PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a woman, a resident at Hopwood House Approved Premises, Rochdale, in November 2007

Our Vision

To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision.

This is the report of an investigation into the circumstances surrounding the death of the woman in November 2007. Police officers discovered the woman in a hotel room in Sheffield during the late evening. She had been drinking, smoking cannabis and had taken an overdose of methadone. She had been a resident at Hopwood House Approved Premises in Rochdale for 11 weeks. She was 41 years old.

This investigation has been undertaken by one of my investigators. I would like to thank the staff and residents at Hopwood House for their co-operation in this investigation.

The loss of a family member in such circumstances must be very distressing. This cannot have been helped by the delay in producing this report, for which I apologise. My investigator and I offer our sincere condolences to the woman's family and friends for their loss.

Although the woman had been subject to self-harm monitoring immediately before her release from prison, she was considered by the approved premises staff to have no further thoughts of self-harm and seemed to be coping satisfactorily. There is no clear indication as to exactly why she took her life, but she had a number of unresolved issues. It is likely that the separation from her children and her inability to have contact with them during key events such as birthdays became too much for her to live with.

I make three recommendations in this case relating to record keeping, risk assessment of significant dates and the need for managers to attend following serious incidents.

This version of my report, published on my website, has been amended to remove the names of the woman/man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Deputy Prisons and Probation Ombudsman **February 2010**

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SUMMARY

In January 2005, the woman was admitted to a psychiatric hospital. She left the hospital on 2 March. Later the same day a fire occurred at her home which resulted in her being charged with arson, being reckless. Although she was granted bail, her youngest daughter was formally placed in the sole care of her elder daughter. On 29 March, following an argument with her eldest daughter the woman was charged with threats to kill both her daughters. On 6 December, at Chester Crown Court she was convicted and sentenced to three years imprisonment.

Whilst she was still in custody at HMP Styal, she was told that her ex sister-in-law had been given special guardianship of her daughter. She was unhappy about this and began to self-harm. The woman was eventually released from Styal on licence, for the second time, on 16 August 2007. Immediately before leaving prison, she had been subject to the Assessment, Care in Custody and Teamwork (ACCT) procedures. (ACCT is a prisoner-centred assessment and care planning system for those at risk of self-harm or suicide. It aims to identify individual needs and offer personalised care and support before, during and after crisis, in a safe and caring environment.)

The woman arrived at Hopwood House Approved Premises at about 3.10pm on 16 August. The Senior Probation Officer (SPO) in charge at Hopwood House, told my investigator that she interviewed her on the afternoon of her arrival as she was concerned about her being on an open ACCT document. The SPO said the woman told her that she was relieved to be out of prison and had no suicidal thoughts or intent to self-harm at that time.

A court hearing took place on 20 September, to determine custody of the woman's youngest daughter. The woman's ex sister-in-law had refused to provide the woman with photographs of her daughter. This was one of the matters expected to be resolved at the hearing. An entry made in the woman's contact log on 19 September, indicated that staff asked her if she wanted to discuss the case prior to the hearing. (The contact log is used to record all contacts between staff and a resident.) She declined and asked to be given a "wide berth" on the following day. There are no further entries in the log relating to either the outcome of the hearing or the woman's reaction.

30 October was the birthday of the woman's son and her daughter's birthday was the following week. Three entries were made in the contact log over the next two days relating to her children and her mood. There is no entry on 2 November relating to her daughter's birthday.

The woman left Hopwood House during the morning on 4 November. At about 3.05pm, a friend of the woman who was one of the residents received a text message from her which read "you have been great, love you". A few minutes later a second text was received saying "text me straight away". The woman's friend telephoned the woman and it soon became clear that she intended to take her own life. The woman's friend went to the office and told staff on duty.

Throughout the day, residents and staff attempted to contact the woman to establish her whereabouts. She refused to speak with staff. The police tried to trace her by tracking her mobile telephone. The woman's body was discovered late in the evening in November in a Travelodge hotel in Sheffield. Apparently she had taken cannabis and had been drinking wine. A half empty bottle of methadone was discovered by her side.

