiencing an aura. He was told that he had already been given his daily tablet and the record indicates that this was at 4.30pm. Similar concerns were raised by the man to those he had mentioned at Altcourse. He said that he had been told previously by a doctor that he should take a clobazam tablet when he started to experience an aura. Nevertheless, there are a number of occasions in prison and at the approved premises when a doctor instructed that he should not have clobazam in his possession and should take one tablet at night. The man was advised to discuss the medication issue with the doctor. As he was worried that the GP would not listen to his concerns, in order to reassure him, he was told that a staff member would accompany him to an appointment.
59. The following night, the man asked for his clobazam at 12.45am and then went up to his room. When a member of staff was making the security checks a little later, he noticed the man in the games room. Staff asked him to go to his room because the doors had to be locked but the man was described as staring blankly as if he did not understand. The staff member noted that the man seemed really confused and he saw him on the security camera trying to get into his old room (Room 18a). The staff member went upstairs and helped him into his own room. The man sat on his bed staring at the walls but thought that he seemed okay after about three minutes and so left him alone.

Later, the staff member went back up to the man's room to check on him and noted in the log that he was "asleep and breathing normal and steady".

60. The man did not go out the next day but, after the evening meal, said he was going to meet his girlfriend. He returned to the approved premises at 11.27pm, smelling strongly of alcohol and saying that he wanted to return to prison. Despite staff trying to reassure the man, he remained adamant that he wanted to return, saying that he felt isolated, the hostel was more oppressive than prison and he was being treated as a sex offender by the locals. The night worker tried to reassure the man and reiterated that a staff member would go with him to his doctor's appointment the next day.
61. The Probation Service Officer talked to the man the following morning and he referred to feeling very low over the weekend. He told her that he was worried about a number of things, including a custodial sentence and his grandchildren. He was also worried about his medication and believed that doctors were not listening to him or prescribing the right medication for his epilepsy. The doctor would not give him anti depressant medication because it could be harmful if taken at the same time as his clobazam.
62. The Probation Service Officer later went to see the doctor with the man. The doctor told her that he could not prescribe anti depressants because of the man's limited time at the approved premises. Instead, the doctor told the man that he might benefit from cognitive behavioural therapy (CBT). (CBT is a type of talking/counselling therapy.) The Probation Service Officer said that the doctor had assessed the man and concluded that he was not currently suicidal. However, the contact log outlines that his mood did not improve after the appointment. No consideration was given to opening the ACT procedure but staff continued to spend time with the man.
63. The day before his death, the man went fishing with another resident and also went to see his solicitor. He spent the afternoon at the approved premises and again raised his concerns with staff about his epilepsy medication and that he felt the doctor did not recognise his diagnosis.
64. At 4.00pm, the man went to the Probation Service Officer to collect his medication (clobazam). He had been given seven tablets by the local pharmacist that morning. However, when the Probation Service Officer gave the man one of the tablets he said that it looked different from those he had previously been taking. The Probation Service Officer said that she did not think the pharmacist would be wrong and that sometimes medication looked different because it was made by a different company. The medication was in a blister pack, in a box with the man's name on it and he eventually took one tablet
65. One of the residents at the hostel told my investigator that after this, the man approached him and was panicking about the tablet he had taken, saying that it was the wrong medication. The resident described the man, "his eyes were closing; his face had drained, massively drained to what he's normally like. He just looked half the person". Other residents reported him as spilling his

tea over himself and being very drowsy. The resident said that he then went with the man to the chemist and spoke to the manager who agreed to find out what had happened.

