



**Investigation into the circumstances surrounding the
death of a man, while a resident
at Ealing Approved Premises in July 2011**

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

July 2013

This is the report of an investigation into the death in July 2011, of a man, a resident at Ealing Approved Premises in the London Probation Trust. He was found dead on the tracks at a train station, having been hit by a train. He apparently took his own life. He was 67 years old. I offer my condolences to those affected by his death.

The investigation was carried out by an investigator. I am grateful for the assistance of the manager of Ealing Approved Premises and his staff, who cooperated fully with the investigation. I would also like to thank the residents who contributed information. I apologise for the delay in producing this report.

The man was a high risk offender who had been a resident in the Approved Premises for three and a half weeks at the time of his death. He had been arrested and bailed for pre-existing offences the day after his arrival, but appeared to have settled into a routine. He spent his days attending his supervision appointments, visiting the library and letter writing. On several occasions, he voiced his dissatisfaction with the management of certain aspects of his licence, such as the restrictions which prevented him from travelling abroad or visiting his mother without prior notification. He was also fearful of being recalled to prison and was convinced there was a conspiracy by some officials to try and effect this.

Probation staff had formally assessed the man and concluded that he was not at risk of harming himself. During meetings, they also asked him directly if he had any thoughts of self-harm and he denied this. The resident who last spoke to him as he left the hostel to make his way to the train station identified nothing in his demeanour to suggest he was low in mood or would take such action. However, he believed, with hindsight, that a remark he made as he left could be interpreted as a clue to his intentions. His death came as a shock to staff and residents. He left several letters which made clear his actions were premeditated and the method had been planned.

The investigation identified good collaborative working between the various individuals and agencies responsible for managing the man. The supervision process adhered to the guidelines for managing high risk offenders and there was nothing overlooked by staff that would reasonably have enabled them to predict that he had it in mind to take his own life.

I have made one recommendation as a result of this investigation, in relation to the requirement to pay funeral expenses.

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.

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Prisons and Probation Ombudsman

July 2013

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SUMMARY

1. The man was a high risk offender who had been convicted of serious offences in January 2008 and sentenced six weeks later. The Court of Appeal later reduced the minimum period to be served in prison. At 63 years of age, this was his first time in prison and he spent time in HMP Wandsworth and HMP Littlehey.
2. In January 2011, the Parole Board recommended the man's release from prison, subject to a robust risk management plan, additional licence conditions and gaining accommodation in an Approved Premises. Extensive planning and preparation for his release was made in the following months and final approval was given by the Parole Board in June. He left Littlehey on 4 July and arrived at Ealing Approved Premises late that evening. The following day, police arrested and bailed him for other offences and he returned to the Approved Premises.
3. The man settled and spent most of his days attending supervision appointments and programmes, as well as going to the library, reading and writing letters. Formal assessments indicated there was no risk of self-harm and when asked directly by probation staff whether he had thought of harming himself or felt depressed, he replied no. He was vocal about his resentment of what he perceived to be a conspiracy to get him recalled to prison. Probation staff attempted to reassure him on this point, but he does not appear to have taken this on board. At no time did he intimate any thoughts of self-harm. On 23 July, he visited his brother in Kent to collect some possessions. When he returned to the Approved Premises, he sorted through and destroyed a volume of paperwork.
4. During the 11.00pm well-being check at the Approved Premises, at the end of July, a relief worker noticed that the man was missing. After checking that he had not been admitted to hospital, the manager of the Approved Premises initiated the process for him to be recalled to prison. The last person to see him was one of the other residents, who said that the man had made a comment about being run over as he was leaving the Approved Premises that evening. The following day, the police reported that a man had been hit by a train. It seemed likely that it was him, but he was not identified until 2 August. Residents were aware of his disappearance and had heard rumours about what had become of him, but the manager rightly only informed them of his death once the formal identification had taken place. He left a number of letters, making clear his intentions to take his own life and giving instructions for the disposal of his property and money.
5. The investigation has concluded that probation staff managed all aspects of the man's supervision effectively. There was a high standard of record keeping which enabled the investigator to follow systematically the processes and events before and after his arrival at the Approved Premises. On the basis of the information known to probation staff and his demeanour throughout his residence, they could not have predicted that he would take his own life. One recommendation has been made.