The efforts made to find the woman by residents and the staff on duty at Hopwood House during the day on 4 November should be commended. Sadly, it is possible that if she had told her friends where she was she may not have died.

THE INVESTIGATION PROCESS

1. My investigator made initial contact on 8 November with the SPO in charge at Hopwood House. During the conversation, the SPO provided my investigator with a verbal overview of the events. Numerous documents were requested and either provided immediately or sent to my investigator shortly afterwards.

2. Prior to the investigator arriving at Hopwood House, notices were issued to staff and residents. They announced the investigation and invited anyone who had information about the woman's death to make themselves known. In the event, three residents came forward.

3. On 21 November, my investigator visited Hopwood House and collected all other available documents likely to be required for the investigation. Interviews commenced on the same day.

4. My investigator carried out a total of 11 interviews, eight with staff and three with residents. All the interviews were recorded and copies of interview transcripts are attached to this report.

5. One of my family liaison officers contacted the woman's next-of-kin, her brother, to explain the scope of this investigation and offer the opportunity to participate in the investigation. I hope this report helps the family to better understand the events leading up to her death.

HOPWOOD HOUSE

6. Hopwood House is an approved premises managed by the Greater Manchester Probation Trust. Approved premises were formally known as probation and bail hostels. Their purpose is to provide an enhanced level of residential supervision in the community for offenders, as well as a supportive and structured environment. Each approved premises works to national standards determined by the National Offender Management Services (NOMS).

7. Approved premises provide accommodation for people before and after sentencing. Offenders are usually housed in such accommodation when there is a good reason for them not to return to their previous address. There are seven approved premises managed by the Greater Manchester Probation Trust. Hopwood House is the only one that provides accommodation solely for women.

8. Hopwood House accommodates up to 14 residents. Each resident normally stays for approximately four months, however, at the time of the woman's death one resident had been there for over a year. Trained staff work with the residents to help prevent re-offending and to protect the community.

9. Approved premises are managed by a senior probation officer (SPO). Each resident has an appointed key worker who supports the resident and ensures any offence related work is completed.

10. All residents are expected to abide by the rules and regulations of the approved premises. They include booking in and out when they enter or leave the premises and observing a strict overnight curfew. During the day, residents are free to go out unaccompanied and are not required to say where they are going.

11. Residents who are thought to be at risk of self-harm or suicide are monitored using a Probation Service Assessment Care and Teamwork plan (ACT). This is a similar process to the Assessment, Care in Custody and Teamwork (ACCT) plan used by the Prison Service and has the same aims.

12. While the woman was resident at Hopwood House, she was under the care of a local community doctor who was responsible for her medical needs. Although the staff at Hopwood House were aware of some of her medical conditions, medical confidentiality prevented her doctor from passing on any information.

KEY EVENTS

13. On 2 March 2005, shortly after the woman had discharged herself from a psychiatric hospital, she set fire to her own home. She was unhurt but was taken to the Accident and Emergency department at Macclesfield District General Hospital (MDGH). One of the doctors at MDGH carried out a review of her notes from the psychiatric hospital. He considered the notes indicated that there was no evidence of psychiatric illness. The woman's diagnosis was assessed as substance dependency and maladaptive personality traits. She was placed in police custody and later released on bail.

14. During the day on 29 March, the woman had an argument on the telephone with her eldest daughter. Her daughter was by this time the sole carer for the woman's youngest daughter. As a result of the argument, the woman was charged with making threats to kill both her daughters. She was remanded in custody and later released on bail for a short period before returning to custody.

15. On 6 December 2005, at Chester Crown Court the woman was convicted of threats to kill and arson, being reckless. When summing up the judge said that the previous four or five years had been tragic for the woman and her family. He added that her actions on 2 March 2005 were desperately dangerous to all concerned. They had been followed by threats made to her eldest daughter some four weeks later. The woman was sentenced to three years imprisonment.

16. During her time in custody, the woman's mental health became stable although there were still concerns about alcohol abuse. Her Probation Service contact records indicate that she did not seem to think that her drinking was much of a problem. Some difficulties were experienced finding accommodation for the woman prior to her release. She had indicated that she did not want to move into a hostel and wanted a place of her own but this was impossible to arrange. The woman then told probation staff that she would live with her brother in Congleton. Prior to her release, the youngest daughter left her sister's home and went to live with the woman's ex sister-in-law in Macclesfield. (She was the wife of her other brother.)

