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 man at Ysbyty Gwynedd Hospital, while he was a resident at Approved Premises in the Wales Probation Trust, in January 2011

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 death of a resident at approved premises in Wales. He was discovered in his room with a ligature around his neck on 17 January 2011 and died in hospital five days later. I offer my sincere condolences to his family and friends.

The investigation was carried out by an investigator. HMP Altcourse and Wales Probation Trust co-operated fully with this investigation. I am sorry for the delay in issuing this report.

The man was 54 when he was remanded to Altcourse on 8 January 2011. It was his first time in prison. Owing to previous attempts and continuing thoughts of self-harm, staff put in place support measures. However, healthcare staff were not invited to the relevant review and monitoring procedures were inappropriately closed the day before he was due to appear in court. Shortly afterwards, the man was released on bail to reside at the approved premises. Unfortunately, information about the man's risk of suicide and self-harm was insufficiently shared between the prison and the approved premises. Accordingly, three recommendations are made to the Director of Altcourse in relation to these issues.

The probation referral to the approved premises lacked any detail about the man's risk of self-harm and his impaired mobility which made the approved premises unsuitable for his needs. In addition, the procedure did not require approval by the approved premises's manager. Just before he hanged himself, a decision was made to remove the man's place at the approved premises. We do not know whether the man somehow discovered this. A recommendation is made to the National Offender Management Service about the need to improve the referral process for bail applicants and the information considered when doing so. I recognise that the Wales Probation Trust has made changes to policy and practice in the light of the man's tragic death and I am satisfied that a number of important lessons have been learned.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2014**

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SUMMARY

1. The man was arrested on 4 December 2010 and remained subject to police bail until 7 January 2011, when he was taken into police custody, as he had become homeless. The following day, he was remanded to HMP Altcourse and the documents accompanying him noted he had recently taken an overdose of medication. Once at Altcourse, suicide and self-harm monitoring procedures were put in place as the man said he had recently taken an overdose of drugs. He told staff that he would kill himself if given the chance and that his life had gone in a downward spiral over the previous fifteen years. The man was visually impaired and his mobility was restricted due to hip replacements and arthritis.

2. On 9 January, a mental health nurse assessed the man. He told the nurse that he had a long history of depression and that he would kill himself if he had the opportunity but lacked the ability to do so in prison. The nurse said that the man's homelessness appeared his primary concern. This was the man's first experience of prison, and although he was described as settling into prison life he maintained on more than one occasion that he wished to die.

3. In a case review on 13 January, with only custody officers present, staff decided to close suicide and self-harm monitoring arrangements as it was considered that the man had had a positive court appearance that day and had settled well. He hoped to be released on bail at his court appearance the following day. The decision not to involve healthcare staff in that review meeting was flawed and the closure of monitoring arrangements so soon before a court appearance was premature, particularly as the man had expressed thoughts of suicide but said it was difficult to do so in prison. This suggested he would be at higher risk once released. Recommendations have been made to the Director of Altcourse in respect of the handling of those procedures.

4. It is a concern that the documents which accompanied the man to court the following day noted only that he was a "self-harmer". None of the documents regarding his risk of suicide and self-harm were forwarded with him to escort staff or to the Probation Trust who managed the approved premises, to which he was released on bail. We make a recommendation about this deficiency.

5. The referral to the approved premises by a Court Duty Officer, which led to the man being allocated a place at the approved premises, was incomplete and written on an out of date form which did not prompt all the necessary information. The officer did not interview the man directly and as a result did not assess his physical suitability for the approved premises or take into account his risk of suicide and self-harm. The Wales Probation Trust has made improvements to their processes since that time to ensure that existing procedures are more closely followed but we make some further recommendations about this.

6. Staff at the approved premises were surprised when they first saw the man as they had not been made aware of his mobility difficulties and had no suitable ground floor accommodation available. Following a fall on 16 January, the man told a member of staff that he wanted to stop eating so that he would die and when he went to bed at night he hoped he would not wake up in the morning. Staff decided to check on him hourly that evening until midnight. We consider that management and monitoring of his risk of self-harm should have been more comprehensive. Subsequently, improved suicide and self-harm management procedures have been fully implemented and the approved premises staff trained.

7. On the morning of 17 January, the manager of the approved premises decided to withdraw the man's place as she considered that due to his mobility problems it was not safe or suitable. The man was not informed of this decision. Staff had seen the man around the premises that morning and one member of staff had spoken to him to check on his welfare. However, at 10.30am when a member of staff went to the man's room, they found him hanging. Having alerted the emergency services he returned with another member of staff to cut the man down. They had some difficulty, eventually using scissors from the office. Cut-down knives have subsequently been issued to staff.

8. After staff attempted resuscitation, paramedics quickly arrived and detected the man had a faint pulse. They took him to hospital but he never regained consciousness and died five days later on 22 January.

THE INVESTIGATION PROCESS

9. The investigator was formally notified of the man's death on 25 January 2011. Notices were subsequently issued to both staff and residents at the approved premises, informing them of the investigation process and giving them the opportunity to contact the investigator with any relevant information. No one came forward as a result.

10. The investigator visited the approved premises on 31 January 2011 and was provided with the documents relating to the man. She returned to the approved premises on 18 and 19 April, to interview staff. The investigator also interviewed staff at HMP Altcourse on 20 April. She provided feedback during the investigation. We apologise for the subsequent delay in issuing this report which was due to pressure of work and unforeseen circumstances on the part of the investigator.

11. The investigator wrote to the Coroner's office to inform them of the nature and scope of the investigation. HM Coroner will be provided with a copy of this report.

12. One of our family liaison officers, contacted members of the man's family on 16 February 2011, to explain the purpose of the investigation and invite them to put forward any questions or concerns. The man's cousin, listed as his next of kin, responded that she did not want to be involved in the process but would like a copy of the final report. She had one concern, which was why the man had been residing in approved premises when he had dementia as a result of his alcohol misuse.

13. On 10 June 2011, the family liaison officer also contacted friends of the man who had indicated they wished to be involved with the investigation. They raised no issues of concern at the outset of the investigation but will have the opportunity to receive and comment on this report.