THE INVESTIGATION PROCESS

6. The investigation was formally opened on 5 August, when an investigator, accompanied by an Assistant Ombudsman, visited Ealing Approved Premises. They had a meeting with the manager of the Approved Premises. They were also shown around the building, including the room in which the man had resided and met other members of staff and a few residents. The manager gave the investigator copies of the man's probation records.
7. Notices had been issued to the Approved Premises to inform both staff and residents of the investigation, including an invitation to contribute information. No one responded to this directly but, on request, two former residents agreed to be interviewed.
8. Arrangements were made to conduct formal interviews at Ealing Approved Premises on 8 and 9 September. However, owing to circumstances beyond her control, the investigator had to postpone them and the Assistant Ombudsman advised the manager of this in early September. Unfortunately, this delayed publication of the report. They returned to Ealing Approved Premises on 2 November, where they interviewed staff and a former resident at the Approved Premises. The investigator subsequently spoke on the telephone to another resident who had shared a room with the man. (The Offender Manager is responsible for managing the offender's sentence and any risk; the Offender Supervisor is responsible for forming and maintaining effective relationships with individual offenders; supporting, motivating and consolidating learning as well as brokering resources on behalf of the Offender Manager, advocating on behalf of the Offender and liaising with other interventions providers.)
9. When the man arrived at the Approved Premises, he nominated his brother as next of kin. However, when the British Transport Police broke the news of his death to his brother, he declined to be involved and instead referred them to their sister.
10. One of our family liaison officers wrote to the man's sister on 22 August to explain the purpose of the investigation and invite her to contribute to the investigation. She responded shortly afterwards enclosing copies of lengthy letters her brother had written to friends just before his death, as she considered they were useful indicators of his thoughts and feelings around the time of his death. His sister asked to see a copy of the draft investigation report. She commented in response that she did not think sufficient attention was paid to two factors that she thought contributed to her brother's decision to take his life. One was the failure to finalise arrangements for him to visit his mother and the other was his re-arrest on new charges.

EALING APPROVED PREMISES

11. Some offenders are released from prison to continue serving their sentence in the community, rather than in prison. This is known as being released on licence and conditions are attached to their release. They are then supervised by the National Probation Service and some high risk offenders are required to reside in Approved Premises, formerly known as Probation and Bail Hostels. The purpose of an Approved Premises is to provide an enhanced level of residential supervision in the community, within a supportive and structured environment, for offenders assessed as presenting a high risk of harm. While residents have to comply with their individual licence or bail conditions, curfews and the Approved Premises house rules, they are essentially free to go in and out of the building.
12. Ealing Approved Premises is one of around 100 Approved Premises in England and Wales. It is a large, detached Victorian house on three floors, located in a residential street in the London Borough of Ealing. It has 17 beds, six of which are in shared rooms. Residents share kitchen and bathroom facilities. Ealing is the smallest Approved Premises managed by the London Probation Trust and is the second smallest in London. It has been operating since 1976, when it was originally a bail hostel and then in 2000, started taking offenders on licence. All the residents are either high or very high risk offenders and it is rare for anyone residing there to be in a lower risk category than this.
13. The Approved Premises is staffed 24 hours a day by probation employees, whose role is to provide support and ensure that residents comply with the rules and licence conditions. In addition to the manager, there is a deputy manager; two intervention offender supervisors who act as key workers; five residential assistants, of which two work at night and the other three during the day; around nine relief staff to cover absences; and a part-time administrator. There is a general curfew between 11.00pm and 6.00am (residents are not allowed to leave during these hours). This is enforced by a check in which a member of staff goes to see every resident and gets them to sign to confirm they are present. If they are asleep, the member of staff signs on their behalf. Each resident is allocated a dedicated key worker, a trained member of staff who works closely with him to offer support and guidance to achieve compliance with their licence conditions. Residents are responsible for their own health and usually register with a local general practitioner (GP).

Previous deaths

14. Since 2004, when this office began investigating all deaths in Approved Premises in England and Wales, there have been four deaths (including the man's) at Ealing Approved Premises. Two of the previous deaths were self-inflicted and the other due to natural causes. There are no similarities with the circumstances of his death.

MAPPA

15. Multi-Agency Public Protection Arrangements (MAPPA) support the assessment and management of the most serious sexual and violent offenders. The aim of MAPPA is to ensure that a risk management plan is drawn up for the most serious offenders and benefits from the information, skills and resources provided by the individual agencies co-ordinated through MAPPA. There are three levels of MAPPA:

- Level one - An offender on level one MAPPA is normally managed by a single agency. This is the lowest monitoring procedure available under the MAPPA system.
- Level two - As with level three, anyone who has been identified as falling into the level two heading would be managed by more than one agency, very often limited to probation and the police. However, it is possible to involve more agencies if the circumstances warrant it.
- Level three - Anyone subject to level three is considered as being the highest risk case, where more than one agency will take responsibility for the management of the person concerned.

Offender Assessment System (OASys)

16. Used as part of sentence planning, the Offender Assessment System is a risk assessment tool intended to provide a proper assessment of a prisoner's needs and to help select an appropriate prison for a sentenced prisoner. It 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. The aim of the system is to improve the consistency of offender assessment, provide courts with better informed sentencing advice, and support informed decisions on release and interventions.