66. In interview, the Probation Service Officer said that during the afternoon the pharmacist's assistant went to the approved premises to ask for the man's medication. Staff gave it to her and she took it back to the pharmacy. Within minutes she had returned to say that it was incorrect. She told the staff that the pharmacist had said that there would not be any "huge side effects" and the medication had now been corrected.
67. My investigator obtained copies of the pharmacist's statement to the police about giving the wrong medication. The statement informs that the man had been given clonazepam instead of clobazam. (Clonazepam is also a benzodiazepine and is used to reduce anxiety.) The report states that the side effects would be "dizziness, light headedness, drowsiness and general groggy symptoms". The pharmacist said that the effects of the medication would be out of his system by Thursday morning at the latest. The pharmacist also mentioned that the man had spoken to him the day before about keeping his medication in his own possession but the pharmacist told him that he had no authority over the approved premises rules.
68. Later that night at around 9.30pm, residents told staff that the man seemed to lose balance and fall to the floor in the kitchen. He seemed unsteady on his feet but told staff that he had drunk some alcohol earlier. Staff took him to his room after making him a cup of tea and they checked on him 20 minutes later, to find him asleep. My investigators asked staff about the policy relating to residents consuming alcohol. A staff member explained that:

"... although part of the hostel rules are that residents must submit to regular alcohol and drug testing, it is only on those people who have identifiable drug and alcohol issues. Although we're always monitoring people's behaviour so if for example, somebody started to come in every evening and they were clearly intoxicated. Then we may well ask them to submit to a test."

The day of the man's death

69. It was recorded that the following morning the man was hard to rouse from sleep and when he woke up he "didn't appear with it at all". Staff later helped him with his benefits claim, which the contact log confirmed had been an ongoing problem since his arrival at the approved premises which was another stress factor for the man.
70. At 4.48pm, a supervisor at the approved premises noticed the man struggling to remember the code for the door. This was something that other staff mentioned throughout the man's time at the hostel. She went to help him and he said he was okay. He then went either upstairs to his room or for his dinner but at that time the supervisor was not sure which. Later, at around 5.15pm, the supervisor received a telephone call from the cook to say that the

man had not collected his meal. She asked the cook to save a meal for him and, after discussion with her colleagues, they decided that someone should go and check in the man's room to tell him that his dinner had been saved.

71. The Probation Service Officer went to the man's room 25 minutes later at 5.40pm. She knocked on his door but did not get a reply. She then opened his door and noticed him sitting on the floor with his back to the radiator. At first, because of his medical history, she thought that he might have had a seizure. However, within seconds, she noticed that he had a belt round his neck which was attached to the window. She later realised that he had put one of the holes in the belt over the window fastener strut.
72. The man's face was a blue colour, his body was very pale and his eyes were half open and so the Probation Service Officer thought that he was still alive. She said that he was still warm to touch but he did not respond to her and so she immediately tried to work out how she could release him. She realised that she could not do this on her own and considered using her personal alarm to get help. She decided that it was not appropriate to use her personal alarm because the other two staff members were in different places in the building. She told the investigator that "... if I press my alarm now it's going to be chaos downstairs they are not even both in the general office to talk to each other".
73. The Probation Service Officer rushed downstairs to the office, which she described as taking a few minutes, told the supervisor what had happened and asked for an ambulance to be called. She rushed back upstairs and the other member of staff on duty went to the man's room. The Probation Service Officer said that it took a very short space of time to come down to the office and get back to the man's room but she could not be more specific. Although my investigators were told that there was an anti-ligature knife on the premises, the Probation Service Officer did not take it with her. She told my investigator that she did not know where it was and did not think she had been told how to use one, even though she had recently completed ACT training.
74. Together, the Probation Service Officer and the staff member who was also on duty managed to lift the man off the window strut and laid him on the floor but the belt was still around his neck. The Probation Service Officer went to check with the supervisor, who was still in the office downstairs, whether the ambulance was on its way. The ambulance control was on the telephone line and asked to speak to the Probation Service Officer. They asked her if she was first aid trained and she explained that she had been but her qualification ran out in July and she was due to go on refresher training.
75. A staff member told my investigator that he had not had first aid training since 2005 because of a personal medical condition. My investigator asked him if he had completed any cardio pulmonary resuscitation (CPR) training and he said that he had not.