THE APPROVED PREMISES

14. Approved premises, (formerly known as probation and bail hostels), are approved by the Secretary for State within section 9 of the Criminal Justice Act and Court Services Act 2000. They provide a structured, supportive environment in the community for high risk offenders, many of whom have been released from prison as part of a supervision plan agreed with the person's offender manager (formerly probation officer) and for some people on bail. The purpose of approved premises is to provide an enhanced level of residential supervision in the community in a supportive and structured living environment. In The man's case, he was referred to the approved premises as he was of no fixed abode and could not be released on bail until he had an address.

15. The approved premises is located near the town of Bangor. It has the following aims:

- protect the public
- prevent re-offending
- provide residents with an opportunity to address their problems in a stable environment
- enable residents to face up to their offending behaviour
- complete the conditions of their order or licence
- facilitate their resettlement into the community.

16. The approved premises has an established routine for inducting all new residents carried out by the member of staff who is on duty at the time a new resident arrives. During the process, residents are told about the local house rules and their expected behaviour. Possession of alcohol and drug use is strictly forbidden. Breakfast and dinner is provided to all residents.

17. As well as having their own offender manager (probation officer) in the community, each resident has a key worker at the approved premises who acts as their primary point of contact during their stay and helps residents deal with practical issues. Residents at the approved premises are all asked to register with a local general practitioner (GP) and approved premises do not provide healthcare.

18. While at the approved premises, residents are required to pay rent and abide by the rules and regulations, which include staying in the premises between the hours of 9.00pm and 12.00pm, unless they have a doctor's appointment, employment or other authorised appointments. During the afternoon, residents are free to leave the approved premises unaccompanied. When leaving the premises residents are required to sign out and sign back in on their return.

19. A Senior Probation Officer (SPO) manages the approved premises under the responsibility of an Assistant Chief Officer (ACO). In addition, full and part-time Residential Support Officers (RSO),

Probation Support Officers (PSO) and a Business Administrator (BA) staff the premises. The approved premises sometimes uses relief staff to cover shifts.

20. This is the third death at the approved premises since the Ombudsman took on the responsibility for the investigation of deaths in Approved Premises in April 2004. Both of the other deaths were due to natural causes and raised no issues relevant to this investigation.

KEY EVENTS

21. The man was a creative person who pursued artistic training in Wrexham after leaving school. The man worked as a porter in a local hospital and later became a freelance artist, setting up a design and advertising partnership with a friend. Having suffered a number of bereavements and without sufficient work, he found himself without a stable home and moved to Rhyl.

22. The man suffered orthopaedic problems necessitating surgery at different times to both hips and at the time of his reception to custody required the support of crutches. He was also visually impaired.

Arrest and police custody 4 December 2010 – 8 January 2011

23. On 4 December 2010, the man was arrested and remained subject to police bail until 7 January when he was taken into police custody. The following day, he appeared at Llandudno Magistrates' Court. The Person Escort Record (PER) accompanying the man from the police station to court noted that the man had taken an overdose of tablets the previous month and was alcohol dependant. (The PER is a document that accompanies each person between police station, court and prison. It contains information about the individual's needs and the risk he poses to himself and others.) It was also recorded that he walked with the aid of a crutch and wore dark glasses. Once at court, he was initially placed in the observation cell and was checked every ten minutes.

24. The man was remanded into custody at HMP Altcourse on 8 January. He was 54 and this was his first time in prison. He was of no fixed abode and was next due to appear at court for a bail hearing, via a videolink,between the prison and the court on 13 January 2011.

25. At court on 8 January at 9.05am, Prison Custody Officer (PCO) completed a suicide and self-harm warning form. He recorded that the man had harmed himself within the last month, taking the information from the PER. The PCO spoke to the man about his recent self-harm but he would not give any details. The man told the PCO that he was "OK" at present but was not sure how he would feel later. The PCO recorded that the man seemed depressed and that he had previously taken an overdose. He added that observations every ten minutes were required. The PCO escorted the man from court at around 10.40am. It is noted on the form that the Reception Officer received the man at Altcourse at 12.50pm.

HMP Altcourse 8 January 2011 – 14 January 2011

8 January

26. At 1.40pm on 8 January, an officer completed a concern and keep safe form, indicating that the man had attempted to kill himself by overdose

around two to four weeks previously. The man said due to the way he felt at present he would attempt suicide at any opportunity he got. This form meant that the Assessment Care in Custody and Teamwork (ACCT) procedures would be started (ACCT is the suicide prevention system used by prisons to identify and support prisoners who are thought to be at risk of self-harm and/or suicide.)

27. The form was given to the unit manager, who completed an immediate action plan with the man. This required five observations per hour and one conversation each in the morning, afternoon and evening to be carried out. It recorded that the man was aware of telephone access and the Carers scheme (Carers are prisoners at Altcourse trained with some input by the Samaritans to support other prisoners). The unit manager also noted that a mental health nurse would assess the man that day.

28. At 3.29pm, the doctor recorded on the man's health record that this was his first time in prison, that the man felt he would, "kill himself if given the chance" and he was subject to ACCT monitoring. The man told the doctor he had been homeless for the last eight days. He also said that he had undergone an operation on his right hip and was normally prescribed a morphine-based painkiller but he had not taken any for ten days. He told the doctor he had previously tried to overdose on these painkillers, paracetomol and alcohol.

29. The doctor recorded that the man's heart sounded normal, his chest was clear and he was fit and well. The doctor also concluded that the man was alert, oriented in time and place, had a mild tremor of his fingers and was mobile with an elbow crutch. He noted the man's alcohol misuse and prescribed medication to lessen any withdrawal symptoms. He recorded that there was no evidence of past or present mental illness, but requested a medical/psychiatric report because of the opiate-based medication.

30. At around 4.00pm, a PCO completed the ACCT assessment interview with the man in the activity room in the healthcare centre where he was located. The PCO told the investigator that the purpose of this interview was to gather information regarding the man's current feelings and any history of suicide and self-harm. The man told the officer that "everything in his life has fallen apart over the last 15 years". He related issues of bereavement, homelessness, losing his business and alcohol misuse. The man repeated that he had last attempted suicide two to four weeks previously by overdosing on medication and alcohol.

31. The man told the officer that he wished to die and had thought so for many years but was unsure whether he would try to kill himself while in prison. The man also told the officer he had made previous suicide attempts and had considered jumping off a building. The PCO told the investigator that the man was obviously in pain, which the man confirmed was due to his arthritis and artificial hips. The man also told

the officer that he had a videolink scheduled for 13 January. He said his solicitor was confident that he would not get a custodial sentence and was trying to get him a bail hostel.

