

**Investigation into the death of a man, who was a resident  
at an Approved Premises under the management of the  
Probation Service**

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

**February 2013**

This is the report of the investigation into the death of a resident at an Approved Premises managed by the Probation Service. The man was found hanging in his room on 7 July 2012. He was 48 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. Staff at the Approved Premises cooperated fully with the investigation.

The man arrived at the Approved Premises on 4 July 2012 after being released on licence from HMP Northumberland. He was allocated a key worker who carried out his induction. The man had no recorded history of any recent acts of self-harm and he appeared to be settling into life at the Approved Premises.

On the evening of 6 July, the man had been out with a friend and when he returned to the Approved Premises the night supervisor chatted to him and said he appeared to be in a good mood. The next afternoon, a fellow resident said that he was concerned that he had not seen the man all day. When a member of staff went to check, he discovered the man hanging from the door of his room. It was clear that he had been dead for some time.

The lack of checks on residents during the weekend meant that the man was not discovered for some hours. In addition, the member of staff who discovered the man did not have ready access to emergency equipment. However, I am satisfied that the Approved Premises has since made appropriate changes in the light of these events. I do not consider that staff could have predicted or prevented the man's death.

The 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 & Probation Ombudsman**

**February 2013**

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## SUMMARY

1. The man was born in 1966. He was 48 years old when he died on 7 July 2012 at an Approved Premises, when he was found hanging from the door of his room.
2. On 13 March 2012, the man was convicted and sentenced to 16 months imprisonment. He arrived at HMP Durham on the same day. It was recorded that the man had a history of alcohol abuse. No other medical problems were noted. The man transferred to HMP Northumberland on 30 March.
3. On 4 July, the man was released from prison on licence. As part of his licence conditions he had to reside at an Approved Premises. When he arrived he was met by his key worker who carried out his induction.
4. The man was not prescribed any medication when he was released from Northumberland. During his induction at the Approved Premises, it was recorded that the man had asked for medication to help him cope with anxiety. It was explained that this could not be given without a prescription. As he had a history of alcohol abuse, an appointment was made for him to see a drug and alcohol counsellor on 12 July.
5. During the evening of 6 July, the man left the Approved Premises with a friend. They returned after 10.00pm and he seemed to be in good spirits.
6. At around 4.30pm on 7 July, one of the residents told a member of staff that he was concerned that he had not seen the man all day. Another member of staff went to the man's room but was unable to get a response so unlocked the door. He discovered the man hanging from the door closing mechanism by his belt. The member of staff then summoned assistance and, as he did not have an anti-ligature knife, had to get a knife from the kitchen before cutting the man down. It was apparent that the man had been dead for some time, so staff did not attempt to resuscitate him. An ambulance was called and paramedics pronounced the man dead at 4.45pm.
7. We are satisfied that there was nothing to alert staff at the Approved Premises to the man's subsequent actions and there was nothing staff could reasonably have been expected to do to prevent his death. Appropriate changes to procedures have since been introduced.

## THE INVESTIGATION PROCESS

8. The Ombudsman's office was informed of the man's death on 9 July 2012. The investigator issued notices to staff and residents at the Approved Premises informing them of the investigation and asking anyone who had relevant information to contact him. He also contacted staff at HMP Northumberland. No responses were received. The investigator examined the man's relevant probation and prison records, including his medical records.
9. The investigator visited the Approved Premises on 5 and 6 September, to conduct interviews with staff. The investigator spoke to the man's offender manager and other staff involved in his care. On 6 September, he gave initial feedback to the Head of Interventions and subsequently confirmed this in writing.
10. The investigator contacted Her Majesty's Coroner to inform him of the investigation and to obtain a copy of the post-mortem report. The post-mortem report was not received before this investigation was completed. This report will be sent to the Coroner to assist his enquiries.
11. One of our family liaison officers contacted the man's family. She outlined the purpose of our investigation and gave them the opportunity to raise any questions that they wanted to be addressed. The man's family did not have any specific issues they wanted the investigation to consider. The family received a copy of the draft report and they raised no further concerns in light of the findings.

