Investigation into the circumstances surrounding the death of a man while a resident at an approved premises in April 2011

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

Ashley House, 2 Monck Street, London SW1P 2BQ Tel: 020 7035 2876 Fax: 020 7035 2012

This is a report into the circumstances surrounding the death of a man while he was a resident at an approved premises in the West Midlands. He had been found hanging on open land in April 2011. He had previously failed to return to the approved premises before his curfew on 14 April. He was 36 years old at the time of his death. I offer my sincere condolences to his family and all those who knew him.

The investigation was conducted by a Senior Investigator. He was assisted by an Assistant Ombudsman. The staff at Staffordshire and West Midlands Probation Trust co-operated fully with my investigation. I am sorry that the report has been delayed.

The man was released from HMP Hewell on 8 April 2011. As part of his licence conditions, he was required to live in an approved premises. He lived there without incident for six days, although he did mention to a member of staff that he felt anxious and was finding it difficult to adjust to life outside prison. On the night of 14 April, he did not return to the approved premises, and his licence was revoked. His body was found a few days later.

The investigation has carefully considered the adequacy of the assessments conducted by staff from Staffordshire and West Midlands Probation Trust of the man's risk to himself. Although these came to different conclusions, each appears to have been appropriate given the information available at the time and no fault is found with staff. There has also been careful scrutiny of the possible confusion the man felt with regard to his curfew times. It is evident that these times were explained to him, but the written instructions could have been clearer and I make one recommendation to ensure clarify in future. However, the investigation does not link this to the man's tragic 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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2012**

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SUMMARY

1. On 17 January 2008, the man was convicted of wounding and endangering life at a crown court. He was sentenced to five and a half years in prison. His release date was 8 April 2011.

2. In March 2011, the man's Offender Manager began to make preparations for his release. Because of the risk that the man presented and the fact that he would have nowhere to live upon release, a decision was made that he would be required to reside in Approved Premises (operated by the Probation Service to provide additional monitoring for and restrictions on certain offenders). This was agreed on 21 March.

3. The Offender Manager completed a pre-release assessment of the man. Part of this assessment concerned the risk of self-harm and suicide. Based on the evidence available to him at the time of the assessment, the Offender Manager indicated that the level of such risk was low.

4. The man was released on 8 April. He attended an appointment with an offender manager who explained his licence conditions and the likely result that he would be returned to prison if he failed to comply. The man then went to the approved premises, and attended an induction with the Deputy Manager. The Deputy Manager explained that whilst the man's normal curfew time (that stated on his licence) was 9.00pm, he would have to be at the hostel by 7.00pm each evening for the first week of his stay.

5. The Deputy Manager completed a risk assessment of the man and, based on his presentation and the information available, indicated that his risk of self-harm was medium.

6. On 14 April, the man told the offender manager that he felt anxious and was finding it difficult adjusting to life outside prison. Although the offender manager reported that the man was in "good spirits", she said she would try to arrange counselling for him. She reported her meeting with the man to a member of staff at the approved premises.

7. Later that evening, the man failed to return to the approved premises. He made two telephone calls to the hostel and was advised to return as soon as he could. When he still did not return, his licence was revoked.

8. Probation staff did not have any contact with the man on 15 April. Shortly thereafter, he was found hanging on open land in an area of Birmingham

9. Issues around risk assessments and curfew times were investigated. This resulted in one recommendation.

THE INVESTIGATION PROCESS

10. A senior investigator and Assistant Ombudsman were appointed to conduct the investigation. Notices of the investigation were sent to Staffordshire and West Midlands Probation Trust for distribution and display, giving staff and other residents of the approved premises the opportunity to contact the investigator with any relevant information.

11. On 19 April 2011, the investigator spoke to the manager of the approved premises about the man and the circumstances of his death. The investigator also made arrangements to obtain a copy of the paperwork held by Staffordshire and West Midlands Probation Trust about the man.