76. Ambulance control told the Probation Service Officer to go back to the man and gave her instructions, which she wrote down. She then went back to the man's room and saw that a member of staff had removed the belt from the man's neck. (In her police statement made soon after the incident she said that she "could not remember whether the belt was still around [the man's] neck or not".) The Probation Service Officer said that she thought her colleague was hyperventilating as he had previously had experience in a similar situation and she was worried about his health. In her police statement she said that her colleague said, "There was no point because he had gone", meaning that he thought that the man was already dead. However, she told my investigator that although her first aid training had run out she felt she had to do "something". She then started to give chest compressions on the man. She managed about ten, then gave him some rescue breaths, using a mouth guard that was kept on the key chain. By then she had given two or three breaths the first ambulance responder arrived at the scene. The paramedics then took over and very quickly said that the man had died.
77. After the paramedics took over, senior managers arrived at the approved premises, as did the police. The Probation Service Officer said that the hostel was full of people and she did not consider that she had the opportunity to be somewhere quiet to collect her thoughts. Managers called the residents into the lounge and explained what had happened. They were told that they could talk to the Samaritans or staff if they needed support. The deputy manager said that he later produced a letter to the residents with information about contacting the Samaritans and, with the permission of the man's next of kin, gave information about attending his funeral. Some residents did not feel that they were supported or helped to attend and, although they originally wanted to be there, they decided not to go.
78. One of the residents said that although they had been given the details of the Samaritans, it would be difficult to make a personal call because the telephone box was in a public place at the hostel. If residents needed to make personal calls they used the office telephone, where staff would be present.
79. A family liaison officer was appointed and she visited the man's next of kin, who was listed as his ex-girlfriend. She also visited the man's daughter and dealt with both parties as next of kin and started a log about the contacts.
80. Staff told my investigator that although there are two way radios at the approved premises, they are not generally used because they are large and cumbersome and often do not work properly. My investigator asked the deputy manager whether staff had anti-ligature knives, although one was not used on this occasion. The deputy manager said that there was an anti-ligature knife in the general office. However, having discussed it with staff, they did not all seem to be clear about where it was kept or when and how to use it should it become necessary.

81. The staff interviewed by my investigators who were on duty the night of the man's death said they felt supported by Cheshire Probation management. My investigator asked how the staff who were not on duty were told of the man's death. The duty manager said that he had made some calls himself and then asked the administrator to telephone the others. He was asked if the administrator was trained to notice and support people if they were upset or shocked and he said that he did not think that they would need specific training.
82. My investigator asked the deputy manager if the hostel had offered to pay towards the funeral costs and whether they were going to provide a plaque or some kind of memorial for the man, as stated in the approved premises Manual. He explained that would be a matter for his line managers but this had not been done after previous deaths at the hostel and had not been considered in this case.

ISSUES

Assessment, Care and Teamwork (ACT) suicide and self-harm monitoring process

83. The ACT policy used by Cheshire Probation Trust states that “an ACT should be opened if someone states intent to harm themselves or to take their life”. The man had told staff that he would harm himself during his induction, although he did not said how or when he might carry this out. Following this disclosure, staff sought advice from the deputy manager about whether to open the ACT support and monitoring procedures but it was decided that it was not appropriate at that stage. The discussion regarding the decision not to open an ACT was not recorded.
84. In my view, staff seemed to be reluctant to open a concern form, which would have facilitated this recording of the decision making process and may have triggered further reviews. Whilst full-time staff have had ACT training, some relief staff have still not attended the full training. The only person trained as an ACT assessor is the manager of the approved premises. He is not always on site and cannot always immediately attend the approved premises because of other duties. I appreciate that he had not met the man and did not have the advantage of a face to face conversation with him. Nevertheless, as the senior member of staff and the only one with up to date ACT training, I would have expected greater leadership and caution to be exercised. The decision not to open a concern form was made after a discussion with the deputy manager over the telephone. The ACT assessor was not able to personally assess the man.
85. In 2006, my predecessor made several recommendations to the then Cheshire Probation Area (now the Trust), including the need to review the ACT procedure and make sure that staff were sufficiently trained to make appropriate assessments. Whilst I am aware that the procedure has been reviewed and amended and that most staff have been trained, I am concerned that staff at the approved premises missed a number of opportunities to start the ACT process and open a concern form in respect of the man. I am also concerned that at least one member of the relief staff only had a short one to one training session with the hostel’s deputy manager, especially as Cheshire Probation undertook to train every staff member whether permanent or relief. I am disappointed that I must reiterate the recommendation made in 2006. I have slightly recast it here.