KEY EVENTS

17. The man was privately educated at a boarding school. He then spent some time in the Army at Sandhurst, then three years as a musician in London and subsequently gained a degree in History of Art and Business Studies. He was also fluent in several languages, including Russian and French. For most of his life, he was employed as a Museum Curator and Art Historian in prominent posts. Prior to his conviction, he had a high standard of living and lived in Central London. The background papers also revealed that he had attempted to take his own life following the end of a relationship prior to his marriage.
18. The man was convicted of a number of serious offences on 4 January 2008 and sentenced to Indeterminate Imprisonment for Public Protection (IPP) on 15 February, at Crown Court. (IPP prisoners have no automatic right to release at the end of their sentence; they are only released once the Parole Board is satisfied that the risk of harm to the public has reduced to a safe level.) He was also ordered to be on the Sex Offender Register for life and a Sexual Offences Prevention Order was imposed (to protect the public from serious harm). Following a subsequent appeal at the Court of Appeal on 10 October 2008, his tariff (the minimum period of a life sentence that must be served in custody) was reduced from four and a half years to three years, minus 298 days spent in custody on remand. He had admitted to the majority of the offences, but a few months before his release he retracted his admission to two of them. He was 63 years old at the time of his conviction and this was his first time in prison.
19. During his imprisonment, the man spent time at HMP Wandsworth and HMP Littlehey. Prisoners may ask to be segregated in the Care and Separation Unit (CSU) of a prison for their own protection, for example, if they have committed an offence of which other prisoners disapprove or have accumulated a debt. At Wandsworth, he was housed in the (CSU) owing to the nature of his offences. Before moving to the CSU, he taught basic literary skills to other prisoners and ran English as a second language classes.
20. The man's probation documents contain a detailed history of his background, offences and his engagement with various agencies within the criminal justice system. While serving his sentence, he completed the Core Sex Offending Treatment Programme and other relevant programmes. He was said to have complied wholly with the prison regime. He had no disciplinary hearings; staff had completed positive reports; and he had developed a relationship with the chaplaincy and practised his faith. There were no concerns by staff, although at Wandsworth he was subject to a reverse Osman warning, having colluded with another prisoner to threaten the life of his ex-wife. An Osman warning had been given to his wife. (An Osman warning is given by the police to the intended victim when there is a risk to their life. A reverse Osman warning is given to the person suspected of making the threat to make them aware that the police know about the threat and should something unnatural happen, they would be considered a suspect.) This is used when police are aware of a threat but there is insufficient evidence to charge the individual with an offence.

21. Once the man had completed his tariff, there was a delay in arranging his release. The reason was he intended to make daily visits to his elderly and frail mother, but police and probation staff had to ensure that he avoided contact with one of his victims, who lived opposite her home, as well as handling concern about the risk to others nearby. The police therefore had to take additional action in managing the disclosure process to alert those potentially at risk of the likelihood of visits, as well as making arrangements for the visits to take place at a suitable time to avoid inappropriate contact.
22. The Parole Board sat at HMP Littlehey on 11 January 2011, to review the man's case and consider his application for direct release on licence. (The Parole Board is an independent body that assesses prisoners' risk to decide whether they can be safely released into the community.) The Board's decision, communicated to the London Probation Trust a week later, was that they were minded to direct his release on completion of a robust risk management plan, imposition of additional licence conditions and confirmation of a place at an Approved Premises. Although the London Probation Trust, Prison Service and the Police were of the view that the level of risk he posed could not be safely managed in the community, they were obliged to implement the Parole Board's directive.
23. The arrangements for the man's release were taken forward by a senior probation officer at Westminster Probation, who conducted an interview with him on 1 February and subsequently prepared a risk management plan and report. In the report, she said that during their interview, she invited him to give examples of strategies he had learnt which he would use in high risk situations. He was unable to do this but simply asserted repeatedly that he would never go back to prison. He gave a stock response of "I just know I won't". He also reiterated his perception that he was a victim. She undertook to secure a place for him at Ealing Approved Premises within three weeks of receipt of the Parole Board's final decision and prepared a risk management plan proposing the imposition of a number of "bespoke" licence conditions in addition to the standard set.
24. Amongst other things, as part of his licence conditions, the man was required to reside at Ealing Approved Premises for at least six months; prohibited from travelling abroad; precluded from using the internet; and subject to management under the MAPPA process. He had told those supervising him that, financially, he would only be reliant on his state pension. However, during a search of his cell before he left prison, documents suggested that he would have access to considerable funds. He was particularly opposed to the conditions restricting his travel and use of the internet as he said it would impede his intention to work both in this country and abroad.
25. On 1 June 2011, a further Parole Board hearing took place at Littlehey and the decision that the man should be released on 4 July was communicated on 9 June. The following day, the referral for a bed at Ealing Approved Premises was accepted. In accordance with the MAPPA procedures, a Multi Agency Public Protection Panel meeting was convened. This is a panel, often