12. One of the Ombudsman's Family Liaison Officers spoke to the man's nominated next of kin, his ex-partner, on 27 May. She provided information which has proved useful in completing this investigation, specifically relating to events after the man left the approved premises. She was concerned that he was confused about his curfew times on the evening that he did not return to the approved premises. We would like to thank her for her cooperation, and extend our sympathies to her and her daughter for their loss. The issue of curfew times has been addressed as part of this report.

13. This report has been delayed by workload pressures, and was further delayed by some IT issues within this office. We apologise if this has caused additional distress for the man's family.

14. On 14 November, the senior investigator and Assistant Ombudsman visited the approved premises and interviewed the Deputy Manager and a Supervisor. The investigator also went to a probation office to speak to the man's Offender Manager.

15. Following the interviews, the Assistant Ombudsman contacted the Safer Custody Co-ordinator at HMP Stocken to see if there was any confirmation that the man had harmed himself while there. The Safer Custody Co-ordinator checked prison records and spoke with both healthcare staff and his personal officer, but could not find any evidence that he had harmed himself.

16. In response to the draft report, Staffordshire and West Midlands provided some clarification about certain factual matters. Where accepted, these comments have been reflected in this version of the report.

THE APPROVED PREMISES

17. The approved premises is one of 101 approved premises in England and Wales and it accommodates 32 residents. The residents are either on licence from prison or have been directed to reside there as part of their bail conditions or Community Order.

18. There are 32 bedrooms, a communal kitchen and a television room. During the day it is staffed by a senior probation officer (the manager), a probation officer (deputy manager), two approved premises supervisors, a probation service officer and administration staff. During the night an approved premises supervisor stays at the approved premises with a night officer. There is also a duty manager on call. All staff carry personal alarms for emergency situations.

19. On arrival, the resident is given an induction by a member of staff. They are given information about rules, procedures and expectations during an induction. Details of next of kin, personal information and medical information are recorded and a compact is agreed setting out the standards of behaviour expected of residents.

20. As part of the induction process, staff screen all residents when they arrive for signs that they may harm themselves. The manager or his deputy then decide whether a resident should be placed on monitoring arrangements and the frequency of the monitoring, which can range from every 15 minutes to four hours. The frequency can be adjusted and a review takes place daily. The purpose of the monitoring is to check on the resident's physical well-being and to look for any changes in mood, behaviour or circumstances. The observations are recorded in handover sheets so that all staff are aware of the situation.

21. All residents are required to register with the local doctor's surgery unless they are already registered locally. The relationship between the doctor and the offender is a confidential one, but medication prescribed by a doctor must be handed in to staff for risk assessment in relation to NOMS guidance for Medication In Possession. Any medicines not restricted through this process are handed back to residents for them to keep in their room. Lockable cabinets have been installed for this purpose.

22. This was the fourth investigation conducted at the approved premises since the Ombudsman began investigating deaths in approved premises in 2004. None of the issues covered in the previous investigations are directly relevant to the circumstances around this man's death, although a previous investigation resulted in a recommendation that suicide and self-harm training should be reviewed. In response to this recommendation, Staffordshire and West Midlands reported that staff had received training in suicide and self harm. There is also an ongoing training programme to provide staff with refresher events and training for newly appointed staff.

KEY EVENTS

23. On 17 January 2008, the man was convicted of wounding and endangering life at a crown court. He was sentenced to five and a half years in prison. His release date was 8 April 2011. He had served a number of previous prison sentences.

24. In March 2011, the man's Offender Manager began to make arrangements for his release. Approved premises are considered for prisoners who, upon release, continue to present a high risk of harm. As a result, and also because the man would have nowhere to live upon his release, his Offender Manager made a referral to the Approved Premises section of Staffordshire and West Midlands Probation Trust, in an attempt to secure accommodation at the approved premises. On 21 March, the Deputy Manager at the approved premises emailed the man's Offender Manager agreeing to his request subject to them having a vacancy at the time. The Deputy Manager asked the Offender Manager to explain to the man that all new residents would have an earlier curfew, from 7.00pm, for the first week of their stay.