32. The man's Cell Sharing Risk Assessment (CSRA) was completed. A history of suicide or self-harm the previous month was noted and that the man stated he wanted to kill himself. (The CSRA assesses the risk of harm a prisoner presents to a cellmate if they are required to share a cell.) The man voiced no concerns about sharing a cell and requested vulnerable prisoner (VP) status. (VPs are located on a separate wing and are those deemed to be at risk from other prisoners either due to the type of offence they have committed or are charged with or other reasons such as owing money to other prisoners). It was noted he would need a bottom bunk due to mobility issues and he was assessed a low risk of harm to others.

33. The man also had an interview with a Carer on 8 January. The Carer noted that he felt able to cope although he was anxious, depressed and worried. He also noted the man had thoughts of suicide or self-harm and was aware of support available in prison. A Carer stayed with the man overnight in his cell.

9 January

34. On 9 January at 9.33am, the doctor recorded that he was not sure why the man was located in healthcare and that he was a VP on alcohol detoxification who was fit for normal location whenever an appropriate place was found.

35. At around 11.00am, the nurse, a registered mental health nurse, recorded that she had assessed the man, following a referral from admissions and his ACCT book. The nurse recorded that the man presented as settled, was pleasant in mood and manner and maintained good eye contact throughout the assessment. He told the nurse he had a long history of depression, dating back 20 years and had been prescribed anti-depressants previously by his GP but had chosen not to accept them as he was self-medicating with alcohol. He had become depressed following the breakdown of a relationship and his business failing and had started misusing alcohol. He told the nurse he had taken an overdose three weeks previously due to housing issues and that, "given the option he would kill himself" but since he was in prison he "lacks the material".

36. The nurse told the investigator that the man's homelessness seemed to be his primary concern. The nurse noted he was on maximum observations in respect of the ACCT procedures which should be maintained until he was assessed further. She told the man that the resettlement department would visit him in due course regarding his housing issues. The nurse also offered the man counselling which he declined. She told him that the Prison Community Mental Health Team

(PCMHT) would conduct a review and gave him advice and support about prison issues.

37. The nurse told the investigator that the PCMHT review would usually take place within seven to 14 days but if a member of staff had more urgent concerns they would review him within 24 hours.

38. Following the nurse's assessment, the PCO and a Senior Nurse joined her and the man for his ACCT review. The man said he had had suicidal thoughts most of his life but that he would only attempt to end his life by drinking alcohol and taking medication. It is recorded that he said he had been admitted to Glan Clwyd hospital for four days recently (incorrectly recorded as from 30 January 2011). Records show that a request was made the same day to find out more about this hospital admission. The man told those present that if he was not released on 13 January he would go on hunger strike. The man also confirmed that he had no contact with his family and did not want them involved in his care.

39. Since a suitable place had become available for the man on a VP wing, the nurse and the VP wing manager, conducted a discharge review. The procedure for collecting his medication was explained to the man who said he had no suicidal thoughts at that time and no concerns about moving wings.

40. At 1.20pm, the man was relocated to Reynoldstown Blue, the VP wing. The officer took him from healthcare to the new wing. The officer told the investigator that the man asked him a lot of questions about basic life on the wing and told him that he had some physical health issues. The officer said the man's mobility issues were clearly visible and restricted the speed at which the man could walk.

41. The officer was also the case manager for the man's ACCT arrangements. He told the investigator that this meant he oversaw the work the officers were doing with the man. He also chaired the case review meetings. Before chairing a case review, he would ask staff to observe a prisoner on the wing and read his wing file to see how he was settling into the prison.

42. At 2.05pm, the chaplaincy spoke to the man and recorded in his ACCT booklet that he was feeling suicidal as he "dislikes life" and was feeling "particularly bad because of the circumstances that have led him here". An initial resettlement interview was also completed on the same day and a referral made to Shelter Cymru, who run housing services for Welsh prisoners at Altcourse.

10 January

43. The man's solicitor wrote to Wales Probation Trust on 10 January (the letter was received the following day), requesting that they assess the man for his suitability at approved premises on bail.

44. At 8.20am, the PCO spoke to the man who told him that "given a choice he would rather be dead than alive but feels he does not have the means to commit suicide while in prison". The PCO told the man about the Carer on the wing and that he could speak to staff any time he needed to.

45. At 1.55pm, an ACCT case review took place with the man, the officer and the nurse. The man's was concerned about getting back to Wales if he was given bail on 13 January. They explained he would be given a prison issue train ticket to return to his home area if released from prison. The man said he had no current thoughts of suicide or self-harm and the nurse assessed there were no signs of such at the time. They agreed to reduce observations to twice per hour during the night and one conversation in the morning, afternoon and evening. The next ACCT review was scheduled for 13 January.

46. The man's personal officer, the PCO, first met the man at 7.45pm. (The personal officer scheme assigns a named officer to each prisoner who they can approach for advice or to resolve complaints.) They discussed the man's recent suicide attempt and his concerns about his housing situation.

11 January – 12 January

47. On 11 January, the PCO spoke to the man who told him he was feeling more settled and enquired as to how different processes worked on the wing. At 4.25pm, he told an officer that he "despises life" and had attempted suicide on several occasions but would not try while in custody as he had no access to alcohol or medication. He repeated this thought later on that evening to another officer. The following day when asked again, he said he had had thoughts of suicide while in prison but it was virtually impossible to do so. At 4.00pm, he told staff he felt sick and dizzy. An officer told him to make a warm drink and he would ask a nurse to see him later. There is no further reference to this in the record.

13 January

48. On 13 January, an administrator, recorded in the medical record that she tried to get information from Glan Clwyd Hospital Accident and Emergency Department who put her through to the department where the medical records were kept. There was no answer and the administrator made a note that she would keep trying. There are no further entries about this on the medical record.

49. At 8.35am, the PCO recorded in the ACCT document that the man was getting used to how things worked in prison and that he said he would not harm himself while in custody as he "feels he does not have the means to do so." Later that afternoon the man said he felt "fine".

50. A safer custody representative spoke to the man that morning. He recorded that the man seemed "nervous" and "agitated" and did not know what was happening with his case at court that day.