The Chief Executive of Cheshire Probation Trust should review the ACT training policy to ensure that sufficient staff are trained as ACT assessors and able to make informed decisions when a manager is not available. He should also satisfy himself that staff are not reticent to use the procedure and feel confident and supported to open a concern form at the earliest opportunity, whenever there is a risk of self-harm.

Referral to approved premises process for people who are on bail

86. As the man was unconvicted and had no recent offending history, little was known about him and there was no OASys assessment. Used as part of sentence planning, the Offender Risk Assessment System (OASys) is a two part risk assessment tool. One part considers dynamic risk and asks about the offenders accommodation, relationships, financial position, family relationships, education, physical health and life skills. Another part concerns the risk of harm the offender poses to others, to property and to themselves. If the offender is deemed to be a high risk of harm to others this should be completed by a qualified probation officer. If it is low then it can be completed by a Probation Service Officer but anyone completing an OASYS should have completed OASYS training. This risk assessment tool is intended to provide a rigorous assessment of a prisoner's needs and risk of harm and is completed on those who have pleaded guilty to their offences at pre sentence report stage and if not then, when they have been sentenced. On sentenced offenders, or at pre sentence report stage it is completed by the offender manager, either in the probation or the prison service. It provides sharing of data and operational information between the Probation Service and Prison Service IT systems so that updated offender information can be accessed securely by either organisation.
87. Whilst a referral form was completed by the Bail Information Officer at Altcourse, which asks similar questions to the OASys part one above, it does not include the OASYS risk of serious harm (ROSH) screening. There also appears to be an over reliance on the information that the man provided. Probation Circular 37/2005 states the information to be provided to an approved premises at the point of referral, which includes completion of the OASys ROSH screening as a minimum. This should be mandatory in all cases. The Approved Premises Manual 2011 states:
- “For defendants on bail the referring officer should, prior to admission, provide the AP with:
- A full OASys risk assessment if available, and as a minimum an OASys risk of harm screening assessment
 - An indication from the court of the purpose of the placement, the likely length of stay, the intended move-on plan, and the assessments/interventions that AP staff are expected to undertake during the bail period
 - Any other relevant information (eg about risk of self-harm) that may be necessary to enable AP staff to support, supervise and manage the resident.)”
88. When the man was bailed to the approved premises there was no forwarding healthcare information about his referral to an outside hospital's neurology department, nor any other clinical information or his current prescribed medication. In the absence of an offender manager there was no OASYS and although the policy states that a risk of harm screening assessment should be completed as a minimum, on defendants on bail, it is not clear who should

complete this assessment and one was never completed. I am aware of the confidentiality surrounding clinical information, however, where there are risks associated with clinical information these should be clarified on referral to an approved premises. At this stage it would have been beneficial for the bail officer to have asked the man about medical disclosure in the absence of an offender manager, so that up to date information could be made available to the approved premises staff. Indeed the bail referral officer herself thought this would be helpful and would reduce risk, in particular the risk of self harm to the man.

