



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a resident at Approved
Premises in the Greater Manchester Probation Area,
in December 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 report considers the circumstances surrounding the death of a man, at Approved Premises, on 12 December 2007. The man died as the result of falling from a motorway bridge, after absconding from the Approved Premises shortly after 9.10pm that night. He was 34 years old.

I apologise for the delay in producing this report. The investigation was led by one of my colleagues. I would like to thank the Senior Probation Officer and Manager of the Approved Premises for the cooperation of staff and residents during this investigation. I would also like to thank the Offender Manager from Atherton Probation Service Office and Stockport Substance Misuse Service (SMS) for their assistance. I am grateful to the Pennine Care National Health Service (NHS) Trust, for allowing me to use their serious and untoward incident report which reviews the care that the man received through the Stockport SMS.

The man had been convicted of a violent offence which led to him being categorised a high risk offender. He had a history of occasional alcohol misuse, anxiety and whilst at prison was diagnosed with histrionic and narcissistic personality disorders. Despite this troubled past, the man had not been perceived as a risk to himself, only to others.

On release from HMP Risley in October 2007, the man was subject to strict licence conditions and Multi Agency Public Protection Agency (MAPPA) panel reviews. Three of the licence conditions were that he reside at Approved Premises for high risk offenders, abide by his curfews and address his alcohol misuse. The man moved to the Approved Premises on the day of his release. He quickly settled and made a positive impression on staff. A small concession was made to the restrictions relating to alcohol in early November to reward his good progress. The man was allowed to drink alcohol within the legal drink/drive limit, measured using breathalyser tests as and when required. He initially chose to abstain or only drink low alcohol drinks.

A MAPPA panel meeting, held in November 2007, discussed his risk level and licence conditions but decided that no changes should be made at that time. The man had hoped for some leniency and was disappointed with the decision. His mood became changeable, often low and he disengaged with both hostel staff and his offender manager. As he became more frustrated he began to slowly increase his social drinking. However, this was never to a noticeable excess.

On 12 December, the man was late for his 9.00pm curfew and was asked to take a breathalyser test. He refused to do so and left the hostel. Staff were unsuccessful in their attempts to persuade him to come back and the duty manager and police were immediately notified. The man's body was found by the police at 11.00pm after he had fallen from a nearby motorway bridge.

Despite the events in the period leading up to his death, staff and his offender manager all said the man's decision to abscond and his subsequent death could not have been predicted. He had not presented as being at risk to himself. If anything, staff felt his risk to others might have increased, although some remarked that the irrationality of his actions was not entirely out of character. Those who had worked closely with the man reported that his decisions could at times be erratic. Nevertheless, his death came as a great shock to all and I would like to offer my sincerest condolences to the man's friends and family.

I do not think the man's decision to abscond was intentional, but a reaction to the fear and possibility of being recalled to prison. Although a recall had not been mentioned to the man, he would have known that under certain circumstances it could happen. I am unable to come to any conclusion on the circumstances around his fall from the bridge. However, the police investigation concluded that no third party had been involved.

I am confident that staff at the Approved Premises and his offender manager acted appropriately in meeting the man's immediate needs. However, I have made two recommendations regarding the accessibility and recording of information and one national recommendation regarding formal guidance for staff when dealing with a possible breach of conditions.

Stephen Shaw CBE
Prisons and Probation Ombudsman

May 2009

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SUMMARY

The man was convicted of a violent crime in 2003. He received a seven year sentence and was classed as a high risk offender under the Multi Agency Public Protection Arrangements (MAPPA). The man was released on licence on 5 October 2007. The conditions of the licence required him to live at Approved Premises for high risk offenders, abide by a curfew, address his alcohol issues, not enter Lancashire, or attempt to contact his victims.

The man suffered from anxiety and depression. He had a history of periodic heavy drinking linked to these conditions and his offending behaviour was said to have been triggered by heavy drinking combined with his prescribed medication. During his time in custody, the man was diagnosed with histrionic and narcissistic personality disorder.