51. Later that morning, the man appeared via videolink from the prison at Llandudno Magistrates' Court. As a result, the Offender Manager, was telephoned at Colwyn Bay Probation Office since he was back-up court duty officer (CDO) for the day. The court requested that the offender manager complete a bail assessment for approved premises for the man and adjourned his case until the following day, so that the offender manager could make these enquiries.

52. The offender manager told the investigator that he did not travel to the court to interview the man via videolink since he did not believe the link would still be connected or that the court would make provision for him to carry out the interview. He estimated the journey would have taken him approximately 30 minutes. Instead the offender manager spoke to the man's solicitor twice on the telephone and also used a printout from the Police National Computer (PNC) of the man's previous convictions, current charges and a case summary.

53. The same day, an ACCT case review took place at 7.00pm with the man present, along with the officer and the PCO. The officer explained to the investigator that he did not invite the nurse, as he believed the man was settling well in prison and that the bail hearing that day had been a positive one for him. Therefore, the ACCT review was not multidisciplinary. Staff noted that the man had settled on the wing, come to terms with his imprisonment, had been prescribed medication to lessen withdrawal symptoms from alcohol and was supported by healthcare. The review records:

> "He remains positive and the appearance at court on 14.1.11 he thinks is to grant him bail to a local hostel. This was discussed on videolink today. No issues of self-harm. Booklet closed."

54. Therefore, the man was no longer to be subject to monitoring under ACCT arrangements and a post-closure review was set for 20 January. The officer told the investigator that the decision to end the ACCT measures was a joint one between himself, the PCO and the man. The officer believed that since the man was likely to be released to approved premises he was no longer homeless, which had been a big issue for him. The officer said that the man had:

> "stabilised, he was participating in everything we had to offer and there were no acts of self-harm in the period he'd been with

me. Progress had been clearly seen. This was a decision based on the evidence I had in front of me on that day."

14 January

55. On 14 January at 7.20am, the man was taken from Altcourse to Llandudno Magistrates' Court. The PER accompanying him noted "self harmer", the risks to others was managed and alcohol issues. The recent ACCT was not attached, or marked as attached, on the accompanying sheet.

56. The offender manager referred the man to the approved premises. He telephoned the approved premises and discussed the referral with a Probation Service Officer (PSO). The PSO agreed the approved premises would accept the man and the offender manager faxed her a referral form, a copy of the man's previous convictions and details of the charges against him. The man was allocated a single room.

57. The referral form the offender manager used was out of date. The risk of suicide marker box was not ticked and there were no questions about the man's physical health or any mobility impairments which are included in the up to date form. The offender manager told the investigator that he had asked the man's solicitor whether he had any mental health issues and the solicitor had assured him that the man did not. The offender manager did not mark this information on the referral form. He said he had known the solicitor for nine years in a professional capacity and did not believe he would give misleading information, as this would damage his reputation with the court.

58. The offender manager could not remember seeing the solicitor's letter, which had requested the bail assessment two days earlier, detailing the date the man would be appearing in court.

59. On the basis of the offender manager's assessment, the man was granted bail on the condition he resided at the approved premises. The man's next court appearance was scheduled for 2 February. No information was passed on from the prison to the court or probation staff regarding concerns about his risk of suicide or self-harm.

The approved premises 14 January – 17 January 2011

14 January

60. A Probation Service Officer (PSO) met the man when he arrived at the approved premises between 4.00pm and 4.30pm on 14 January. The PSO was surprised to see that the man was using a crutch. A Senior Probation Officer (SPO) with responsibility for managing the approved premises, also saw the man for the first time as he arrived. She too was surprised by the man's limited mobility, especially as the only room for men with physical disabilities on the ground floor was occupied. She

was concerned whether the approved premises could meet his needs and immediately spoke to the PSO about this.

61. The man was shown the kitchen by another resident and had a cup of tea with him as part of the settling in procedure. The PSO then asked the man whether he was able to walk up and down the stairs and asked him to demonstrate this, as he was concerned for the man's safety, in the event of a fire and the need for evacuation. The PSO recorded that the man managed it but "he did struggle".

62. In light of the lack of information regarding the man's limited mobility, the Senior Probation Officer telephoned the offender manager to discuss his referral. During this conversation, she learnt that the offender manager had not actually seen the man or spoken directly to him but had relied on the information provided by the man's solicitor. The Senior Probation Officer clarified to the investigator that, at the time, all referrals were agreed by the PSOs and not referred to managers so she had not been involved in the decision-making process.

63. Due to her concerns about the quality of this referral, the Senior Probation Officer telephoned the offender manager's manager, an SPO and followed this up with an email highlighting her concerns and issuing guidance to be shared amongst court duty officers (CDOs). This covered CDOs having physical sight of those they are assessing for bail placements in approved premises and not relying on information solely from a defendant's legal representative. If interviewing via videolink, The Senior Probation Officer instructed that CDOs should give special attention to questions about mobility and other health related issues. She also asked that CDOs use the correct referral forms which include a prompt about mobility issues. The Senior Probation Officer then left the approved premises but as the out of hours duty manager for the weekend, she asked staff to keep her informed if there were any issues about the man's mobility and his placement at the approved premises as his room could be withdrawn at any time.

64. The SPO told the investigator that she did not have the opportunity to address this with the offender manager that day but spoke to him the following week. She was also aware that the handling of the referral would be addressed as part of an enquiry into the man's death.

65. Following his arrival for the evening shift around 5.00pm, a locum relief staff member completed the man's induction with him. The relief staff member told the investigator that this involved explaining the rules to the man, what he could expect from staff, processes such as medication and showing him round the building.

66. The PSO had asked the relief staff member to check that the man was able to cope with the two flights of stairs up to his room, as he was concerned that Ty Newfydd was not suitable. The man said he could get up and down the stairs as long as it was not several times but might

need a chair in the shower. The man told the relief staff member that he was having problems with his hip and he was told he would see a doctor on Monday, as all new residents did. The man agreed to this and said he had all the medication he needed until then and he had no immediate issues. The man signed a copy of the approved premises' rules. The relief staff member then showed the man round the approved premises, including the toilets and fire exits. He left the man in his room getting settled. The relief member of staff said he had no concerns when he left him.

67. Residents are subject to care and security checks at allotted times during the day and evening to check they are present when required. It was acceptable to conduct these checks via CCTV images. The PSO completed the 7.00pm check on the man and the relief staff member the 9.00pm check. The relief staff member could not remember if he had seen the man in person or on the CCTV at this time. The relief staff member had no concerns about any risk of self-harm or suicide.