convened prior to a high risk prisoner's release, comprising of local agencies (Police, Probation, Social Services, health, and/or other agencies where appropriate) to assess and manage the risk a prisoner poses on release. Held quarterly, they monitor the level of risk and ascertain what action to take, if necessary, in respect of an offender being managed under the arrangements. He was designated as MAPPA level 3, the highest level of risk. He was also classified as a Critical Public Protection Case. During interview, the manager described this as the "critical few of the critical few", the critical few being MAPPA level 3 offenders. Those within this category are either very high risk offenders or those who might be subject to media attention and therefore require extra resources to manage them. In addition, government ministers have to be briefed about them weekly and their local Member of Parliament is advised of their release into the area.

26. It was agreed that, on release, the man would be initially dual managed by both Westminster and Ealing Probation for a period of around one month. On 1 July, a few days before his release, his offender manager at Ealing visited him at Littlehey. The purpose of the visit was to introduce himself and discuss the man's feelings, concerns and worries about release and discuss the licence conditions. The offender manager told the investigators that during the meeting, the man was very concerned about the prospect of being recalled to prison and was frightened that something bad would happen to him. He explained to him at length the recall process and assured him that he would not be recalled without good cause.
27. In view of the man's comments, the offender manager explicitly asked him if he was thinking of harming himself. He denied this and said he was more concerned that someone else might hurt him. He was also fearful of what he regarded as a "police project" and conspiracy to get him recalled which he believed had started well before his release. The offender manager said that in subsequent meetings, the man reiterated his concerns about recall, often saying that he had got his bag packed and that he had still not unpacked it. He regarded it as a serious concern but said that, at the same time, it almost became a running joke.
28. Westminster Probation was not satisfied with the man's licence conditions. However, on the morning of release, the National Offender Management Service (NOMS), Public Protection Unit, who are responsible for processing releases from and recalls to prison, telephoned the offender manager at Westminster Probation. They said that the Chair of the Parole Board panel was satisfied with the licence and advised them to apply for it to be changed after release. The probation records show that shortly afterwards, the offender manager emailed the Public Protection Unit to express concern that the licence conditions were not sufficiently robust and to request a review and the imposition of additional conditions before the man's release. He said the Probation Service could not support his release without them. In spite of these objections, the release went ahead.
29. The man was released from Littlehey on 4 July 2011. (The police had planned to arrest him at the gate in respect of other offences, but this did not

happen as they were told that his release might be deferred until the following day. They had also stated an intention to oppose bail as they considered him a “flight risk”.) At interview, the manager explained that owing to confusion about the extra conditions attached to his licence, the man was not released until 5.30pm. In view of the distance to Ealing, he did not arrive at the Approved Premises until 9.30pm. He was assigned to room 16a and only a brief induction was given due to the late hour.

30. The following morning the manager met the man. Although they touched on his supervision and transfer arrangements, it was a relatively brief discussion, as he was due to attend a meeting with his offender manager at Westminster Probation Office. During the conversation, he voiced his concern that the probation and police services were conspiring to get him recalled and kept in prison.
31. Later that day, the man went to a meeting with offender managers at Westminster Probation Office. Immediately after the meeting, the police arrested him at the probation office and took him into police custody in connection with the false documents that had been found in his possession at the time of his first arrest in 2007. He had never been formally interviewed about this matter. He was held in custody overnight and appeared at Magistrates’ Court the following day, where he was given bail on condition that he report to the police station every day between 7.00pm and 9.00pm. He pleaded not guilty on the basis of his belief that thousands of people have such documents and they were not illegal. A committal hearing was arranged for 17 August 2011. (A committal hearing is when magistrates decide whether there is enough evidence for the case to go to trial.) Once released, he went to Westminster Probation Office for a pre-arranged meeting.
32. During his detention at the police station, the man had asked the police to telephone his ex-wife. As a consequence of this, his offender manager later (on 13 July) issued a formal warning to him for attempting to contact his ex-wife when in police custody, in breach of his licence conditions.
33. Owing to his late arrival at Ealing and subsequent arrest, the man’s full induction did not take place immediately. However, probation records show that this was completed 8 July and an induction meeting with the deputy manager was held on 12 July. The induction with the deputy manager covered the usual information such as health and safety, registration with a doctor and completion of relevant documents such as information on next of kin, risk assessment and an ethnicity questionnaire. He told the manager he was, “convinced the police have it in for him and will find reasons to have him arrested or even recalled”. The manager tried to reassure him about this. Similarly, the deputy manager recorded that he was convinced that he would be recalled any day and that he was being persecuted by the police who would find a way of recalling him. She attempted to point out that it was his responsibility not to do anything to breach his licence conditions and warrant a recall.