On release from prison, the man moved to the Approved Premises. Prior to his move and during his introduction at the hostel, the man was told about curfews, the hostel rules and the restrictions on consumption of alcohol. He was also warned about breaching licence conditions and how this could lead to being recalled to custody. The police coordinated an emergency contingency plan in the event of the man absconding as he was a high risk offender. This was shared with probation staff. The man was not aware of its existence.

During the man's first week at the Approved Premises he said he felt anxious and had difficulty sleeping. However, staff reported that the man soon settled after a doctor from the local surgery prescribed an antidepressant.

From 8 October, the man had regular meetings with the Stockport Substance Misuse Service (SMS) team to address his previous alcohol misuse. In the first session, the man said his past bouts of heavy drinking were linked to depression and anxiety. In the second session, he told the substance misuse worker that he occasionally had suicidal thoughts. The man said he was prone to high and low moods, but these were stabilised by his antidepressant. He told the substance misuse worker that he had no current thoughts of harming himself.

Staff reported that the man initially made a positive impression and fully engaged with the hostel regime. In view of his good progress, a concession was made to the conditions relating to his alcohol contract in early November. The alcohol ban was lifted and the man was permitted to drink to the legal drink/drive limit. As before, he would continue to be breathalysed as and when required. The substance misuse worker supported the move to a moderate alcohol contract.

The man regularly told staff he was frustrated with his curfew times. He requested a relaxation in his signing times and asked if he could apply for home leave. Residents may only make an application after eight weeks of being at the hostel. However, his offender manager told the man that his request could be raised during the MAPPA meeting scheduled for 15 November.

The MAPPA panel meeting on 15 November was attended by the Approved Premises Manager, the man's offender manager, Lancashire and Greater

Manchester Police, and a Chairperson. The purpose of the meeting was to review the man's risk following his release from prison, address any arising matters and discuss his progress.

The man's offender manager updated the panel on the man's progress and suggested that consideration be given to relaxing one of his signing times in recognition of his positive engagement. The Approved Premises manager supported the man's offender manager's comments. The police raised concerns about the man's drinking, his prescribed medications (for anxiety), the sensitivities surrounding a home visit (the man had been previously charged after a dispute with a neighbour) and maintaining the ban on entering Lancashire. The panel was divided on the issue, but decided that it was too early to relax any conditions. This would be reviewed at the next meeting in early January.

The man's offender manager advised the man of the MAPPA panel's decision by telephone the following day. The man was angry and frustrated by this decision. He repeatedly told staff that he felt let down by the Probation Service and other authorities. The man's keyworker, managers and the man's offender manager spoke to the man regularly about his frustrations and encouraged him to remain positive. Despite this encouragement, the man started to withdraw from life at the hostel (refusing to eat with other residents) and said that the authorities were conspiring against him. The man pushed the boundaries of the hostel rules on occasion. However, this did not result in any formal warnings.

On 26 and 27 November, the man suffered panic attacks. The first was during a group work session. The man told the deputy manager, that he did not feel comfortable in a large crowd. The second happened the following evening. The man went to the office, complaining of chest pains. The paramedics were called and were able to calm him. The man saw the doctor the next day, who prescribed sleeping tablets to help with his increased anxiety. The man attributed his stress to being grouped with high risk offenders, group work, restricted contact with his family and his relationship with the Probation Service.

Staff at the Approved Premises and the man's offender manager had numerous discussions about handling the man's disengagement. It was thought that the MAPPA decision had negatively impacted on their work with the man. On 29 November, the deputy manager wrote to the man's offender manager and the Approved Premises manager. She believed there would be therapeutic value in relaxing the man's signing times and thought that his increased resentment could heighten his risk to others. The Approved Premises manager raised these concerns with the MAPPA Chair. The Chair declined to make any changes and said it would be for discussion at the next meeting in January.

The man started to increase his social drinking. The combination of alcohol whilst taking prescribed medications was noted by a member of staff on 3 December, who raised her concerns with management. It was discussed with the man, who assured staff that he was aware of the need for caution when mixing alcohol with his medications. He said that it was under control. However, the substance misuse worker remained concerned and offered to refer him to an alcohol support group. The man declined.