89. Cheshire Probation Trust said that people arrive from prison on a Friday afternoon, without any information about their medical needs and medication. They are then unable to make arrangements with the local doctor and often the medication cannot be obtained until after the weekend. I think that the referrals system for people on bail who do not yet have an offender manager needs to be more robust. In all referrals from prison, irrespective of the person's status (whether on bail or convicted), full information regarding risk of harm and any physical and mental health issues and details of their medication should be provided to ensure consistency of care upon release to an approved premises.

The National Offender Management Service, the Chief Executive of Cheshire Probation Trust and the Director of HMP Altcourse should review and clarify the policy and guidance on referring people on bail to approved premises. They should clarify the qualifications and training of the person who completes the assessment and when it should be completed and ensure that it informs any decision relating to acceptance to an approved premises. Staff should seek information from other relevant bodies, including healthcare so that a comprehensive risk assessment can be made in the absence of an allocated offender manager.

First aid training

90. Although the relief supervisor had an up to date first aid certificate, the two members of staff who attended to the man did not. The Probation Service Officer had attended training but her certificate had expired at the point when she treated the man. The other staff member said that he had not completed first aid training because of a medical complaint.
91. Probation Circular PC2006-35, entitled "Preventing Deaths of Approved Premises Residents" considers the issue of first aid. Paragraph 17 says:

"Both PPO [Prisons and Probation Ombudsman] reports and correspondence from coroners following inquests have highlighted the importance of staff having appropriate and up to date first aid skills. Probation areas should refer to the Health and Safety Risk Assessment

“Approved Premises Management Guidance” which has been circulated to Areas and is also available on EPIC. This states that “all supervisory staff must be trained, as a minimum, in basic first aid including CPR”.

In this particular instance, at least one person on duty had such training and the approved premises therefore complied with these requirements. However, it is a matter of concern that the certificate of one member of staff had expired, especially as the other staff member was precluded from carrying out first aid for medical reasons.

The Chief Executive of Cheshire Probation Trust and the deputy manager of the approved premises should ensure that all relevant staff have up to date first aid training, or at the very least CPR training.

Mobile telephone/radios

92. When staff discovered the man hanging, the emergency services could only be called when the member of staff returned to the main office. The emergency services control room staff wanted to talk directly to the staff who were carrying out CPR but could not do so because it was happening elsewhere in the premises.
93. I am aware that radios are available at the approved premises. However, they are not routinely used because staff say they are large and cumbersome, the reception is poor, they do not trust them to work properly and cannot hear clearly what is being said . The approved premises policy states that they should be tested daily but this seems not to be current practice.
94. Probation Circular 35/2006 clearly states:

“Summoning assistance immediately on discovery of an incident may be critical to avoiding fatalities. Approved premises managers should ensure staff carry personal alarms and other safety equipment such as radios at all times. Mobile phones should be made available and carried by staff patrolling the premises so that they can summon assistance from the emergency services immediately in the event of an incident”.

The deputy manager of the approved premises should ensure that either a mobile telephone or a reliable radio system is available and regularly used when staff check rooms. This should be checked every day to ensure that it is in good working order.

Anti-ligature knives

95. I understand that there is one anti-ligature knife at the approved premises but staff did not use it when they found the man. They were unsure where it was located and the person who found the man said that she did not know that there was one, nor would she know how to use it in an emergency. My investigators were told by the deputy manager that it was kept in the main office. Further, after each use of this equipment the blade should be

replaced, I was not assured that this was current practice or that equipment was regularly checked.

The deputy manager of the approved premises should ensure that staff are trained in the use of the anti-ligature knife and remind all staff, including relief staff, of the procedures when a fatal incident occurs.

Support for staff and residents

96. One resident told my investigator that although the Samaritans was suggested as a source of support, it would be very difficult for him to make a private call because the hostel phone was in a very public place. He suggested that they have a mobile telephone, specifically for use to talk to the Samaritans, similar to that used in prisons.

The Chief Executive of Cheshire Probation Trust should consider ways of providing residents with confidential access to the Samaritans.