34. It is recorded that around an hour after the induction meeting with the deputy manager, the man had the first of his weekly sessions with his key worker. During this meeting, the man was described as very nervous about breaching his licence conditions unintentionally. He said that the police were setting him up to fail and he had packed some of his belongings in case he was recalled. (He repeated this in subsequent sessions.) She asked him if he felt depressed and he said no.
35. The investigators asked the deputy manager about the man's demeanour. She described him as very reserved, quite angry, very organised and that he considered himself a victim and thought he was being persecuted by the police. She said he used to talk to his room mate as well as another resident, who had since left the hostel. However, he did not spend much time in the public areas of the residence such as the television lounge and preferred to go to the library. He also spoke to staff, usually about specific needs rather than general conversation.
36. In response to a question by the investigator, the keyworker elaborated on the entry regarding whether the man felt depressed. She explained that as part of discussions concerning his health, she always asked him if he felt depressed as she was conscious that he didn't fit in, given how different it was to his previous lifestyle. He said that being in the Approved Premises, having no money and having to sign at the police station daily was depressing, but he did not feel depressed. She added that, although he was not "happy-go-lucky", he didn't mope around. She was therefore very shocked by his actions. She suspected that he might have been organising his affairs to perhaps abscond and go abroad at some stage, but did not consider that he would harm himself.
37. The day after the man's induction meeting with the deputy manager and his first session with his keyworker, 13 July, he attended a meeting. The purpose of the meeting was to reinforce his licence conditions and discuss the following: how he had been spending his time; the logistics of travel and finance; finding a church; his exclusion from his mother's address and issue the warning letter referred to earlier. The record of the meeting made by the offender manager described him as appearing pretty anxious about being recalled at any time. He also reacted angrily to the warning and described the police information as lies and part of the conspiracy against him.
38. The offender manager carried out an OASys assessment of the man that day and emailed the NOMS Public Protection Unit to ask for the licence variation to be processed as a matter of urgency. The assessment included questions regarding the risk of self-harm, suicide and his ability to cope in custody and an Approved Premises. There were no concerns regarding those issues. The sentence plan listed the following objectives: the need to increase his awareness of the impact of his offending behaviour on his victims as well as himself; obtain suitable accommodation; improve self-management/use of coping skills/self control; improved use of alternative styles of thinking; increased awareness of the consequences of unacceptable or inappropriate

behaviour and how this would impact on his sentence; and obtain employment.

39. The man spent the next few days mostly attending his probation and police appointments, reading in his room, going to the library, mainly to write letters. He had asked to visit his brother to collect property. During this time, arrangements were discussed and relevant safeguards put in place for him to make the trip at an appropriate time. His keyworker had another session with him on 19 July, in which she asked again about his plans for registering with a doctor and he told her that he would find out if he was still registered with the local doctor near his former home in Central London. On the same day, probation staff confirmed that he would be permitted to visit his brother on 23 July. The following day, he had a meeting with his offender manager, in which he again expressed his belief that he would be recalled imminently. His case was also formally transferred from Westminster to Ealing Probation that day.
40. The visit to the man's brother took place as planned, on 23 July. The following day, staff saw him sort through paperwork and he placed some in the confidential waste bin in the office. In a session with his keyworker on 26 July, he said he did not have enough time to sort through his possessions and had brought back three boxes of documents but very few clothes. She did not see him again as she then had a few days leave. When she returned to work the day after he disappeared, one of the residents told her that he had jumped in front of a train.
41. The investigator also spoke to the man's room mate to gain further impressions of his demeanour and anything significant that would assist the investigation. The room mate said that they arrived at the Approved Premises on the same day. The man spent a lot of time in the room and kept the curtain that separated the two parts of the room closed. He was very quiet and kept himself to himself. They talked, but not a lot. He described him as a "stiff upper lip", elderly man who was less willing than others to get out and do things.
42. The room mate spoke about an instance when the man didn't return to the Approved Premises one night. He returned the next day and said the police had "pulled him in". He had seemed distraught and complained about being persecuted. (It is assumed that the incident referred to was his arrest the day after he went to live at the Approved Premises.) He did not mention any problems to the room mate, other than those with the police. He was also upset about the rules of the hostel and complained that curfews were "silly for a man of my age".
43. The only unusual thing that happened was one night, three or four days before the man's death, the room mate returned to the room at his usual time (just before the evening curfew). He used his key to enter the room and when he entered, the man was walking around the room naked. The curtain between the living spaces was open. He said he thought it was "very weird" as surely he had heard the noise of his key in the lock. He said, "What are

you doing? This isn't on!" The man then went behind the curtain and neither referred to the matter again. He did not mention it to the staff.