17. An entry was made in the probation contact records. It said that the woman wanted to make a will as she intended to kill herself because she had nothing else to live for. She told one of the probation staff that she would kill herself if she was forced to go out of the Macclesfield area.

18. The woman was released on licence from HMP Styal on 2 January 2007 and went to live with her brother in Congleton. Conditions of the licence prevented her from communicating in any way with her children or her ex sister-in-law. It was also a requirement that she resided at her brother's home and address her alcohol misuse. On 21 February, the woman breached her licence and was recalled to Styal. A decision was soon made that she would again be released on a licence, this time with a requirement for her to stay at an approved premises. The Probation Service had a good deal of difficulty finding a place for her not only because she was female but also due to the need for her to

address her alcohol abuse. As there are no female approved premises in Cheshire, it was planned that she would go to Adelaide House in Liverpool. This place was later withdrawn and a place was provided at Hopwood House in Rochdale.

19. Whilst the woman was still in custody at Styal she was told that her ex sister-in-law had been given special guardianship for her daughter. She was unhappy about this and began to self-harm. The woman was eventually released from Styal on licence, for the second time, on 16 August. She was subject to an open prison ACCT document at the time.

20. The woman arrived at Hopwood House at about 3.10pm on 16 August. She underwent basic induction training and was allocated a shared room with another resident. Her assigned probation officer and her key worker. The SPO in charge at Hopwood House, told the investigator that she interviewed the woman on the afternoon of her arrival as she was concerned about her being on an open ACCT document. The woman told her that she was relieved to be out of prison and had no suicidal thoughts or intent to self–harm at that time. However, the SPO added that the woman did say that she "might go downhill" after a few days. The SPO decided that it was not necessary to open an ACT. At about 3.00am the next morning the woman was awake and chatted to the night staff. An entry in the staff log indicates that she said she was on "cloud nine" and could not believe she was out of prison.

21. During the next few days, the woman completed her induction into Hopwood House. She met her offender manager, probation officer and assigned probation officer for a three way risk assessment meeting. She began to settle into Hopwood House. All the appropriate documentation was completed and supporting entries were made in the probation contact log. Staff made numerous contact log entries over the following few weeks. It is clear from the entries that staff were getting to know the woman and her issues. They included alcohol, bulimia, anxiety and lack of contact with her children. However, the woman was not sleeping well and, for the benefit of her room mate, she moved into a single room at the end of August.

22. On 5 September, the woman's assigned probation officer made an entry in the contact log. She had telephoned a social worker about an upcoming court hearing on 20 September, regarding the custody of the woman's youngest daughter. The entry mentions that the woman's ex sister-in-law was currently refusing to provide her with photographs of her daughter. It was hoped that this would be one of the matters resolved at the hearing. An entry in the log on 19 September indicates that staff asked the woman if she wanted to discuss the case, due to be heard on 20 September. She declined and asked to be given a "wide berth" on the following day. There are no further entries in the log relating to either the outcome of the hearing or the woman's reaction to it.

23. One of the other residents at Hopwood House, told the investigator that she became friendly with the woman on the day she arrived at Hopwood House. She said that the woman went to bed early each night and would always be up early in the morning. She added they would sit and have a drink and a chat

together at 5.00am each day as she went to work early. Their friendship developed and she told her a good deal of information about her life. They discussed matters relating to her children, her relationship with her siblings and her battle with bulimia. The resident told the investigator that the woman was informed a few days after the court hearing that her ex sister-in-law had been given sole custody of her youngest daughter and that she took this badly. She added that the woman began to collect items in a box that were to be given to her daughter when she grew up.

24. It was the birthday of the woman's son on 30 October. At 3.00am that day an entry was made in the occurrence book. It said that she felt sick as it was her son's birthday that day and her daughter's birthday the following Thursday. There are no other entries in the occurrence book relating to the matter that day. On the same day, the resident made an entry in the probation contact log as the woman had told him she "felt down". She had said that it was her son's birthday that day and her daughter's birthday the following week. The entry goes on to say that she agreed to use all available support over the difficult period. Three entries were made in the contact log over the next two days about her children and her mood.