25. The Offender Manager completed a pre-release risk assessment on the man, using the Offender Assessment System (OASys). This is a standardised risk assessment tool used by all probation areas across England and Wales. Part of the assessment (section 10) relates to emotional well-being. In section 10.5, which assesses "self-harm, attempted suicide, suicidal thoughts or feelings", the Offender Manager gave a score of "2" (described as "yes"). In section R3 of the Risk of Serious Harm Screening (a later part of the assessment), the Offender Manager assessed the risk of the man harming himself. The Offender Manager recorded that he did not have any concerns about the man harming himself or taking his own life, or his ability to cope in the approved premises. The Offender Manager confirmed when interviewed that he believed that "there was no indication that he would potentially commit an act of self-harm or suicide", and that the score of "2" was mistakenly entered and should have been "0", indicating no risk of self-harm.

26. An Offender Manager attended a MAPPA meeting (MAPPA is a Multi Agency Public Protection Arrangements meeting, where members of various criminal justice agencies assess the risk offenders pose to the public) on 5 April, on behalf of the man's Offender Manager. She recorded the outcome of this meeting in a minute on the Staffordshire and West Midlands Probation Trust's case management system, known as Delius. The MAPPA panel decided that the man was a high risk to the victims of his offence and to the public, as well as being a medium risk to staff at the approved premises because he had assaulted staff in prison. The panel requested a curfew of 9.00pm to 7.00am, with additional reporting times of 11.00am, 2.00pm and 5.00pm. It was agreed that, given the level of risk, emergency recall would be initiated if the man failed to return to the AP within 15 minutes of the curfew time. Emergency recall means that the application for the licence to be revoked would be completed within two hours of the risk being identified, rather than the usual 24 hours.

27. The manager of the approved premises also attended the MAPPA meeting and made a note on Delius. He noted the same curfew times as the Offender Manager. He also recorded some further issues, including the following:

Previous use of weapons, which would require regular room searches
Alcohol and drugs issues, which would need regular testing
Emotional issues, including stress, depression and anxiety – the man should register with a GP on arrival at the approved premises

28. On 6 April, a Senior Probation Officer spoke to the Offender Manager about the reporting times that the man would be required to observe. The Probation Officer thought that the total time was more than legally allowed and was excessive. She suggested that the Offender Manager refer the issue to the Ministry of Justice policy section.

29. Later that day, the Offender Manager contacted a member of the Licence Variation team at the Ministry of Justice. He said that it was illegal to have three reporting times on the licence, but that he would allow a 12.00pm reporting time. The Offender Manager spoke to the head of the MAPPA panel who agreed to the 12.00pm reporting time.

30. The man was released on 8 April from HMP Hewell (he had transferred there prior to his release from HMP Stocken). The terms of his licence (which expired on 21 March 2014) included, amongst others, the following provisions:

- Permanently reside at an address approved by your supervising officer and notify him or her in advance of any proposed change of address or any proposed stay (even for one night) away from that approved address
- You must confine yourself to an address approved by your supervising officer between the hours of 9.00pm and 7.00am unless otherwise authorised by your supervising officer. This condition will be reviewed by your supervising officer on a monthly basis and may be amended or removed if it is felt that the level of risk you present has reduced appropriately.

31. The Offender Manager saw the man at a probation office at 11.15am that morning. They discussed his licence conditions and the possibility that he might be recalled into custody if he failed to comply. He said that he wanted to have regular contact with his daughter, who he had seen while he was in prison.

32. After he left the probation office, the man went to the approved premises. It was the first time he had been required to reside at approved premises. He was inducted by the Deputy Manager who reported that he complied well with the process and seemed motivated to avoid a return to prison. When interviewed, the Deputy Manager said that he explained the curfew procedures to the man to ensure that he understood them. He said he told the man that, whilst his licence specified a condition of 9.00pm to 7.00am, he would be required to adhere to a curfew of 7.00pm to 7.00am for the first week. (The Deputy Manager later showed the investigators a note the man

had made on the notice board on his room, which set out the times of his curfew as being from 7.00pm to 7.00am.) The man said he would welcome a GP appointment as he still felt low following the recent death of his sister and the earlier bereavement of his mother. A GP appointment was made for him for 11 April at 12.10pm. The Deputy Manager decided that the man should initially be on a four hourly watch when he was in the approved premises to ensure his welfare.