44. The room mate believed that the man was down because he talked about being persecuted and kept to himself. However, he said and did nothing to make him think he would take his life.

Events leading up to the man's death

45. On 29 July, the man went to the probation office for a meeting with his offender manager and a member of the police JIGSAW team responsible for managing serious offenders. The offender manager recorded that he had initially appeared, "a little cagey" but then talked about his daily routine and what he had been doing. He attempted to feed back that the man's seemed to be getting more diverse and he appeared to getting his feet on the ground. He responded that he could not settle until someone confirmed that the investigation of a police officer he believed was persecuting him was complete and that he was sure that no one else from the police was after him.
46. During the meeting the man also spoke about the visit to his brother and said that as he had little space, he had put aside some of his possessions to give to friends and had also left some for his brother to have a massive bonfire. He expressed an interest in a further visit to his brother. They also had another discussion about the disclosure process which would enable him to visit his mother. He said he did not understand why disclosure had to take place, but was content that the member of the JIGSAW team was handling this. He told them he needed more time to think about where he wished to go to church regularly and the offender manager explained it would be a relatively simple administration process when he found one.
47. Risk factors were also discussed. The man showed them a letter he had written to a senior probation officer at Westminster Probation Office who had been involved in his case before he left prison. The letter outlined what he considered his risk factors to be and this led to a discussion about early warning signs and protective factors. The offender manager considered that he turned much of the conversation to his own personal loss rather than the task in hand. An appointment was made for them to meet again the following Tuesday. (A few days later, when the offender manager became aware of his death, he made an addendum to the note of the meeting as he recalled that he had been trying to contact an acquaintance who had offered support in custody, but the person appeared to have totally disappeared. He had asked if the offender manager thought it was strange that people could disappear like that.)
48. The next day a relief worker at the Approved Premises staff conducted the 11.00pm check of residents and noticed the man was missing. He spoke to other residents and one of them, Resident A, told him of a conversation earlier that evening in which he had alluded to getting "run over". The relief worker called the man's mobile telephone, but it went straight to voicemail. He also telephoned the manager, who advised him to contact the accident and

emergency department of the local hospital. However, there was no record of him being admitted. The manager took steps to order his recall to prison in light of the apparent breach of his licence conditions. The relief worker also reported the matter to the on-call manager.

49. The manager recorded that, in light of the fact that the man had been identified as a “flight risk” (ie he would possibly attempt to leave the country), his status as both a level three MAPPA and a Critical Public Protection Case and the reverse Osman warning, he decided to request that he be recalled to prison. To begin the process, he telephoned the NOMS Public Protection Unit who, in line with the policy on recalling IPP offenders, advised him to seek the authority of the duty Assistant Chief Officer (ACO). As there was no reply, he telephoned his own ACO who gave authority for the recall. The manager thought there might be a risk of self-harm on arrest and noted this. The relief worker had reported to him the man’s conversation with his room mate, so the manager also telephoned the police to find out if there had been any road traffic accidents in the borough and was told no.
50. The following morning, just before 8.00am, the relief worker conducted another check of residents. He found a note in the man’s room, which he presumed was from his room mate, suggesting that he join them for a film as he would probably be bored on his own. (During interview, his room mate said he had found the note for the man under the door and thought it was from another resident.) Half an hour later, in a further check, the relief worker discovered a letter on his bed with some detailed instructions for his next of kin, as well as two sealed letters. As the letter indicated his intention to end his life, the relief worker telephoned the manager to inform him. The manager informed the police, then he and two police officers attended the Approved Premises, searched the room, opened the letters and viewed the closed circuit television (CCTV) recordings.
51. The unsealed letter gave instructions about contacting particular people “in the event of my disappearance” and the police not searching his belongings without a warrant. He also mentioned that he would have no identifying items on him and expressed concern about media interest. It ended with the statement in capital letters “Saying no to [names] and the abuse of power”. (This was a reference to a police officer and probation officer, respectively.)
52. The two sealed letters were addressed to the man’s mother and brother. The letter to his brother contained a list of tasks, including the depositing of and access to a considerable amount of money and how best to break the news to his mother. He described feeling overwhelmed and said “... I take a practical approach.” It also expressed regret for the inconvenience to rail passengers. Further envelopes in the room labelled some of his belongings with instructions as to where they should go. He also wrote at length to other “friends and supporters” indicating his intentions and some of this correspondence was subsequently sent to the investigators by his sister.
53. While the police were in the building, they were notified that a man had thrown himself under a train at the train station at about 9.50pm the previous night.

(The manager was later told that he lay down on the tracks for the express trains.) On 1 August, the manager notified relevant probation colleagues, the Public Protection Unit and this office of events and how matters stood. British Transport Police took over the investigation and began the identification process once the post mortem had taken place. They also indicated they would visit the man's brother that evening. Just after 10.00am the next day, the police confirmed that the deceased was the man. They also said they had still not managed to contact his brother. (He subsequently declined to act as next of kin and his sister assumed this role.)