25. On 2 November, the day of her daughter's birthday, there is another entry in the occurrence book, again at 3.00am. This entry reads, "She is depressed as it is her daughter's third birthday today and she says she hasn't seen her since she was six months old". There are no further entries relating to this matter on that day and no entry in the contact log on 2 November about her birthday either. However, there is an entry on that day to the effect that the woman told staff she had a date with two men the following day and would go out with the first one that brought her flowers. During the evening of 3 November, she told staff that she had been on a date and would be seeing the man again. Another entry the same day says there were no issues with the woman at that time.

26. A second friend told the investigator that the woman had hoped to get a telephone call from her son. She had sent him her telephone number in his birthday card but did not receive a call. On 2 November, the woman had hoped to receive a telephone call from her daughter's father to let her know how her birthday went. Again, she did not receive a call. The women's second friend said the woman cried and was very upset by this.

The events of 4 November

27. At about 3.00am on Sunday 4 November, the woman was awake and asked the night staff if she could put some washing on as she had been sick after eating a Chinese meal, cream cakes and chocolate. At about 7.50am that morning, she was discovered using a vacuum cleaner in her room. Staff asked the woman to stop as residents were allowed to sleep in on Sundays until 10.00am.

28. The woman's first friend told the investigator that it was normal for the woman to text her early in the morning at weekends, however, she did not text that morning. The woman's first friend found her ironing her bedding in the laundry

room at about 8.45am. She spoke to the woman, who answered in a voice that the first resident described as “proper high”. She thought that there was something wrong as she seemed to be “off” with her. She spoke to another resident who told her that the woman had been told off for hoovering her room before 8.00am. The woman’s first friend made the woman a drink and took it to her. However, the woman told her she had things to do and would drink it in her room. The woman’s friend waited until about 10.00am for her to return and then decided to go back to bed.

29. The weekend residential services worker was the second member of staff on duty on the day. She carried out a check of residents at about 10.30am. She told the investigator that she saw the woman on her bed writing letters. When she asked what her plans were for the day, she replied that she was going out for lunch with a man. They had a brief discussion and then weekend worker left the room.

30. The woman left Hopwood House during the morning. The contact log indicates that she left at 10.36am, however, an entry on the booking in and out sheet, presumably made by the woman herself, indicates that she left at 11.15am. The woman’s friend told the investigator that the woman had planned to catch a bus at 11.15am and so she believed she would have left at about 11.10am. A Residential Service Officer (RSO), who was in charge that day, thought that she had left at about 11.15am.

31. At about 3.05pm, the woman’s first friend woke up with a start as her telephone received a text message. The message was from the woman and read “you have been great, love you”. Initially, the friend thought the message had been sent to her accidentally and that it was intended for the woman’s brother. However, a few minutes later, a second text was received that read ”text me straight away”. She telephoned the woman who told her she was not coming back and that she was far away. Initially the friend thought she was simply not going to return to Hopwood House and told her that she would be looking over her shoulder. The woman replied “No I won’t, and I’m not going to be here”. The friend then went to the office and spoke to the ROS in charge that day.

32. The ROS in charge that day said she thought that the woman’s friend went to the office at about 3.10pm. She said the woman’s friend was in tears, holding her mobile telephone and said “she is going to do it”. A short conversation followed. The woman’s friend said that the woman had bought a bottle of methadone and some wine and was going to end her life. The ROS checked the woman’s room to confirm that she was not in and then contacted the duty SPO for advice. She was advised to gather as much information as she could and telephone the police.

33. Throughout the afternoon, the woman’s first and second friends regularly spoke on the telephone to the woman, each time trying to glean more information about her whereabouts. She told them that she had bought methadone from a friend, a former prisoner at HMP Foston Hall, and was in a flat in Burton-upon-Trent. The RSO in charge that day told the investigator that she attempted to contact the woman but the call went straight to the answering service. The

second weekend worker asked one of the friends to ask the woman if she would speak to her but she refused to to do so.