15 January

68. On 15 January, the care and security check sheet shows that a member of staff saw the man at around 9.00am and that he left the approved Premises at 10.40am. He returned at 3.45pm. The man was seen by a member of staff at subsequent security checks for the remainder of the day at 5.00pm, 7.00pm and 9.00pm.

69. That evening, the man went to the reception and told staff he felt dizzy when he leant forwards or backwards. Staff advised the man that they would telephone an ambulance if he felt he needed urgent medical attention, otherwise they could schedule a doctor's appointment for Monday. He decided to wait till Monday.

16 January

70. On 16 January, staff carried out a care and security check on the man at 9.00am. He left the approved premises at 10.45am and returned at 4.30pm. Further care and security checks took place at 5.00pm, 7.00pm and 9.00pm. In the early evening, another resident told another relief worker, that he had heard a "loud bang" from above the training room where the man's room was and staff went to his room to check.

71. The man told staff that he was fine and had not fallen. He later visited reception and admitted that he had fallen. The relief worker asked him if he required a doctor (she had started work at 4.00pm that day and had not met the man before). He told the relief worker that he had hit his head and shoulder and fallen on his back but that he would wait until the following day to see a doctor. He explained to the relief worker that he suffered from dizziness and, for years, had a history of falling over. He said he had not told a doctor about this as he had "had enough of hospitals over the years".

72. The man then told the relief worker that due to his deteriorating health, he wanted to stop eating so that he could die. The man said that when he went to bed at night he hoped that he would not wake up in the morning. The relief worker recorded that she reassured the man and that he would be checked during the evening. She asked him to talk to staff if he needed anything and offered him the help of a "professional," (meaning a permanent member of staff) which he declined. The relief worker told the investigator that the man had seemed quite calm when she had gone to his room to check on him but when he came to reception, he was shaky and she had sat down with him while they spoke. She had assumed his presentation was due to the exertion of coming down the stairs to see her

73. A decision was made to undertake hourly checks on the man in his room that evening. A Residential Services Officer (RSO), telephoned the Senior Probation Officer expressing his concern about the man's mobility and general health due to his earlier fall and she agreed the hourly checks to be appropriate. The Senior Probation Officer told the investigator that it was her understanding that staff would complete the checks until the man went to sleep and, as far as she was aware, this was what had happened. She told the RSO that she would review his placement at the approved premises the following day.

74. Throughout the rest of the evening, the RSO and the relief worker completed the hourly checks together and, each time, spoke to the man who remained awake between 7.00pm and 12.00am. The relief worker told the investigator that the man was fully clothed and lying under the covers on his bed. She thought he seemed comfortable and she asked if he needed to go to hospital but he declined. The RSO told the investigator that the man had said he wanted to die but that he would not "do it" in the approved premises. The RSO said they discussed the pain the man was in but he declined the offer of going to hospital

75. A logbook entry made by the relief worker states "checked on Charles every hour from 7.00pm to 12.00am. Nothing to report." As was expected for the shift she was working, the relief worker then went to sleep in the staff quarters from midnight until 7.00am, while the RSO stayed awake.

17 January

76. At 3.00am on 17 January, the RSO sent an email to all staff at the approved premises stating that they had checked on the man until midnight and all was well with him apart from him saying he wanted to die. The RSO, who was the Health and Safety representative, expressed concern that since the man walked with a crutch he might not have been able to evacuate the building safely in case of fire. He finished work at 8.00am and did not see the man again.

77. At 9.00am that morning, the man was due for a care and security check by staff. The relief worker actually completed the checks that morning between 6.15am and 8.15am. She told the investigator that she recalled going to the man's room shortly after 6.15am and he was half-awake. A short while later, she went back to his room, a second time, to tell him that she was still trying to get through to the surgery regarding his medical appointment to be scheduled that day.

78. When the PSO arrived at work around 7.45am that morning, the relief worker updated him regarding the man's fall, dizzy spells and his assertion that he did not want to wake up in the mornings. This was a surprise to the PSO who had not assessed any risk of self-harm or suicide. The PSO rang the local doctor's surgery and made the man an appointment for 2.40pm that afternoon. This was a routine appointment, which would be scheduled for all new residents.

79. Staff saw the man leaving his room at 9.00am when he went to the dining room where he made himself a hot drink. Staff observed him on CCTV go and sit in the pool room where he spoke to other residents. Given the concerns about the man, the PSO went to the pool room to speak to him and said the man told him he was feeling fine. The PSO said that, although it was light enough to see around, the man had not switched the light on in the room. The PSO asked why he was sitting in darkness and switched the light on. The man left the pool room at 9.30am and returned to his room. The PSO also wrote an entry in the logbook detailing the man's arrival at the approved premises and his use of a crutch. He added that he did not believe the man was suitable as a resident since the disabled room was already occupied.

80. Meanwhile, the Senior Probation Officer had arrived at the approved premises at around 8.30am. She spoke to the PSO and the relief worker about the man and read the logbook entries. Following these conversations, the Senior Probation Officer made the decision that the man's place would be withdrawn due to her concerns about the suitability of his placement as regards health and safety issues and his lack of mobility. The Senior Probation Officer was also aware of the statement the man had made about not wanting to wake up in the mornings and told the investigator that this was also a factor in her decision to withdraw his place.

81. The Senior Probation Officer telephoned the Assistant Chief Officer (ACO), to discuss withdrawing the place and this was agreed. She made a further telephone call to the head of the Local Delivery Unit, to highlight the concerns about the quality of the referral made by the offender manager and to inform him that she had sent an email to the SPO in relation to this. The Senior Probation Officer then contacted the man's solicitor to tell him that the place was being withdrawn. Afterwards, she drafted a letter to this effect to be shared with the man and told the PSO her decision.

82. At interview, the PSO said that he contacted the man's support worker to advise of the decision. He explained that it would then have been left to the man to make arrangements with his solicitor and possibly go to court to get another bail address.

83. The PSO went to the man's room around 10.30am, to ask him to go to the office so they could tell him the decision. The PSO knocked on the man's door and received no response. The door was slightly ajar. The PSO entered the room and found that the man was hanging by a belt tied to a hinge on a wardrobe door. There was also a chair in front of the wardrobe.