54. Entries in the signing in and out book for the day of the incident show that the man signed out at 9.25am and returned at 5.20pm. He went out again at 8.30pm, returning at 9.10pm. He signed out on the last occasion at 9.30pm and is not recorded as having returned. The last person to speak to him at the Approved Premises was a former resident who has since moved elsewhere. He agreed to be interviewed by the investigators.
55. The former resident gave some background to his acquaintance with the man. He was already residing at the Approved Premises when he arrived and had met him the day after. He described him as very intelligent, cultured, self-assured and an academic type. He said they spoke generally about "run of the mill" things such as cricket, art and poetry and the man's travels around the world. They were not close friends so did not talk about problems and he had never seen him upset. He gave the impression that he was coping with his time at the Approved Premises although he never spoke of the future. The former resident also mentioned that the man's mother telephoned him every night, usually just as she was going to bed.
56. During the evening of the incident, between 8.00pm and 8.30pm, the former resident went to the kitchen to make a drink. The man was there preparing a meal which he described as like a lovely little banquet of smoked eel and granary bread from a local Polish shop. He invited him to try some, which he did. After they finished eating, he put everything away and the former resident finished his coffee. He did not finish all the food, he put the remainder away and the former resident noted that he cleared up and even wiped around the edges of the mustard jar. He described him as very organised. He then told the man that he was going out for a walk a little later and asked if he wanted anything. He replied, "No, I've got to go out later". He then said goodbye, to which the man responded, in a normal tone, "If anything happens to me, if I get run over, you can have my provisions".
57. About ten minutes later, (the signing book showed this to be 8.25pm), the former resident went out for a walk and did some food shopping. On his way back into the Approved Premises, he met the man, who was just going out. He signed out and then the former resident signed in (records show this was 9.30pm). The man then turned around and asked him to put his keys back on the hook. The former resident told the investigators that at that time, his demeanour was normal and calm.

58. The former resident was aware that the man had not returned because staff had asked residents if they had seen him as he had not met the 11.00pm curfew. (The following day, as he was walking up the road, returning to the Approved Premises, two of the other residents asked if he had heard that he had, "committed suicide ... jumped under a train". He was shocked by this. When he got back to the residence he went straight to see the manager to ask if it was true.)
59. At interview, the manager explained that he did not make an announcement to the other residents until the man's identity had been confirmed. Residents were aware of his disappearance and the police activity but it was assumed that it was because he was an IPP offender. They were told in groups or individually, rather calling a formal residents' meeting. He likened it to how an extended family might be told the news. He added that the man had not formed any significant relationships at the Approved Premises so none of the residents seemed very upset.
60. The room mate said that staff told him about the man's death a few days after his disappearance. He had a three-way meeting in which his key worker told him what had happened and explained that was why he had been moved to a different room.
61. The manager said he rang some staff to tell them and subsequently advised them of support via the probation service occupational health arrangements. He received support from his manager and other senior colleagues and staff also talked about their feelings as a staff group.
62. The man's keyworker had been on leave for a few days before his disappearance. The manager could not recollect exactly what attempts he had made to tell her, but thought that he had tried to telephone. She told the investigators that when she returned to work on Sunday 31 August, a resident told her that the man had jumped under a train. She was shocked as she had not heard anything, but at that time his identity had not been confirmed. She said that she would not have wished to be told at home while she was on leave because of her personal circumstances, but would have preferred to have been told by a member of staff rather than a resident. She added that although she is sometimes telephoned at home when serious events occur, such as recalls, she had not been called about previous deaths even in a previous instance when she was the key worker. She had not been offered support but knew how to access it if she felt she needed it. She said she could also discuss it in supervision sessions.
63. Staff packed up and stored the man's belongings as his family indicated that they did not wish to view the room. His niece subsequently collected the property. Funeral expenses were not offered to his next of kin.

ISSUES

Management of the man

64. The Parole Board indicated their intention to approve the man's release from prison, in January 2011, subject to an appropriate risk management plan, additional licence conditions and a residential place at an Approved Premises. During the next six months, there was a lengthy period of preparation by the Probation Service to manage his risk. As a very high risk offender, his case was supervised by a Probation Service Public Protection Team and monitored by the local Multi-agency Public Protection Panel. The Panel comprises the Probation Service, local police JIGSAW Team, social services, housing providers and community mental health teams.
65. From the examination of documents and interviews of staff, the investigators were satisfied that before and after the man's arrival at Ealing Approved Premises, there was strong liaison and communication between those responsible for supervising him, as well as effective collaboration with other stakeholder agencies. Approved Premises staff carried out an induction programme and meetings were held with his offender managers and key worker at the agreed and specified intervals. The investigators were also impressed with the high standard of record keeping. Comprehensive records of information and significant interaction were kept which gave a clear picture of events and action taken by staff.