33. The Deputy Manager completed an initial assessment of risk following the induction. He recorded the man's risk of self harm as "medium". (Page 2 of the form records the OASys assessment, completed by the man's Offender Manager before he was released from prison, when the risk of self-harm was assessed as "low".)

34. The man was given a drugs test on 10 April, which proved negative. The next day, he was given £3.60 to attend a job centre to obtain a crisis loan. However, he did not go to the doctor, saying he would speak to them the next day (though it is not clear whether he did so). That evening, he was given an alcohol test, which also proved negative.

35. No concerns were raised on the next two days. On 13 April, another alcohol test was done, which again proved negative.

36. On 14 April, an Offender Manager went to see the man at the approved premises. He said that he was finding it difficult adjusting to life outside prison, and had some soreness on his lips that he associated with stress. The Offender Manager advised him to ask staff to help him register with a doctor. The man queried why staff were checking on him frequently, and she replied that it might be because he had harmed himself in the past. She noted on Delius that the man had "cut his wrists" four months earlier while at Stocken, when he was told of his sister's death. (This was the first mention in the man's case notes that he had previously harmed himself.) He added that he had previously been prescribed mirtazapine for depression and anxiety, though there was no further information about when this was. The Offender Manager said that she would try and arrange counselling for him. They also discussed the 12.00pm reporting time (when he was required to attend the approved premises in person, and sign in), which she said would stay in place.

37. The Offender Manager recorded that she had hoped to see the Deputy Manager of the approved premises to inform him of the conversation. However, the Deputy Manager had just left the hostel, and she instead told another member of staff that the man should register with a doctor. At this point, the man intervened and said that he would arrange this. The Offender Manager recorded that he was "in good spirits". He told her that he was going to visit a friend in Selly Oak. The Offender Manager reminded him to return before his curfew, and he said that he would.

38. In the AP record of contact, a supervisor at the approved premises made an entry after the Offender Manager had left. She recorded that the man was

feeling anxious following his release from custody and felt that he needed anti-depressants. He said that he would make an appointment with a doctor the next day.

39. By 7.00pm, the man had not returned for his curfew. The supervisor remained on duty at the hostel. She informed the Deputy Manager of the man's failure to return, and a trigger plan to start the process for recall to custody was started at 7.25pm. The supervisor spoke to the duty senior manager within Staffordshire and West Midlands Probation Trust who advised that he should be called after 9.00pm to see if the man had returned to the premises.

40. At about the same time, the man telephoned the approved premises, asking what time he should return. He was told to return as soon as he could. At 8.00pm, he telephoned again asking if he was going to be arrested. The supervisor said that there had been confusion over the curfew times and told him again to return as soon as possible. The man said that he was in Selly Oak and would start to make his way back to the approved premises. He said that he had proof that his curfew was between 9.00pm and 8.00am. The supervisor called the duty senior manager within Staffordshire and West Midlands Probation Trust, who was satisfied with the outcome of the conversation.

41. However, the man did not return to the approved premises. Revocation of his licence was requested that evening, and the paperwork processed by a Senior Probation Officer on 15 April.

42. Later that day, police spoke to the Deputy Manager and confirmed that they had spoken to the man on his mobile telephone. He said that he would return to the approved premises to try and sort out his recall. The police asked the Deputy Manager to call 999 if the man returned to the approved premises.

43. The following day two police officers went to the approved premises to tell staff that they had found the man's body hanging in an area of Birmingham. The Deputy Manager spoke to the duty senior manager within Staffordshire and West Midlands Probation Trust, who went to the approved premises to support staff. The manager of the approved premises held a meeting with the residents to inform them of the man's death and to offer any support if required.