97. The deputy manager told my investigators that whilst he had made some calls to inform off duty staff about the man's death, he had asked the administrator to inform the others. Whilst there is no criticism directed at the administrator, I believe that the senior management team or at least the deputy manager should take on this role. This would give a reassurance to those staff that managers respect the difficulty in hearing such news and the potential impact. It would also remove the burden on an untrained member of staff of dealing with the potential distress of their peers. A recommendation following a previous death at the approved premises in 2005, related to the manner in which off-duty staff were told.

The deputy manager of the approved premises should ensure that in the event of a death, a manager or another person with appropriate authority informs off duty staff.

Funeral arrangements

98. I understand that no one attended to represent the residents at the man's funeral. Some residents who were interviewed said that they wanted to attend the funeral or send a card or flowers but they felt this was not facilitated. However, my investigator was advised by staff that residents were told of the arrangements and that the family were amenable to their attendance, but those who initially indicated they would attend decided not to.

Family issues not covered in the report

99. The man's family asked why he was allowed to have a belt when he had told them that he felt like taking his life. There are fewer restrictions in a hostel about the property which residents can have in their possession compared with when they are in prison. Nevertheless my investigator asked the deputy manager why the man was able to have a belt in his possession. The deputy manager replied as follows:

“The answer to this question relates to the fact that although [the man] did mention at Induction (to the relief supervisor) that he was feeling suicidal and this was then passed on to me, I consulted with the [Probation Service Officer] about the situation with the result that we did not assess that it was necessary to invoke the ACT procedures.

“The decision not to initiate the ACT procedures meant that an Immediate Action Plan was not drawn up - this would have been the mechanism whereby the need to remove items with potential for use to commit suicide would have been identified - i.e. requesting that the resident at risk hand in such items as boot laces or belts.”

100. If the ACT process had been instigated, the man's belt and shoelaces may have been taken off him. However, in the more open nature of a hostel, I believe that he would still have had the opportunity to find other means of taking his life or he could have borrowed such items from other residents. I am therefore satisfied that, although the man had access to his own belt, it is unlikely that the outcome would have been different had he not been allowed to keep it on this occasion.

CONCLUSION

101. At the time of his arrest and remand on bail, the man had several health problems. They were not fully investigated or diagnosed, largely because of the lack in continuity in his healthcare. When he went to Altcourse he was unable to attend his previously arranged appointment at the specialist organisation which helps people with complex needs and when he went to the approved premises, the appointment at an outside hospital's neurology department did not take place. It is fair to say that the man was not always cooperative in attending medical appointments.
102. When he arrived at the approved premises, the man told staff that he wanted to end his life. Crucially and tragically, staff took the decision not to put in place support the ACT suicide and self-harm monitoring procedures. I am careful not to use the benefit of hindsight in my investigations but it is difficult to imagine many circumstances which would have justified it more clearly. The reasons for this decision were not documented. He was initially advised to discuss his feelings at a routine appointment that had been made with his GP. The man repeated his thoughts of harming himself on more than one occasion but no further consideration was given to reducing the risk that he would harm himself.
103. I believe that it is possible that the outcome might have been different if there had been continuity of treatment by health professionals in prison and the community. The outcome might also have been different if staff at the approved premises had put the ACT procedures in place and monitored the man under their suicide prevention procedures. There were opportunities to do so, but staff clearly felt insufficiently trained or confident to take such steps. Instead we have a sad story of a man who seems to have fallen through gaps in provision and, in the absence of support, succeeded in taking his own life.

RECOMMENDATIONS

The Chief Executive of Cheshire Probation Trust provided a comprehensive response to the recommendations, which are summarised below.

1. The Chief Executive of Cheshire Probation Trust should review the ACT training policy to ensure that sufficient staff are trained as ACT assessors and able to make informed decisions when a manager is not available. He should also satisfy himself that staff are not reticent to use the procedure and feel confident and supported to open a concern form at the earliest opportunity, whenever there is a risk of self harm.