## **APPROVED PREMISES APPROVED PREMISES**

12. Approved Premises (formerly known as probation and bail hostels) provide an enhanced level of residential supervision in the community, in a supportive and structured living environment. Residents must be aged over 18 and include those who have committed serious, violent and dangerous offences and who have completed the custodial part of their sentence. The majority of residents are required to stay as a condition of a court order or prison licence.
13. The Approved Premises can accommodate up to 24 men on bail, on community orders or on licence following prison sentences. The manager of the Approved Premises is assisted by probation service officers. The building has closed circuit television and residents are required to sign in and out of the building and follow curfews which are determined by the resident's offender manager. During induction, new residents are told about the local house rules. Residents are also allocated a key worker to be their primary contact. They help with practical issues and provide one-to-one sessions underpinned by the objectives outlined in the offender's sentence plan.
14. Residents are responsible for their own health and usually register at one of the local doctors' surgeries. A doctor from a local practice visits the Approved Premises once a week. As part of the conditions of residence, most prescribed medications are held by the Approved Premises and are issued by staff to residents daily.

## **KEY EVENTS**

15. The man was born in 1966. He was 48 years old when he died on 7 July 2012 at an Approved Premises.
16. On 4 November 2011, the man was remanded into custody and he arrived at HMP Durham the same day. It was not his first time in custody. At a health screen interview it was recorded that the man had a history of alcohol abuse. He said he had no other medical problems. On 13 March 2012, the man was sentenced to 16 months imprisonment at Crown Court for sexual offences. On 30 March, he transferred to HMP Northumberland.
17. A pre-discharge (from custody) report completed on 7 June recorded that the man's supervision outside prison would start on 4 July and was to end on 4 March 2013. It noted that the man was identified as presenting a risk to children due to the nature of his offence. He was required to register under Part 2 of the Sex Offenders Act 2003 and was subject to Safeguarding Children/Child contact procedures. The court had not recommended any additional licence conditions in respect of his offences.
18. On 2 July, the man's offender manager recorded that she had telephoned the manager of the Approved Premises and said that an offender supervisor would be identified for the man the next day (3 July). The offender manager said that she would attend the Approved Premises during the afternoon of 5 July to see the man.
19. The man was released from HMP Northumberland on 4 July to reside at the Approved Premises. This was intended to be a three month resettlement placement, after which he would move on to live in the community. The placement was to enable him to have a stable base to facilitate resettlement into the community.

### **The man's licence conditions**

20. As part of the man's licence conditions, he was to have regular contact with his offender manager and live at the Approved Premises. He was subject to a curfew and had to be inside the building between 8.30am and 9am, 12.00pm and 1.15pm, 7.30pm and 8.00pm and like all other residents, during the night between 11.00pm and 7.00am. The man was forbidden to enter the area of his offence and had to notify his offender manager of any developing relationships with women. He was not to seek or communicate with his victim or her mother without the approval of his supervising officer, and was not allowed to have unsupervised contact with or live in a household with anyone under the age 18 years. The man knew that if he failed to obey these licence conditions he could be recalled to prison. His licence was due to expire on 4 July 2013.

## The man's time at the Approved Premises

21. The man arrived at the Approved Premises on 4 July. He was assigned a key worker with whom he would meet regularly to discuss his progress. The key worker's initial aim with the man was to get him settled into the Approved Premises and the community and to ensure he was fully aware of his licence conditions and curfews.
22. The man was not prescribed any medication before his arrival at the Approved Premises but he asked his key worker for tramadol and co-codamol (strong pain killers) to help to calm his nerves. These could not be administered without a prescription and the key worker advised the man that he would contact the service that provides drug and alcohol treatment advice for residents. An appointment was arranged for the man to be seen at 2.00pm on 12 July at the Approved Premises. It was not possible to arrange an earlier appointment because the man's allocated named substance misuse worker was on leave.
23. During his induction the man made it very clear he was not happy with his offender manager. He said that "she was a waste of time and space and had done nothing to help him", and was also unhappy about how his case had been handled. He was concerned at being assessed as high risk to children and he did not agree with parts of his OASys<sup>1</sup> assessment. The key worker challenged these comments and informed the man that his offender manager would be coming to see him on 6 July and he could discuss his concerns with her then.
24. The key worker noted that the man displayed no victim empathy and disagreed with statements made by his victims. He also made comments about the victim's mother. When challenged on these issues, the man admitted that in the past he had resolved issues by using violence but as he had got older he realised that the best course of action was to walk away or talk things through.
25. The key worker had read the man's file before his arrival at the Approved Premises and there was no information to suggest that the man presented any risk of self-harm or suicide. It was recorded that he had suffered from depression 14 years previously. The man did not mention any self-harm issues or past attempts to take his own life with key worker or any other staff at the Approved Premises.
26. The key worker explained the implications of not complying with his licence and the Approved Premises' rules were fully explained. The man signed to indicate he fully understood. After his induction he was allocated a single room (Room 4) on the first floor.
27. In his statement to the investigator, the key worker confirmed that he saw the man around the premises over the next two days and they engaged in conversation. The key worker said that the man was "in good spirit and was