44. The man's ex-partner and his daughter were told of his death by police officers on the same morning.

45. After the Ombudsman was notified of the man's death, a family liaison officer from this office spoke to the man's next of kin, his ex-partner. She told the family liaison officer that her ex-partner had visited her and their daughter on 15 April and said that he seemed happy in himself and looked in good health. She did not notice anything unusual in his behaviour and said he was smoking and laughing with her.

46. However, she added that he seemed agitated by some confusion over his curfew times. She said the man had showed her his licence paperwork, which said he was required to return to the hostel by 9.00pm. However, he said that staff at the approved premises had told him that he needed to be back by 7.00pm. Before he left her house, he wrote a note saying staff said his curfew was 7.00pm but his Probation Officer said this was 9.00pm. He also wrote down the hostel's phone number. He left the note with his ex-partner but did not explain why. He left her home at 3.15pm.

ISSUES

The man's risk of self-harm

47. On 1 April, the man's Offender Manager completed an OASys assessment for him, prior to his release from custody. The Offender Manager, in this risk assessment section of the report, rated the man's risk of self harm as "low". The Offender Manager confirmed at interview that he had no information that made him think that the man might harm himself. (Information about the man previously harming himself by cutting his wrists only came to light later, after his release from prison.)

48. When he was released from prison on 8 April, the man was inducted at the approved premises by the Deputy Manager. As part of the induction process, he also assessed the man's risk of harming himself. However, he assessed the man's risk as "medium", taking into account what he said about the recent death of his sister and him feeling low. When interviewed by the investigators, the Deputy Manager said that he made this assessment because staff:

> "[W]ould need to monitor his emotional wellbeing more than perhaps we would other residents. So a decision was taken by myself at that point that we needed to put him on a four hourly watch, which would mean that we'd check him every four hours just to make sure that he was safe and well and there hadn't been any incidents or self-harm."

49. An offender manager saw the man on 14 April. When she made a note of this meeting on Delius, she noted that he had previously harmed himself four months earlier by cutting his wrists while at HMP Stocken. This was not mentioned in the OASys record. Investigators contacted the Safer Custody Co-ordinator at HMP Stocken to see if they had any record of this incident. The Safer Custody Co-ordinator remembered the man and said that she could not recall him harming himself. She checked his prison record, and found that he had previously been subject to self-harm monitoring procedures while he was at HMP Blundeston in 2009. She also checked with Healthcare at Stocken, and with his personal officer (who should have been the man's first point of reference if he had any issues). There was no other record of the man harming himself while at Stocken.

50. During the meeting on 14 April, the man also told the offender manager that he was having difficulty adjusting to life outside prison. The offender manager said she would try and arrange bereavement counselling for him, and the man agreed to register with a doctor.

51. While there were two contrasting risk assessments completed within a short space of time (by the man's offender manager and the Deputy Manager of the approved premises), the conclusion of each would seem to be appropriate. The man's offender manager completed his assessment without meeting him, but thought that he did not present a risk to himself, based on documentary evidence. The Deputy Manager interviewed him and made his assessment

based on what he saw. He also acted appropriately in instigating checks to ensure that the man was supported.

52. Investigators have not found any evidence to support the man's comment to the offender manager that he had cut his wrists while at Stocken. Staff at Stocken have no recollection of this, although they clearly remembered the man. As such, we are content that the man's offender manager's assessment was based on all available information. We are also satisfied that all appropriate measures were put in place for him, including several attempts to help him with GP appointments upon his release from prison custody.

The man's curfew times

53. Before the man was released from prison, a MAPPA meeting attended by the manager of the approved premises and an offender manager agreed that the man should be subject to a curfew between 9.00pm and 7.00am, with additional reporting times at 11.00am, 2.00pm and 5.00pm. Concerned that the amount of curfew was outside legal limits, a senior probation officer asked the offender manager to refer the proposed curfew to a member of staff at the Licence Variation team. The member of staff at the Licence Variation team confirmed that the curfew conditions should be amended, with only one requirement for the man to report during the day.