During early December, staff described the man's mood as changeable and, on occasion, strange. Despite this there were no significant concerns. The man maintained that his mood was caused by his licence conditions.

On 12 December, the man had a meeting with the man's offender manager. He appeared no more frustrated nor angry than usual. Later that afternoon, he left the hostel and met some friends at a pub in Stockport. The man left that pub at approximately 8.45pm. He telephoned the hostel at 8.55pm to let a member of staff at the Approved Premises know that he would be late for his curfew as he was experiencing difficulties contacting the taxi firm. She told him to get back to the hostel as soon as possible. The man arrived at the hostel at 9.10pm. The taxi driver came into the hostel with him to confirm the reason for being late.

The man had nothing other than a £10 note to pay for his taxi fare and the driver had no change. The driver and the man left the building and got back in the car. They drove to a nearby petrol station to sort out the fare and quickly returned. The man had not told staff that he was leaving the hostel.

On his return, the member of staff at the Approved Premises noticed that the man had been drinking so told him he would need to be breathalysed. The man said "today of all days, when I will be over the limit". He declined to participate and went to his room. The member of staff did not tell the man that he had breached his licence conditions. (There is an informal understanding at the Approved Premises that residents are not informed at night if they have breached their conditions in case of a negative reaction – absconding, increased risk of self-harm or harm to others. The matter is left for the manager to deal with the following morning or the duty manager if it is an emergency.)

The member of staff told her colleague that she would need to telephone the duty manager to let her know that the man returned late. Before she was able to make the call, the man came down to the office, said "see ya" and left the hostel. The member of staff followed the man to the end of the driveway and called to him to come back but he refused. As he had absconded, the member of staff notified the duty manager and the police. The emergency contingency plan was put into place and the Early Recall and Release Section at the Home Office was notified. At 10.50pm, the police telephoned the Approved Premises to report that someone had died falling from the motorway bridge near the hostel. It was confirmed at 11.00pm that the person was the man.

THE INVESTIGATION PROCESS

1. My investigator opened the investigation on 17 December 2007. She discussed the circumstances surrounding the man's death with the Manager at the Approved Premises. During the initial visit, my investigator received a briefing from the Approved Premises manager about the man's time at the Approved Premises and was given a full set of documents relating to his stay at the hostel.
2. Interviews were held in two sessions at the Approved Premises in late January and February. My investigator interviewed probation staff, a resident and a substance misuse and alcohol worker from Stockport Community Drug Team.
3. A Detective Inspector (DI) from Stockport police undertook an investigation on the Coroner's instruction. His investigation considered the events on the evening of the man's death and whether there were any suspicious circumstances. The police investigation concluded that there were none. My investigator liaised with the Detective Inspector during her the investigation. The Detective Inspector was able to provide further information from his enquiries for inclusion in this report.
4. My investigator did not visit HMP Risley as part of her investigation. All information regarding the man's time at there is taken from his probation records and interviews with staff the Approved Premises and his Offender Manager.
5. Pennine Care National Health Service (NHS) Trust produced a confidential review of a drug-related death. The review was commissioned by the Trust due to the man's contact with the Stockport Substance Misuse Service (SMS). The report considers the appropriateness of the care and support he received from the service during his time at the Approved Premises. It also makes reference to the man's mental health. The Associate Director for Clinical Governance at Pennine Care NHS Trust gave permission to refer to this review in my report.
6. One of my Family Liaison Officers first contacted the man's family on 21 December. She spoke with his mother who confirmed that the family would appreciate a visit to discuss the family's concerns.
7. My Family Liaison Officer and my investigator met the man's mother, her partner and the man's sister on 15 January 2007. His family were concerned that the man had not been adequately prepared for his release from prison. The man's mother said the man had not progressed to an open prison or had any home leave visits before being given parole. She said that when he arrived at the Approved Premises her son found it difficult to adjust to being back in the community. They questioned whether or not the man had been properly inducted at the hostel.
8. Although he eventually adjusted, in the man's mother's opinion, her son remained anxious, particularly about breaking the conditions of his licence or the hostel rules. The man's mother said that her son feared going back to

prison and carried two mobile phones with him to ensure that he always had a means to contact the hostel in the event of being delayed.