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<sup>1</sup> The Offender Risk Assessment System (OASys) provides automatic sharing of data and operational information between the Probation Service and Prison Service IT systems so that updated offender information can be accessed instantly and securely by either organisation.

mixing with other residents". He told the man that during the following week they would sit down together (in key working sessions) and discuss next steps in relation to his rehabilitation.

### **Events on 6 and 7 July 2012**

28. During the morning of 6 July, the man left the Approved Premises at around 8.45am to report to the local police station. Around 12.30pm, his offender manager contacted the Approved Premises to explain that she would be unable to visit the man. She said that she would re-arrange the visit for 9 July. She asked staff to ask the man to contact her if he had any concerns. The message was passed on, and the offender manager said she received no further contact from the man. The key worker did not speak to the man after the offender manager re-arranged her meeting.
29. A Waking Night Supervisor was on duty on 6 July between 4.30pm and 10.30pm. He did not recall seeing much of the man during that shift other than at the standard evening curfew as he had a friend (a non resident) waiting for his curfew to finish. The man's friend was signed in at 8.00pm as a visitor and he and the man left the Approved Premises together at 8.10pm.
30. In his witness statement for the police, the man's friend said that after they left the Approved Premises he drove the man to the local supermarket to buy some groceries and drink. They then sat in the supermarket car park while the man drank some cider and they had a general conversation. The man's friend asked him how he felt and the man said "he felt like hanging himself". He described the man as "annoyed" and said "there was no fight left in him". By the end of their conversation he said he had "perked up a bit". However, as they were about to leave the car park a couple walked in front of the car. The man identified one of the couple as his victim. He did not approach or speak to her. The man then broke down in tears. He continued to drink and by the time they returned to the Approved Premises he had drunk three cans of cider.
31. On their journey back to Approved Premises they stopped to buy a kebab. The man's friend said that when he left him at the Approved Premises at around 11.00pm, the man appeared to be in a good mood and was joking with a member of staff. The man's friend telephoned him at around 11.30pm and the last conversation they had was about the kebab which the man had not enjoyed. He agreed to telephone the man on the following day but when he tried he did not get a response.
32. Another Waking Night Supervisor saw the man with his friend when they returned to the Approved Premises before 11.00pm and he had a brief chat with them and after a couple of minutes informed them both that he had to lock the front door and then check that all residents were in the building. The man's friend then left the premises. When interviewed, the Waking Night Supervisor said that the man appeared to be in good spirits and was in a "jovial, friendly mood". He said the man had clearly been drinking and seemed merry and engaged in banter. He asked the Waking Night Supervisor if he liked rugby league and then wanted to talk about it. He informed the man he was about to

check all residents were in and to make sure that the building was safe and secure. The man said that he would have a “good chat” with him in the morning about rugby. He saw the man going into his room shortly afterwards with a couple of bags of shopping and he “was still in good spirits as he was chatting to a resident opposite him for a few moments”. That was the last time he saw the man. His shift ended at 9.00am on 7 July.

33. At around 4.30pm on 7 July, a resident at the Approved Premises informed staff that no-one had seen the man all day. A member of staff went up to the man’s room to see if he was okay. He knocked on his door and got no reply. The door was locked and he used his master key to open it. He immediately felt resistance and had to push hard to open the door. He put his head around the door he saw the man hanging from the door by a belt. He was facing the wall and the chair was placed directly behind the door preventing access.
34. The member of staff activated his panic alarm, to alert his co-worker to contact the emergency services which they had arranged before he went to the man’s room. Although he had recently completed anti-ligature knife training (anti-ligature knives, or ‘cut down tools’, are specially designed to cut ligatures) he had not been issued with one. He therefore ran to the kitchen on the ground floor to get a knife but could not get in as he had left his keys in the lock of the man’s door. He asked a member of the kitchen staff, to give him a knife and he said within two minutes, he returned to the man’s room, cut him down and loosened the belt from his neck. He then went to the staff bedroom on the first floor to collect a resuscitation mask.
35. When he returned to the room the member of staff checked for signs of life and could not find any. The man’s body was cold and rigor mortis<sup>2</sup> was apparent in his limbs. It was clear from his appearance he was dead, so he did not attempt resuscitation. There was no suicide note. He locked the room and waited for the ambulance and police to arrive, as well as the manager of the Approved Premises (who was also the duty on call manager) and the senior on call manager. Paramedics arrived but did not attempt to resuscitate the man, and pronounced death at 4.45pm