54. In addition to this curfew, all new residents at the approved premises are required to abide by an evening curfew of 7.00pm. The Deputy Manager informed the man's offender manager of this on 21 March, and asked him to inform the man. The Deputy Manager also told the man of the curfew times during the induction. It would appear that the man understood the times, as he had written them in a note on his notice board.

55. However, on the evening of 14 April, the man did not return before the 7.00pm curfew. At approximately 7.30pm, he telephoned the approved premises to check his curfew times, and said that he had "proof" that the curfew started at 9.00pm. He was told to make sure that he returned as soon as possible. After he did not return by 9.00pm, recall action was started.

56. In considering this issue, investigators spoke to the Head of the Approved Premises section of NOMS (the National Offender Management Service, which is responsible for probation services). He confirmed that he intends to issue guidance about "graduated" curfews (which, in this case, refers to the difference in curfew times betweens new residents and those who have been residents for longer periods of time) in the near future. As such, we have not considered, as part of this investigation, whether it is appropriate for there to be different lengths of curfews.

57. We have, however, considered whether the man was given enough information about the curfew he was required to observe. The Deputy Manager was clear from the outset that the man, as a new resident, would be required to observe a curfew from 7.00pm, and asked the man's offender manager to tell him this. The Deputy Manager explained this verbally to him

during induction, and the man observed the curfew without incident until 14 April.

58. However, that evening, the man did not return to meet his curfew time. When he called, he asked if he could check his curfew time. He was told that it was 7.00pm, and that he should return as soon as possible. When he called back, he said that he had proof that the curfew was, in fact, 9.00pm.

59. Although it is not possible to be sure, we consider that on the balance of probabilities the man was aware that he should return by 7.00pm. He had been told by both his offender manager and the Deputy Manager of the approved premises that the curfew would be 7.00pm, and he had made a note of it which he left on his notice board. The timing of his telephone call on 14 April (7.30pm) might also be an indication that he was aware that he was already late.

60. However, it is also true that the man held some paperwork which recorded his curfew time as 9.00pm, as this was the time stated on his licence. While it is not clear if he was confused by this, it is known that he had told the offender manager earlier in the day that he was finding adjusting to life outside prison difficult and was also having difficulty coming to terms with recent bereavements. His ex-partner also said he was not sure about his curfew time. It is possible that, during that evening, he had indeed become confused by the curfew times and had relied on that on his paperwork – which was 9.00pm.

61. In order to ensure that there is no chance for residents to become confused, it would be wise for the approved premises to put curfew times in writing and advise residents to keep these with them at all times. We make the following recommendation:

Staffordshire and West Midlands Probation Trust should ensure that all residents are provided with written confirmation of their curfew times and that they are advised to keep this with them when they leave the Approved Premises.

62. While making this recommendation, however, we do not link this issue to the man's death. Some time elapsed between the events of 14 April and the man being found and it not clear what happened in that period.

CONCLUSION

63. The man was released from HMP Hewell on 8 April 2011. As part of his licence conditions, he was required to live at approved premises.

64. The man was also required to observe a curfew. Although, on his licence papers, this was written as 9.00pm to 7.00pm, it was explained to him on at least two occasions that, for the first week, he was required to observe a curfew from 7.00pm.

65. There were two risk assessments about the risk of harm to himself that the man posed conducted at the start of April 2011. Although these came to different conclusions, each seems to have been appropriate given the information available at the time.

66. On 14 April, the man failed to return before his curfew started. He telephoned the approved premises and was told to return as soon as possible. Although he said that he would, he failed to do so. He was found hanging in another part of Birmingham two days later. It seems that he visited his former partner and daughter on the afternoon of 15 April, and was concerned about his curfew times.

67. This investigation has found that there seems to have been confusion about the curfew times, even though they were explained to the man and he complied with them until 14 April. We have made a recommendation to help prevent a repeat of this confusion.

RECOMMENDATION

1. Staffordshire and West Midlands Probation Trust should ensure that all residents are provided with written confirmation of their curfew times and that they are advised to keep this with them when they leave the Approved Premises.