84. The PSO tried to lift the man but was unable to do so. He therefore locked the door behind him so another resident did not find the man and ran downstairs. He told the business administrator, the situation and asked her to request an ambulance. He then ran to the Senior Probation Officer's office and told her he needed her as there had been a hanging. They both ran back to the man's room but were unable to get the man down. The Senior Probation Officer quickly went back downstairs to get some scissors, returned to the man's room and cut through the ligature. They initially removed the mattress from the man's bed and placed him on it, flat on his back . The Senior Probation Officer believed they then took him off the mattress, placed him directly on the floor and started cardio pulmonary resuscitation (CPR). The PSO completed the compressions and breaths and the Senior Probation Officer assisted him. The paramedics arrived around five minutes later and took over these resuscitation attempts after they had attached their defibrillator to the man.

85. Between 10.40am and 11.00am, the paramedics continued CPR until they found a faint pulse and the man was taken by ambulance to Yspyty Gwynedd Hospital. The hospital telephoned, later in the day, to tell staff that his condition was critical. The man never regained consciousness and died five days later in the hospital, on 22 January.

86. Given the proximity of the man's hanging himself to the decision to withdraw his place at the approved premises, which would possibly have led to his recall to prison, the investigator considered whether it was possible that the man overheard discussion about this. This is particularly so as the man used a means of attempting to kill himself, by hanging, which he had so far appeared to rule out when discussing the possibility of suicide in prison. He had also expressed anxiety about his accommodation arrangements. However, the investigator was satisfied that the staff offices at the approved premises are sufficiently private and removed on a separate corridor from the residents' areas as to make this unlikely. The investigator tried to contact the man's solicitor to check whether he had possibly discussed the situation with but received no reply to telephone messages left for him.

Events after the man was taken to hospital

87. On 18 January, the Senior Probation Officer asked staff to be vigilant about how residents with any previous or current history of self-harm or suicide might be feeling and to check on them hourly between 8.00pm and 12.00am. She also asked that during security and care checks, staff should ensure that they had physical sight of a resident and did not just view them on CCTV.

88. The Senior Probation Officer telephoned the hospital later that day and spoke to the nurse in charge of the man's ward. The nurse said that there had been no change in his condition and they would make a decision whether to withdraw medical support, in consultation with his next of kin. She told the Senior Probation Officer that she would need to obtain the family's permission before sharing any further details. The Senior Probation Officer telephoned twice a day for the following few days to check on the man's condition, but was not always able to get information.

89. On 19 January, the Senior Probation Officer circulated a document to all staff about coping with a traumatic event and offered them both group and individual counselling. When the man died, hospital staff did not contact the approved premises and it was only when the Senior Probation Officer called them for an update on Monday 24 January, following a few days absence from the approved premises, that she was told of his death.

90. On 3 February, the Senior Probation Officer spoke to the man's uncle, giving him basic information outlining the circumstances leading up to the man being taken to hospital and his eventual death. The following day, after the man's funeral, he went to the approved premises, and spoke to the Senior Probation Officer.

ISSUES

Management of the man's risk of self-harm and suicide at Altcourse

91. The man disclosed to police officers that he had taken an overdose in recent weeks and this information was appropriately recorded on the PER which accompanied him to court. Once remanded into custody on 8 January, the man acknowledged feelings of wanting to take his own life and staff therefore placed him under the ACCT suicide and self-harm prevention procedures. Over the following few days, he told various professionals that he wished to die but doubted whether he would take his own life in prison where he lacked the means to do so (by which he appeared to mean medication and alcohol) as had been the case in his previous attempt.

92. ACCT reviews took place on 9, 10 and 13 January, when the monitoring stopped. Staff believed that the man had sufficiently settled into life on the wing and had had a positive appearance at court via videolink that day with the prospect of bail the following day. Two staff, the unit manager and a PCO attended this review, together with the man.

93. Best practice is that such reviews should be multidisciplinary, although it is accepted that this is not always possible. However, the unit manager explained that given the progress the man had made, he considered it unnecessary to invite a member of healthcare to the meeting. It therefore seems that the decision about ending the ACCT process was pre-judged, whereas the expectation is that such decisions should be made after discussion, taking into account of anything said during the review. In view of this, we make the following recommendation:

    The Director of Altcourse should ensure that whenever possible staff conduct multi-disciplinary ACCT case reviews recording the reasons when this does not happen and take considered decisions based on discussion at the review.

94. Staff had to make a balanced decision in terms of ending the ACCT monitoring. Staff believed that the man had settled in and he had indicated he would or could not kill himself in prison. Staff also considered that the resolution of the man's homeless position was a reason for closing the ACCT but he was not formally referred, or accepted to approved premises until the following day. Nor could temporary bail accommodation be regarded as a long term solution to his homelessness.

95. We are concerned that the ACCT was closed when staff knew that the man was attending court the following day and could potentially be released on bail. The man had said on more than one occasion, including the day before, that he wanted to die but lacked the means to take his own life in prison. He had also disclosed that he had recently taken an overdose of medication and alcohol while in the community.

His potential release should therefore have been seen as a raising his risk of suicide and self-harm. In addition, his accommodation position had not been resolved.

96. PSO 2700 instructs that ACCT monitoring should not be stopped within 72 hours of a known transfer to another establishment. While the man was not being transferred, an attendance at court, especially with the possibility of release to approved premises, should be considered to raise similar issues and fall within the spirit of the PSO. It would have been prudent to continue the ACCT monitoring until after the man had actually attended court just one day later. We make the following recommendation:

The Director of Altcourse should ensure that staff do not close ACCT procedures within three days of a known court appearance which could significantly change a prisoner's situation.

Information transfer regarding the man's risk of suicide and self-harm

97. On 18 January, the Senior Probation Officer, the manager of the approved premises, contacted the mental health team at HMP Altcourse to gain more information about the man. She was given a brief history of his time there. Staff also informed her that he had been subject to suicide and self-harm monitoring procedures at Altcourse, although not at the time of his release. She later spoke to the safer custody department who told her that only when a prisoner was currently or very recently subject to ACCT monitoring and released from the prison on licence would they contact the approved premises to share this information.

98. The safer custody officer told the Senior Probation Officer that in all bail cases they would not proactively share any information about ACCT procedures as the prison would not know if a person was likely to be bailed from court or returned to the prison. The Senior Probation Officer highlighted to her manager that she felt this was unsatisfactory.