Risk of self-harm

66. As a younger man, several decades before his imprisonment, the man had harmed himself and seemingly attempted to take his own life following the breakdown of a relationship. None of his records indicated any inclination, in recent years, to self-harm. However, there is evidence that the question of self-harm was explored explicitly with him by different probation staff before and after he took up residence at the Approved Premises.
67. The man's offender manager visited him in prison a few days before his release. During the course of their discussion, he asked him whether he was considering harming himself and he replied no. An OASys assessment completed by the offender manager nine days after his release from prison indicated that there were no concerns about him in respect of the risk of self-harm, suicide or his ability to cope in the Approved Premises. Also, on the same day, he had a session with his key worker and she asked him if he was depressed. He responded that although his circumstances were depressing, he was not feeling depressed. Staff and residents described him as very polite and organised. Although he was very open with those supervising him about his hostility towards certain police and probation staff who he believed to be conspiring to have him recalled to prison, he did not confide anything to suggest that his fears might lead to self-harm.
68. Probation documents indicate that, in part, the man viewed himself as a victim. For example, "he considers it unfair, unnecessary and down to the

incompetence/inefficiency of the CJS [criminal justice system], that he was not released when his tariff expired". He was also said to be perplexed by a family member's refusal to have direct contact with him and repeatedly expressed concern about the delay in arranging visiting rights to his mother.

69. Although we do not know when the man started planning his intended actions, it is clear from his correspondence, written instructions and, with hindsight, verbal comments to a resident that he intended to take his life. Staff and residents described it as a shock and said they did not foresee this. We are satisfied that there were no signs of his thoughts of self-harm and it is reasonable that staff had never put in place suicide prevention monitoring or taken any other preventative action.

Actions taken after the man's death

70. There was a period of three days between the man's disappearance and the formal confirmation of his death. Understandably, speculation as to what had happened to him had spread during that time. The former resident, who was the last person to speak to him, was told in the street by other residents but we judge that this could not realistically have been avoided.
71. The Approved Premises Manual 2011 instructs managers to ensure the emotional and physical well-being of staff and advises to notify staff at home, in some instances. The man's key worker had been on leave from work for a few days and was unaware of events. She was told the news by a resident just as she arrived for work while he was still missing. Again, the fact that a resident happened to see her before she had contact with a member of staff seems unavoidable. These were unusual circumstances as those involved had surmised that the person found on the railway was him, but he was not formally identified until a few days later. Furthermore, she said she would not have wished to receive the news at home. She was not directly offered support on this occasion, but knew exactly how to access support and her entitlements.
72. Paragraph 23.39 of section D of the Approved Premises manual specifies that Probation Trusts are required to offer to contribute reasonable funeral costs of up to £3,000. In this instance, no such offer was made. Accordingly, we make the following recommendation:

The manager of Ealing Approved Premises should ensure that, following the death of a resident, reasonable funeral costs are offered, in accordance with national guidelines. This requirement should also be included in the local instructions for actions following a death in custody.

CONCLUSION

73. The man had been convicted of serious offences, the nature of which impacted on his life once released from prison as it meant that his movements and access to certain facilities and family members were necessarily restricted. The indications are that although the Approved Premises was a rather alien environment to him and he felt restricted by his licence conditions and the consequent inability to travel and work, he had settled into a routine. He divulged no thoughts or feelings of self-harm to either his offender manager, Approved Premises staff nor to other residents.
74. Although the man was deeply resentful of what he considered to be unwarranted restrictions and attention from some police and probation staff, he appeared to be compliant with his licence conditions as well as hostel rules and gave staff no cause for concern.
75. The man was open about some matters, such as his fear of being recalled to prison, but more guarded about financial matters as well as his feelings about the future. He had plenty of opportunity to discuss those thoughts but chose not. We can only conclude, particularly given the degree of planning as well as the thoughts expressed in his correspondence, that he was determined to end his life and had resolved not to make it known until he had fulfilled this.
76. We are satisfied that the man was properly managed by those responsible for his supervision in the community. Regular meetings with him were held by his offender managers and key worker but his demeanour did not betray his plans. Once it was discovered that he had disappeared, staff took prompt and appropriate action to find him and having failed, requested his recall to prison. By then, unbeknown to them, he was already dead.

RECOMMENDATION

The manager of Ealing Approved Premises should ensure that, following the death of a resident, reasonable funeral costs are offered, in accordance with national guidelines. This requirement should also be included in the local instructions for actions following a death in custody.

London Probation Trust has accepted this recommendation.