34. A police officer arrived at Hopwood House at about 4.00pm and searched the woman's property with the RSO in charge that day. They discovered a variety of documents that clearly indicated that she had intended to end her life. They included a copy of her will, money for a funeral and letters to her solicitor and brother. The police began the search for the woman, including attempting to trace her through her mobile telephone. The woman's second friend was asked to try to get as much information as she could from her whilst the RSO in charge that day gathered information for the police, contacted her line managers and managed the office. The second weekend worker remained with the residents and tried to keep them calm as they attempted to contact the woman. During conversations with her, she initially led them to believe that she was in Burton-upon-Trent then possibly at a friend's home in Barnsley. The search for the woman focused on identifying the friend's address.

35. Sometime between 5.00pm and 5.30pm, the woman's second friend spoke to the woman who told her that she had purchased a bottle of champagne on her "tab". This information was passed to staff as residents then thought it was likely that she was somewhere in a hotel. The RSO in charge that day, in turn, passed the information to the police. At about the same time, the police officer told the RSO that the woman's telephone signal had been located somewhere in Sheffield.

36. During the telephone conversation with the second friend, the woman said that she would like to speak to her brother. The woman's first friend telephoned the woman's brother, explained the situation and asked him to call his sister. In addition, the second friend said that the RSO in charge that day also spoke to the woman's brother using her telephone. She added that staff later told her that he had spoken to the woman and she had sounded drunk. The RSO in charge that day said that contact with the woman eventually ended at about 7.30pm. She was told by the woman's first friend that her speech was very slurred at that time.

37. Sometime during the afternoon, the RSO in charge that day telephoned the senior probation officer in charge at Hopwood House at home and told her that the woman was missing. The senior probation officer offered her support but did not go to the premises as she was going out. At about 8.00pm, the RSO in charge that day again spoke to the SPO. They talked for about half an hour and the SPO again offered support.

38. The second weekend worker went off duty at about 8.40pm. At that time, police had narrowed the search area to within one square kilometre of the woman's location. The RSO in charge that day briefed the oncoming staff before she went off duty at about 9.30pm, but no further information had been received at that time.

39. The woman's first friend told the investigator that she continued to call the woman's mobile telephone throughout the evening. The first staff on duty overnight said the police rang her at about 9.30pm and asked for her details as they had been checking the woman's telephone records. At about 9.50pm, the police informed the friend that the police had narrowed the search to within a very small area. The friend said she went to bed thinking "they may find her in time".

40. Two staff on duty overnight at Hopwood House. After receiving handovers from the staff going off duty, they spoke with residents and carried on their normal duties. They received telephone calls from the SPO in charge at Hopwood House and the duty SPO. Both asked if there was any news and offered support. At about 11.00pm the police officer arrived at the premises and told the staff that the woman's body had been found at a Travelodge hotel in Sheffield. Apparently, she had taken cannabis, drunk wine and a half empty bottle of methadone was discovered by her side. The second night duty staff telephoned the SPO in charge at Hopwood House and they discussed how to inform the residents. The SPO in charge of Hopwood House decided they should not be told until the morning and arranged to come in early the next day to talk to residents and staff.

Follow-up action

41. The SPO in charge arrived at Hopwood House at approximately 7.30am on 5 November. She told the investigator that this was about an hour earlier than normal as she wanted to speak to staff and certain residents who she was concerned about. She also intended to talk to all the residents at their 9.00am group meeting. She informed all the relevant authorities and followed the Death in Approved Premises Circular Instruction. She arranged for the local Crisis Intervention Team to visit to carry out a critical incident debrief.

42. The Director of Interventions and Support Services, and the Area Manager, also went to Hopwood House that day to offer support and advise staff of the availability of individual counselling and the Crisis Intervention Service.

43. The police had told the woman's brother of her death during the evening on 4 November. Her brother attempted to confirm this with Hopwood House staff but was advised to telephone the following morning after 9.00am. The SPO in charge of Hopwood House spoke to him during the morning on 5 November. After a brief conversation, they agreed that he would collect items removed by the police and then visit Hopwood House for the woman's other belongings. Two days later, the visit took place and the woman's brother received the remainder of her property.