99. As a result, the Head of Local Delivery in Wales Probation Trust, wrote to the Welsh Courts and Tribunal Service and Head of Safer Custody at the National Offender Management Service (NOMS), requesting that both the PER and ACCT documentation be made available to CDOs doing bail assessments. NOMS replied that it appeared that the instructions in PSO 2700 had not been followed.

100. When the investigator showed the SPO the man's PER form she said it was not a form she had ever seen before and it was not practice for probation staff in the North Wales area working in courts to have sight of the form. She said, while it would not replace the Probation Trust's assessment, it would certainly help inform that assessment. The offender manager was not aware that the man had been subject to ACCT monitoring while in prison and had been subject to monitoring

even at the time he was responsible for making a bail application on the man's behalf. He had never heard of a PER nor seen one. Since the man's death, the guidance has been revised and the approved premises manual states that referrers should seek to gain information from all sources, including the PER, to ensure that the risk of suicide and self-harm is fully addressed in supervision and risk management plans.

101. The PER prepared for court on 14 January 2011 noted only that the man was a "self harmer". The ACCT was not attached. Given the man's repeated assertions that he would kill himself but not while in custody as he lacked the means, it was important to have included this information on the PER since there was a chance the man would be released that day. The ACCT, which had been closed only the previous day should have been included with this PER. This would have provided staff with information about the man's state of mind as well, as the required post-closure review should he be transferred to another establishment. .

102. PSO 2700 directs that:

> "Where a prisoner in the post-closure phase of ACCT (i.e. the ACCT Plan has been closed, but the final post-closure review has not been signed off) is leaving the establishment (i.e. moving to another place of custody such as court or prison, not final discharge):
> - The closed ACCT Plan must accompany them.
> - Discharging reception staff must make receiving escort staff aware that the prisoner has a recently closed ACCT Plan.
> - This must be recorded on the Prisoner Escort Record (PER), the bottom copy of which is retained by the establishment."

103. The PSO states that where an at-risk prisoner released at court is to reside in approved premises (including if on bail), the manager must be provided with a photocopy of the final case review, the plan for care, front cover and inside front cover of the ACCT plan. As ACCT monitoring had just ended the day before his release and the post-closure review had yet to be held, the man was still within the ambit of ACCT procedures and should therefore have been regarded as at risk. Since circumstances relevant to his risk of suicide and self-harm were changing, it should have been seen as essential for the approved premises to have been given this information.

104. Following a meeting with the investigator and discussions between Altcourse and Wales Probation Trust, on 13 May 2011, the SPO sent an email to staff working in courts with information explaining the PER and care of at-risk prisoners' ACCT forms. She detailed that these forms would be provided by the prison to the agency providing escort staff (GSL) and that they would highlight any ongoing or previous concerns regarding self-harm or suicide. The SPO directed that all staff completing bail assessments must obtain a copy of these forms from GSL staff to inform their assessment of suitability for a bail placement.

She further added if there is any issue obtaining these forms, a manager should be contacted immediately.

105. The issues regarding transfer of information regarding the man's risk of suicide were twofold. Firstly, Altcourse did not complete the PER sufficiently or attach ACCT documentation as required by PSO 2700. Secondly, GSL staff failed to pass on the contents of the PER and staff from the Wales Probation Trust failed to request this information. We note that the Welsh Probation Trust has made significant efforts to improve this situation locally such that PER and ACCT documentation is to be requested by all CDOs completing bail assessments. However, there is no national guidance requiring probation staff to ask for this information if it is not received. We, therefore, make the following recommendation:

The Director of Altcourse should ensure that staff complete PERs to the required standard and ACCT documentation is attached, where appropriate, as directed by PSO 2700 and in any case where there is potential ongoing risk.

Quality of referral to the approved premises

106. The offender manager could not remember seeing the solicitor's letter received at the Probation Office on 11 January, requesting a bail assessment for the man. Had he seen it, this would have provided him with advance notice that he would need to attend court on 13 January to assess the man.

107. The offender manager completed the referral to the approved premises on a previous, obsolete version of the referral form. He told the investigator that he was aware of a newer form, introduced in March 2009, which he should have used but mistakenly used this older version. He did not consider that the newer form would have led to a more detailed assessment. By contrast, the Senior Probation Officer said that the up to date referral form had much more detail, including questions about mental health treatment, any current or previous risk of suicide or self-harm, any perceived risks to staff and any mobility issues. The offender manager had not ticked the risk of suicide marker and had based his assessment only on conversations he had with the man's solicitor.

108. The SPO told the investigator that once a CDO had received a bail assessment request she would expect them to telephone the approved premises and other service providers to establish whether they had any vacancies. This would happen before going to the court in order to avoid any wasted journeys. If there were vacancies, she would then expect the CDO to go to the court. The SPO said that the court was normally obliging in allowing CDOs to use the videolink to interview potential bailees and realised they needed to interview the person for a complete assessment. She told the investigator she was unsure

whether there had been any particular issues with the videolink on 13 January, but that this was sometimes the case.

109. In relation to the referral form, the SPO said that she would have expected much more detail to have been completed in relation to the charges the man was facing and any potential risks to others he presented. She added that the question regarding any psychological or psychiatric problems should not have been left blank but should have been answered either positively or negatively. The SPO also indicated that the contact with other agencies section should have been completed.

110. On 25 January 2011, the head of the Local Delivery Unit sent an email to probation staff. This included a link to the bail assessment form, with instructions that it had to be filled in from a direct interview with the defendant and that all risks of self-harm must be considered, including information from any previous stays at approved premises. It required information relating to any issues while in custody to be obtained, such as health issues, mobility, suicide risk or mental health concerns. The Senior Probation Officer told the investigator that this was not a change in process but reminded staff of the correct procedures. We are therefore satisfied that appropriate steps have been taken to ensure that staff are aware of the process regarding bail assessments and that sufficient safeguards have been put in place to prevent inappropriate referrals being accepted.

111. As the man was on bail and had not had any previous contact with the Probation Trust, they had very little information about him. The Offender Assessment System (OASys) is a two-part risk assessment tool used by Probation Trusts. 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. It assesses a person's likelihood of re-offending as well as their risk of harm to others and themselves.

112. Probation Circular 37/2005, which was in force at the time of the man's death, states the information to be provided to approved premises at the point of referral:

> "A full OASys risk assessment if available and as a minimum an OASys risk of harm screening assessment … Any other relevant information (e.g. about risk of self-harm) that may be necessary to enable approved premises staff to support, supervise and manage the resident."