### **Events after the man’s death**

36. After the man’s death, staff at the Approved Premises immediately invoked their contingency plans and began to inform all the necessary agencies. Staff told other residents of the man’s death during the evening of 7 July.
37. The police visited the Approved Premises to conduct interviews and found no suspicious circumstances. They interviewed both staff and residents. They later interviewed the man’s friend. At their request, the police were given the man’s next of kin details and they informed them of his death.

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<sup>2</sup> Rigor mortis is a condition of extreme stiffness affecting the arms and legs after death making it virtually impossible to bend the wrists, elbows or knees.

38. There were varying accounts of the man's state of mind. In his statement to the investigator, a resident suggested that the man was upset following an argument with his ex-partner. In his witness statement to the police, the man's friend suggested that he was upset after he had seen his victim while he was out during the evening of 6 July. The man's family also suggested he might have had an argument with ex-partner. His family thought the man's ex-partner might have been giving him false hopes of reconciliation.
39. After the man's death, the managers spoke to his family who later visited the Approved Premises. They met staff and residents and collected the man's personal belongings. The Approved Premises also contributed financially towards the man's funeral in line with national policy.

### **Post-mortem report**

40. At the time of writing this report, the post-mortem report was not available. The toxicology report records that the man had relatively high levels of alcohol in his blood stream. The post mortem was received after the draft report was issued and confirmed cause of death as hanging. The consultant pathologist drew attention to the results of the toxicology report and stated that the increased levels of alcohol would have had "a detrimental effect on motor and cognitive function".

## ISSUES

### Checks on residents

41. During the working week at the Approved Premises, staff check on residents at 7.30am to ensure they are in the premises. This also acts as a check on their welfare. The practice at the time of the man's death was that at weekends there were no scheduled checks on residents. This meant that the man was not discovered for some hours. It is a concern that the man was not discovered until late afternoon. Since the man's death the Approved Premises has revised its policy for checking residents at weekends, checks are now carried out on any residents who have not been seen by staff by 10.00am.

### The emergency response

42. Staff discovered the man hanging in his room on 7 July after another resident had raised his concern at not having seen him all day. Within minutes an ambulance had been called through a pre-arranged sign between staff. As it appeared that the man had been dead for some time, attempts were not made to resuscitate him. Paramedics arrived at the Approved Premises and pronounced death at 4.45pm.
43. We are concerned that when staff discovered the man he was unable to cut him down immediately because he did not have readily available an anti-ligature knife. He had to go to the kitchen to get a knife, to cut the man down and then had to go elsewhere to get a resuscitation mask. Only after this did he check for signs of life. Although it is clear that the man had been dead for some time, in other circumstances the delay in cutting someone down and checking for signs of life could be crucial.
44. Since the man's death, anti-ligature training has been organised for all staff at the Approved Premises. We understand that once trained, staff are to be issued with a hip bag containing an emergency first aid kit (including a resuscitation mask) and an anti-ligature knife. Staff will be expected to wear the bag at all times while on duty and account for/replace any missing first aid kit or kit which is used during their shift. We are satisfied that this is an appropriate action. At the draft report stage, the National Offender Management Service (NOMS) provided the following response:
  - Anti-ligature point door closers are being fitted and should be complete by the end of January.
  - Staff on duty carry anti-ligature kits with them at all times.
  - Welfare checks are now completed at the weekends as well as weekdays.

## **CONCLUSION**

45. The man arrived at the Approved Premises on 4 July 2012 after being released on licence from HMP Northumberland. He appeared to be settling in to life at the Approved Premises and was abiding by the rules.
46. The man did not give any indication that he was considering taking his own life. There are varying accounts of his state of mind from his friend, staff and his family. We consider that there is little staff at the Approved Premises could have done to predict or prevent the man's death. We are concerned that he was not discovered for some time, and that when he was, there was a delay in cutting him down due to lack of access to the appropriate equipment. We are satisfied that the Approved Premises has taken appropriate action in response to the man's death.