ISSUES

Risk of suicide and self-harm

44. It is clear from documents and information provided during interviews that staff at Hopwood House were fully aware of the woman's self-harm history before she became a resident. Staff had received the appropriate training and ACT documents were available at Hopwood House to be used, if required.

45. There are 140 entries in the woman's Probation Service contact log from her initial court appearance in December 2005 until her death. The entries cover a variety of topics. They demonstrate that staff were supporting the woman to manage her eating disorder effectively and that her medical needs were being addressed through a local community doctor. Regular entries were made and most concerns were identified and documented. It is also evident from the records that considerable time was devoted to helping the woman cope with her life.

46. Entries made in the probation contact log on 16 August, the day the woman arrived at the premises, confirm that staff knew she was on an open ACCT document when she was released from Styal and had attempted self-harm by using a ligature about eight weeks before. At interview, SPO in charge at Hopwood House told the investigator that she discussed self-harm with the woman on the day of her arrival and she said that she "might go downhill" after a few days. Unfortunately, there is no record of that meeting in the contact log. There is however, a note of a meeting between them the following day. The notes of that meeting indicate that the SPO in charge at Hopwood House assessed the woman's wellbeing as she had been on an ACCT document. The notes confirm that she was coping well and would be further assessed the following Monday at the three way risk management plan meeting with her assigned offender manager.

47. The woman went to the risk management meeting on 20 August. The woman's assigned probation officer made an entry about the meeting in the contact log but it did not include any specific reference to the history of self-harm. On 21 August, the SPO in charge at Hopwood House made an entry in the contact log about a meeting between the woman and a social worker. The entry indicated that she was not expressing any thoughts of self-harm at that time and was managing to cope with most issues. It went on to say that the trigger for her self-harm tended to be when she dwelt on her own responsibility for the separation from her children.

48. The woman told her first friend that she had thought about suicide quite a few times whilst she was in prison because she could not live without her children. The woman's friend went on to say that the woman told her every day that she still found it difficult to live without them, in particular her youngest daughter.

49. When asked if she had noticed any recent signs that the woman might be considering taking her own life, the woman's first friend told the investigator about a conversation a couple of months earlier. The woman had told her how

easy it would be to buy a bottle of methadone for £1,000. The first resident challenged the woman who told her about the residence order for her youngest daughter. A few days after the hearing, which took place on 20 September, the woman was told that her sister-in-law had been given custody. The friend added that they did not get on well together and the woman felt she would not see her daughter again.

50. A few days before she died, the woman asked her first friend if she knew a good solicitor as she wanted to make a will. The friend was surprised by this. She asked if she thought she was a bit young and the woman replied "no". The friend said she realised that the woman was serious and the conversation came to an end. The woman also bought a new set of clothes and a top as a gift for the friend. Again, she thought this was unusual. They went out together on the Friday evening before the woman's death which was the birthday of her youngest daughter. She paid for a meal for them both wanted to have some wine with her as she said she would not get the chance to drink with her again.

51. The woman's first friend said she did not realise the significance of any of these events until after the woman's death. With hindsight, she believed that the woman had planned everything. She told the investigator that she felt the woman could not continue to live her current lifestyle and she wanted her old life back. A day did not go by without her talking about her children and her brother. It is clear that the first friend was very close to the woman and was well aware of her problems. However, the friend did not share this information with staff. She told the investigator that neither she nor the woman was the type of person to go to the office unless they had to.

52. The woman's key worker told my investigator that the woman had not discussed her offence in any detail. Her work with the woman focussed mainly on self-harm issues. They included discussions on bulimia and anorexia. The woman's key worker had told her that she never felt in control and that managing her diet gave her that control.

53. I am satisfied that appropriate efforts were made by staff to support the woman at Hopwood House. In particular, staff were aware of the significance of particular dates and events. There is evidence that staff considered placing the woman on ACT monitoring but decided against doing so as she appeared to coping. Evidence also shows that staff were aware of the significance of the custody hearing on 20 September, although I am surprised that there does not appear to be an entry in the contact log about the result.