9. The man's mother told my Family Liaison Officer and my investigator that her son never spoke of being a drug user or having problems with alcohol. As a result, the man's family were not aware that he might have found his moderate alcohol contract problematic.
10. The man's mother told my investigator that her son had also told her that a resident had bullied him to provide a urine sample. My investigator found that the incident did take place, but there was no evidence of bullying. The man told his outreach worker that a resident had approached him for a urine sample as the resident wanted to use it for a drug screen test, to guarantee a negative result. He said that he had not felt threatened by the request, but simply found it strange that he had been asked. The outreach worker informed staff of the incident. Staff monitored the situation and changed the drug screening policy.
11. Despite the issues discussed with his family, the man never gave them any sign of being depressed or distressed. When they had last visited him, the man had seemed very happy. Since his death they have spoken with his supervising officer who told the man's sister that he had no idea that the man had felt suicidal. His death came as a shock to all.
12. The man's family asked that my investigator answer the following questions as part of her investigation:
 - What does the MAPPA process involve and how are reviews carried out?
 - Why was the man's mother unable to appeal the MAPPA decision to not relax the man's conditions of licence or signing times during the November meeting?
 - What were the conditions of the man's alcohol contract?
 - What are the limitations on hostel staff when on duty at night? Why did someone not pursue him beyond the hostel driveway?
 - What did staff say to the man when he arrived late for his curfew? Was he told that he had breached his licence conditions or could be recalled back to prison?
 - Who was on duty at the hostel that night? What are agency staff and were there any on duty on the night that the man died?
 - Did staff have the man's mother's contact details? On ringing the hostel the man's mother was asked to leave her phone number so that she could be contacted.

- Did the Detective Inspector take a statement from the taxi driver who brought the man back to the hostel?
- Did the Detective Inspector speak to the man's friends who had been in the pub with him earlier that night?
- What happened to the rucksack that the man was carrying when he left the hostel? It was not with him when he was found.
- Was there any CCTV footage of the man's movements after he left the hostel?

All of these questions are addressed within the body of this report.

THE APPROVED PREMISES

13. The Approved Premises is a 25-bed Approved Premises for adult men, run by Manchester Probation Area. There are six double occupancy rooms and the rest are single.
14. The hostel is staffed 24 hours a day by probation employees who provide support to residents and ensure their compliance with the hostel rules, license and bail conditions. There are 15 members of staff. Between the hours of 8.00am to 10.00pm there are two residential service officers (RSOs) on duty. From 10.00pm to 8.00am there are two residential service workers (RSWs). The main distinction between the roles is that the RSOs are keyworkers (see below). The management team comprises a deputy manager (probation officer) and manager (senior probation officer, SPO). Managers are present during the daytime. A duty manager (a SPO) provides out of hours cover between 5.00pm and 9.00am. Arrangements are similar during weekends.
15. Residents have their own keys and are permitted to come and go as they please between curfew hours. Upon entry and exit, staff record movements on resident monitoring sheets. Residents also record their entry and exit times on a central journal. A system of curfew operates between 11.00pm and 6.00am. Residents have to agree to comply with this and the other rules of residence as a condition of their court order or as a requirement of their release from custody.
16. Each resident is registered with the local medical practice - Heaton Moor Healthcare Centre. Prescribed medication is stored in a locked cabinet located in the general office at the hostel, unless the resident has been assessed as able to have medication in possession. Having medication in possession was introduced as a pilot scheme at the Approved Premises in May 2008. Therefore the policy was not in place when the man was a resident. In any case, the man would not have been eligible.
17. The surgery sends residents' prescriptions to the local pharmacy, which then delivers the medication to the hostel. My investigator was told by the Approved Premises manager that some doctors (possibly locums) hand the prescription directly to the resident, who should then bring it straight to hostel staff for collection. Residents were actively discouraged from collecting prescriptions as it makes it difficult to monitor their medications and assess risk.
18. Residents are allocated a keyworker (one of the RSOs) soon after their arrival. The RSO acts as their primary point of contact for dealing with practical issues. A keyworker manages a maximum of six residents. Regular keywork sessions, which take place approximately every ten days, give residents the opportunity to discuss any problems in depth. Although these sessions are not governed by a set agenda, issues such as benefits, health and move-on accommodation are routinely discussed.
19. The day-to-day regime at the Approved Premises is relaxed, although all residents are expected to attend the daily morning meeting which commences

at 9.00am. The meeting is chaired by a member of the hostel staff and acts as a forum for staff to pass on information to residents, such as details of appointments, activities available at the hostel on that day and menu options for the evening meal. Residents are expected to use their time at the Approved Premises productively, and are actively encouraged to pursue training and employment options.