113. Revised guidance in the Approved Premises Manual 2011, which was issued after the man's death, directs that:

> "For defendants on bail the referring officer should, prior to admission, provide the AP with:

- A full OASys risk assessment if available, and as a minimum an OASys risk of harm screening assessment.

- An indication from the court of the purpose of the placement, the likely length of stay, the intended move-on plan, and the assessments/interventions that AP staff are expected to undertake during the bail period.

- Any other relevant information (eg about risk of self-harm) that may be necessary to enable AP staff to support, supervise and manage the resident."

114. If the offender manager had used the correct form and ensured it was completed in full, it is likely that this information would have been included in the referral. Additional guidance has now been issued. Nevertheless, in line with national policy, we make the following recommendation:

    The National Offender Management Service should amend guidance on referring people on bail to approved premises, to clarify the process and explicitly include requesting PER and ACCT documentation from court staff and to require staff to carry out appropriate risk and needs assessments before accepting a person at approved premises.

115. At the time of the man's death, referrals to the approved premises did not have to be approved by a manager and his referral was accepted by a PSO who did not ask the offender manager for any further information other than that contained on the old referral form he had completed. The Senior Probation Officer changed this practice the day the man died and she now has oversight of all referrals, which she has to approve. The Senior Probation Officer said this meant that she now has the opportunity to address any referral issues before a resident arrived. This is now in line with the guidance in the Approved Premises Manual.

Managing the man's risk of self-harm and suicide at the approved premises

116. The original referral to the approved premises lacked a risk of self-harm or suicide assessment and crucial information had not been passed on from the prison to the escort agency to the Probation Trust. During his short time at the approved premises the man told members of staff that he wanted to stop eating so he would die and was disappointed when he woke up in the mornings that he was not dead. He also said that he wanted to die but did not think he would "do it" while at the approved premises. This was the evening before he apparently took his own life.

117. During that evening, staff checked on him hourly until midnight when staff said he remained awake. We consider that given the man's state of mind, consideration should have been given to continuing checks

throughout the night and the following day until a more thorough assessment could be made. We recognise that such checks can be intrusive but there was no strategy to manage his risk during that period. The national policy at the time, required all probation areas to have in place a local strategy for reducing sudden deaths and self-harm. Approved premises managers were instructed to ensure that all staff were made aware of the local strategy for reducing sudden deaths and self-harm and other relevant guidance.

118. The subsequent Approved Premises Manual states that every probation trust must have a written strategy on reducing self-inflicted deaths of residents and that they should make sure that their staff are fully trained. The Approved Services Manual states that a number of trusts have adopted ACCT or a version of it for use in approved premises (known as ACT – Assessment Care in the Community and Teamwork). There is no requirement for them to do so as long as they have a " coherent strategy that achieves the same aims".

119. The Senior Probation Officer told the investigator that when she started managing the approved premises in December 2010 only one member of staff was trained in using the ACT support plans. The Senior Probation Officer had put this item on the agenda for her first team meeting so that they could cascade their knowledge to other team members. Sadly, this was scheduled for a few days after the man's death. This training has since taken place and the Senior Probation Officer told the investigator in April 2011 that ACT plans are now used and were a helpful framework for staff to work with those considered to be at risk of self-harm or suicide. As the approved premises has adopted the ACT approach and staff are now trained, we have not made a recommendation on this issue.

120. There is no evidence that the man overheard discussion, or was informed of the decision to withdraw his place at the approved premises on the morning he hanged himself but the proximity of the two events suggests this possibility cannot be discounted.

Emergency Response

121. When the man was found in the morning of 17 January, the PSO immediately requested an ambulance and got the assistance of the Senior Probation Officer to try to cut the man down, since he had not been able to do so on his own. Despite their best efforts, a lack of appropriate equipment made this difficult and they eventually managed by retrieving scissors from the reception office.

122. Since the man's death, all staff at the approved premises have been issued with cut-down knives. The Senior Probation Officer also decided to remove all doors and hinges similar to the ones on the man's wardrobe.

CONCLUSION

123. A previously productive and settled individual with his own business, the man seems to have reached a crisis point in his life whereby he was misusing alcohol, was of no fixed abode, had suffered a number of bereavements, had no employment and was remanded into custody for the first time at the age of 54. He was consumed with his issue of homelessness while on remand in prison and told staff a number of times that he wished to die. Appropriate measures were put in place to prevent self-harm, but we believe they were stopped too soon.

124. Having been released on bail to reside at approved premises six days after his remand, the man again told staff that he wished to die. Unfortunately, staff at the approved premises had not been provided with sufficient background information before his referral. Staff were concerned the facilities at the approved premises were unsuitable to meet the man's needs and a decision was made to withdraw his place there. When staff went to inform him of this, tragically, they found him hanging in his room and he died a few days later in hospital.

125. It is impossible to determine whether, ultimately, the man's apparent suicide could have been prevented. We do not know whether he had somehow discovered the decision to withdraw his place at the approved premises and hanged himself in despair. However, it is without doubt that there must be robust and reliable systems for sharing information between criminal justice agencies about risk and vulnerabilities. Just as importantly the criminal justice agencies must follow these processes and their own systems to try and reduce incidents of self-harm and suicide in the future.

RECOMMENDATIONS

1. The Director of Altcourse should ensure that whenever possible staff conduct multi-disciplinary ACCT case reviews recording the reasons when this does not happen and take considered decisions based on discussion at the review.

2. The Director of Altcourse should ensure that staff do not close ACCT procedures within three days of a known court appearance which could significantly change a prisoner's situation.

3. The Director of Altcourse should ensure that staff complete PERs to the required standard and ACCT documentation is attached, where appropriate, as directed by PSO 2700 and in any case where there is potential ongoing risk.

4. The National Offender Management Service should amend guidance on referring people on bail to approved premises, to clarify the process and explicitly include requesting PER and ACCT documentation from court staff and to require staff to carry out appropriate risk and needs assessments before accepting a person at approved premises.

   NOMS Offender Management & Public Protection Group accepted recommendation 4 and will consider what improvements can be made to the guidance, within the limits of the information normally available to court duty staff (as not all AP referrals will be for people being released from remand). No response was received in response to the recommendations to HMP Altcourse.