54. Staff were also aware that two of the woman's children had birthdays during the week before she died. I am concerned that there is no entry in the log relating to her youngest daughter's birthday on 2 November. The woman's key worker made an entry in the contact log on 31 October which read:

> "The woman looks better than she did yesterday and tells me that she feels better, just down because of her son's 18th birthday yesterday and she was hoping he would phone her. Her daughter's birthday on

Friday 2nd. Hostel staff are aware D will need some support to get through this day."

The woman's key worker was not on duty again after 2 November until after the woman's death. There are no further entries relating to her daughter's birthday in the log.

55. A further entry in the contact log for 2 November refers to a risk management meeting but no details are provided. The woman's assigned probation officer, told the investigator that staff were concerned about her bulimia and her health seemed to be deteriorating. When the investigator asked if she was aware that it was the woman's youngest daughter's birthday that day she replied "yes". There is evidence that staff were also aware of the birthday on 2 November and it is also possible that they discussed it with the woman. There is however no documentary evidence to confirm that staff either read the woman's key worker's note or acted on it. I consider that an entry should have been made on the day to both confirm that the entry by the woman's key worker had been read and that it had been acted upon.

56. Had the woman been placed on an ACT document when she arrived at Hopwood House, significant dates and events, such as birthdays, are likely to have been identified and then managed when they arose. The entries in the contact log merely relate to the dates. They do not contain any evidence of how the impact would be managed.

57. I consider that when an individual with a history of self-harm or attempted suicide is received at an approved premises, a note of significant dates likely to have a negative impact on them should be made. The possible impact and the vulnerability of the individual at the time of the significant date should be risk assessed and a plan put in place to manage the individual appropriately throughout the relevant time period. This should happen irrespective of whether or not the individual is placed on an ACT document when they arrive.

The Probation Service should ensure that dates of particular significance to a resident who has previously self-harmed should be recorded, risk assessed and managed effectively. When an entry is made in a individual's contact log relating to a possible trigger point for self-harm, such as a key date, a plan should be devised and recorded to manage the individual through the particular event.

Record keeping

58. The occurrence book contains daily entries about a range of issues about the residents at Hopwood House. Two significant entries were made in the early hours of each morning of the birthdays of the woman's two youngest children. One entry clearly states that the woman said she was depressed. I can find no evidence to confirm that any of the staff on duty the relevant days either saw the entries or acted upon the information. I believe if staff had read the information, it is likely that either an ACT document would have been opened or

details of an in depth conversation with the woman would have been made in the contact log.

59. It is essential that the information contained in the occurrence book is read on a daily basis by an appropriate person. Any follow up action should be noted in the occurrence book and a more in depth entry should be made in the individuals contact log. I believe it should be the responsibility of the manager in charge of Hopwood House to ensure that this process is followed. Written evidence that the manager has checked the log should also be provided.

The Probation Service should ensure that the manager of the approved premises checks the occurrence book each day and ensures that all entries have been read and arising issues dealt with. The manager should then sign the book to confirm that the check has taken place.

The events of November

60. The first resident was distressed and crying when she entered the office, at about 3.25pm in November, and informed staff that the woman was missing and threatening to take her own life. Over a period of several hours, along with other residents, she was in contact with the woman attempting to gather information that might help the police locate her. The staff on duty at Hopwood House that day not only had to carry out their routine tasks but in addition had to manage information from residents to be passed to the police who were attempting to locate the woman. This is likely to have placed both the residents and the staff under considerable pressure. The senior probation officer in charge at Hopwood House was told during the afternoon that the woman had told residents that she had taken an overdose and that police were attempting to locate her. The duty SPO was also kept informed.

61. Both staff on duty left the premises at the end of their shifts whilst the search for the woman continued. It is likely that they were suffering from the stress of coping with several hours of intense incident management at the time. Residents at Hopwood House also spent several hours involved and are also likely to have been distressed when going to bed that night. A Probation Service manager did not attend either during the afternoon or in the evening before they had been made aware that the woman had died.

62. I consider this was a mistake. It is likely that both residents and staff would have benefited from the presence and support of a manager as soon as they were informed that the woman had taken an overdose. The duty SPO should be responsible for ensuring a manager's attendance. However, the late return of a resident rarely has such a tragic outcome and so I make no recommendation here. The Chief Probation Officer will wish to consider my remarks.