Accepted – The Chief Executive of Cheshire Probation Trust said that “since the death of the man, all approved premises staff have had the ACT procedures revisited in individual supervision sessions, in addition to time devoted to the subject at team meetings. It has been clarified with staff that risk concern forms must be completed wherever there is an identified concern. The Area manager with responsibility for approved premises has been working directly with the Deputy Manager to ensure that the understanding and the systems are robust.”

2. The National Offender Management Service, the Chief Executive of Cheshire Probation Trust and the Director of HMP Altcourse should review and clarify the policy and guidance on referring people on bail to approved premises. They should clarify the qualifications and training of the person who completes the assessment and when it should be completed and ensure that it informs any decision relating to acceptance to an approved premises. Staff should seek information from other relevant bodies, including healthcare so that a comprehensive risk assessment can be made in the absence of an allocated offender manager.

Accepted – This recommendation will be taken forward by the National Offender Management Service (NOMS). As NOMS is the managing body of Cheshire Probation Trust and HMP Altcourse the recommendation will not apply directly to them.

3. The Chief Executive of Cheshire Probation Trust and the deputy manager of the approved premises should ensure that all relevant staff have up to date first aid training, or at the very least CPR training.

Accepted – The Chief Executive of Cheshire Probation Trust confirmed that the staff member attended a first aid training course in November 2010 and was awarded a full certificate. It was also confirmed that all approved premises staff now have up to date first aid training and that the process for tracking and notifying staff with regard to forthcoming training has been strengthened.

4. The deputy manager of the approved premises should ensure that either a mobile telephone or reliable radio system is available and regularly used when staff check rooms. This should be checked every day to ensure that it is in good working order.

Accepted – Cheshire probation Trust discontinued the use of radios soon after the time of the man’s death. A new mobile telephone system was launched on 14 December 2010. The system is fully operational, organisational procedures have been amended to reflect the change and the need to undertake daily checks. The Deputy Manager undertakes spot checks to ensure that staff are consistently complying with the new procedure.

5. The deputy manager of the approved premises should ensure that staff are trained in the use of the anti-ligature knife and remind all staff, including relief staff, of the procedures when a fatal incident occurs.

Accepted – The Deputy Manager of the approved premises conducted two post incident staff briefings. The first took place on 1 October 2010 and the second on 25 November 2010. This included revisiting fatal incident procedures and a reminder of where the anti ligature knife is located. Cheshire Probation Trust’s Health and Safety Officer has been instructed to research anti ligature kits and the training package that accompanies them. New procedures in the event of a fatal incident will be launched with anti ligature kit training.

6. The Chief Executive of Cheshire Probation Trust should consider ways of providing residents with confidential access to the Samaritans.

Accepted – Cheshire Probation Trust recognises this as a gap and is currently looking at the feasibility of a number of options to ensure that this gap is addressed. A system will be identified and in place by August 2011.

7. The deputy manager of the approved premises should ensure that in the event of a death, a manager or another person with appropriate authority informs off duty staff.

Not Accepted – Although the Deputy Manager of the approved premises said in interview that the administrative officer had contacted some staff about the death of the man, it seems there was some confusion. The Chief Executive of Cheshire Probation Trust explained that the task of notifying relief staff was delegated to the Deputy Manager of the approved premises and he subsequently contacted those staff who had previously had contact with the man. As he had only been resident at the approved premises for approximately two weeks, the majority of relief staff had not had any contact with him. The administrator did not notify any staff of the death of the man.

Please note recommendation 8, (in the draft report), which referred to financial assistance to the man’s family for funeral arrangements, has been withdrawn. The recommendation was made on the basis of the 2011 Approved Premises Manual, which only came into effect in April 2011. There was no provision for approved premises to contribute towards funeral expense prior to this date.