20. For any resident identified as at risk of self-harm or suicide, there is a process in place for observation and monitoring using a tool called an Assessment Care and Teamwork (ACT) document. The ACT is modelled on the document used by the Prison Service. The ACT is for use by all those responsible for a resident's care to better manage the resident's risk. This is done by clearly documenting interactions, observations and assessments, in addition to detailing care plans. The document is accessible to all involved, making care transparent with shared responsibility.

KEY EVENTS

21. The man was convicted of a violent crime in 2003. He received a seven year sentence, with a Home Office licence due to expire in 2013. The licence meant that if he reoffended he could be recalled to prison. The man's last period in custody was spent at HMP Risley.
22. Whilst at Risley, the man submitted three complaints regarding his Offender Assessment System (OASys) score. OASys is a standardised process for assessing risk. It is designed to:
 - assess how likely an offender is to be reconvicted
 - identify and classify offending-related needs including basic personality characters, thinking deficits and social issues
 - assess risk of harm to others and also to themselves
 - assist with the management of risk of harm
 - link assessments with supervision plans and sentence plans
 - indicate need for further specialist assessments
 - measure how an offender changes during the period of supervision/sentence.

An assessment is carried out at the pre-sentence report (PSR) stage, with further assessments conducted (either in custody or in the community) and at the end of sentence.

23. OASys is used for the following groups of people:
 - all offenders subject to court ordered PSRs
 - all adult offenders subject to community penalties
 - residents of Approved Premises, including those on bail
 - adults serving six months or more in custody
 - young offenders serving one month or more in custody
 - those released from prison on licence.
24. The main part of the OASys examines the following factors which predict the likelihood of an offender being reconvicted:
 - offending history and current offence
 - social and economic factors
 - personal factors: drug and/or alcohol misuse; attitude towards offending and supervision; emotional factors such as anxiety or depression.

OASys highlight the impact each factor has on the offender's risk of reconviction, as well as the risk of serious harm to others or indeed himself.

25. The man challenged his score on the basis that he had completed some of his offending behaviour targets, but they had not been reflected on his form. The targets read as either being ongoing or not completed. Although the prison

dealt with his complaints, the man remained dissatisfied with his OASys report and said it was demotivating. He said he could not see the point in engaging and complying if he did not see positive results. The man asked that a Multi Agency Public Protection Arrangements (MAPPA) panel meeting scheduled for 29 August 2007 be postponed until his OASys form was updated.

26. MAPPA agencies comprise Police, Probation, Prison, Housing, in some instances Social Services and other interested parties. The agencies meet to manage an offender's risk once released from prison. The panel considers the risk management of the offender themselves, to staff, to specific individuals/victims and the general public. This is a formal arrangement, put in place to ensure a consistency in information sharing, to protect the public and reduce the likelihood of reoffending. A typical risk management plan might include various degrees of police surveillance, reporting schedules, licence conditions and requirements to undergo specialist treatment orders.
27. Violent and sexual offenders are supervised by Police, Probation, Youth Offending Teams and Mental Health Services. Any of these organisations can refer offenders for consideration by a multi-agency meeting. The task of the meeting is to share information, assess the risk(s) the offender represents, and plan safeguards to protect the public. Every case has built-in timescales for the risk management plan, individual accountability and a mechanism for checking progress.
28. There are three MAPPA levels:
 - Level 1 – agencies can individually assess and manage the risks that people they work with present to the public.
 - Level 2 – cases where there is a high risk of reoffending and causing serious harm¹ that cannot effectively be assessed and/or managed by one agency alone. Agencies together organise and manage level two meetings when they deem it to be necessary.
 - Level 3 – The Multi Agency Public Protection Panel (MAPPP) uses the same formal processes as level two, but deals with the most high risk cases, and requires regular monthly meetings from all agencies involved.
29. The man felt his OASys score might influence decisions made at the MAPPA meeting. In response to his complaints, the man was told that the OASys score would be one of many factors considered in assessing a MAPPA risk level. A probation officer at Risley said that his concerns would be made clear to his offender manager. The probation officer told the man she would also be at the MAPPA meeting and could represent his views. However, the officer stressed