Follow up action

63. On 5 November, the woman's first friend got up at 5.30 to go to work. She asked if there was any news and was informed that they had not heard anything yet. She left Hopwood House and went to work. She told the investigator that she had little sleep and was worried about the woman. The SPO in charge at Hopwood House arrived at about 7.30am and spoke to staff on duty and most residents.

64. When a death occurs a debrief is normally carried out. They are primarily carried out to ensure that staff have the opportunity to discuss emotive issues following serious events before they go off duty. In this case, the staff who went off duty before the woman was discovered and would not have been able to attend. However, along with residents of Hopwood House who were involved in the event, they may well have benefited by being informed on the night of the woman's death.

65. Neither Probation Circular 60/2005 "New procedures for monitoring deaths under supervision" nor 18/2004 "Deaths of approved premises residents" identifies a requirement for a manager to attend an approved premises in the event of a death in custody of a resident. A "Practice Notice" document does give some additional guidance to be followed following the death of an approved premises resident. At paragraph four, the document says that the SPO should "De-brief approved premises staff on the same day if possible".

66. I recommend there should be a formal requirement to do so. It is my opinion that a SPO should go to the approved premises when it is discovered that a resident has died. This should be the relevant approved premises manager or the duty SPO if the manager is not available. Their role should be one of supporting staff and residents, conducting a "hot" debrief and managing the follow up action.

    The Probation Service should ensure that a manager attends the relevant approved premises immediately after being informed that a resident has died.

CONCLUSION

67. It appears that the woman convinced staff at Hopwood House that she had no intentions of taking her own life once she had left prison custody. Staff effectively managed any risk of self-harm linked to her eating disorder. The woman's key worker and both her friends knew a great deal about her and her battle with bulimia. More significantly, her friends knew of her concerns that she would not see her children again. However, there is no evidence to suggest that the woman went into any detail about her children after the custody hearing on 20 September. It is possible that she developed the plan to take her life sometime after she became aware of the result of that hearing.

68. The woman appears to have been distraught during the last week of her life when she did not receive any news of her children on their birthdays. It is possible that she then finally decided to take her own life. Various individuals held pieces of information about the woman. If all the information had been available to one person, it is more likely that it would have been acted on.

69. It seems that the woman intentionally went to an area well away from her friends and then gave them wrong information about her whereabouts to prevent them from intervening. The efforts made by residents at Hopwood House and the staff on duty during the day to find the woman should be commended. Had she told her friends where she was on that day, when they desperately tried to find her, she may not have died.

RECOMMENDATIONS

1. The Greater Manchester Probation Trust should ensure that dates of particular significance to a resident who has previously self-harmed should be recorded, risk assessed and managed effectively. When an entry is made in an individual's contact log relating to a possible trigger point for self-harm, such as a key date, a plan should be devised and recorded to manage the individual through the particular event.

   Greater Manchester Probation Trust response:

   Due to the time that has lapsed since the death of the woman, new instructions were issued some 12 months ago which cover this recommendation. Accepted.

2. The manager of the approved premises should check the occurrence book each day and ensure that all entries have been read and arising issues dealt with. The manager should then sign the book to confirm that the check has taken place.

   Greater Manchester Probation Trust response:

   This is not feasible. Each Approved Premises has one SPO and 1 PO – if they are available they read and sign the log book as a matter of routine. There will be occasions, however, when neither are available for legitimate reasons. Despite reservations about this recommendation, SPO/PSOs in the division will be reminded of the priority to be afforded to this task.

3. Greater Manchester Probation Trust should ensure that a manager attends the relevant approved premises immediately after being informed that a resident has died.

   Greater Manchester Probation Trust response:

   The death took place, off site, late into the night shift. The SPO in charge at Hopwood House was not on duty but was involved throughout the night and attended at 7.30am the following morning. She discussed the situation with staff and the 'out of hours' SPO, and her assessment that there was no need for her immediate attendance is supported by senior mangers in GMPT. Sadly there have been previous deaths in Approved Premises in Greater Manchester and in these cases the SPO has routinely attended. There must be room for assessment of individual circumstances, however and therefore this recommendation is not accepted.