¹ Serious harm - that which is 'life threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be difficult or impossible' - Offender Assessment System (OASys) definition used by MAPPA Responsible Authorities.

that it was ultimately the decision of MAPPA to decide on his risk level and licence conditions.

30. During June and July, the man's offender manager secured a placement for the man at the Approved Premises ready for his release. The placement was offered to the man on the basis that the man's offender manager contact the manager at the Approved Premises or the deputy manager to agree the conditions of his licence and the time and date of the man's arrival.
31. The MAPPA meeting took place on 29 August. The deputy manager attended on behalf of the Approved Premises. Also present were the man's offender manager, the probation officer from Risley and representatives from Lancashire and Greater Manchester Police. On the basis of the meeting, the man was given a MAPPA Level 3 score and rated as a high risk of harm and reconviction. Two further MAPPA meetings were held prior to the man's release, one on 6 September and a second on 27 September. The focus of the MAPPA discussions was the man's offence and safeguarding his victims. The police said they would develop a contingency plan to be activated if the man was to fail a curfew or abscond. Strict measures were to be put in place, including a two-hour recall, which would mean an immediate return to prison should he leave the hostel outside his curfew without prior agreement.
32. Prior to the man's release from prison, the man's offender manager visited him and discussed his licence conditions. The man was given a copy of his licence. The conditions of his release were:
 - he remained under a supervision order, which would expire 7 May 2011
 - he should keep in touch with his offender manager
 - to permanently reside at the Approved Premises.
 - comply with requirements set by his offender manager to address his alcohol and offending behaviour problems
 - provide an alcohol breath test as reasonably required by staff at the Approved Premises
 - comply with the "no alcohol" contract he signed at the Approved Premises
 - abide by the curfew – to remain on the premises between 9.00pm and 9:30am
 - sign in daily at 12 noon and 4.00pm at the Approved Premises, unless given written permission to miss a time
 - not to approach or contact his victims
 - provide his offender manager with details of any travel
 - he should not enter the county of Lancashire
 - he could be subject to a recall to prison if he breached his conditions.

The man's offender manager also talked to him about his resettlement in the community and explained how it would work. The man was contacted by the Approved Premises on 26 September and sent a residents' information pack.

33. The man arrived at the Approved Premises on 5 October, accompanied by his mother and her partner. He was given an introduction to the hostel (based on the information pack he had already received) and taken through the rules and procedures by a residential service officer (RSO).
34. The full introduction process is carried out in stages over the first two days at the hostel. It covers:
 - hostel rules
 - health and safety regulations
 - dietary requirements
 - room allocation and rent
 - job seekers' allowance and registering at the job centre
 - registering with a doctor and medication
 - issues of self-harm or suicide
 - allocating a key worker
 - making appointments with the key worker and hostel manager
 - explaining the hostel regime, groupwork, activities and education through City College.

The man signed the induction paperwork to say that he understood and accepted the hostel rules and regulations.

35. A senior probation officer (SPO) was acting as manager as the Approved Premises manager was on leave. She met the man to reinforce his licence conditions, including the exclusion zone, which stopped him from entering Lancashire (due to his offence). An entry by the senior probation officer in the man's contact sheet (a record of notes is kept for every resident) indicates that he appeared nervous at first, but became relaxed. They also discussed the use of his laptop and Open University (OU) exam work arrangements. The man was allowed to keep his laptop as it complied with hostel rules and he needed it for his OU work. The man's exam was to take place during the afternoon of 9 October.
36. After the meeting, the senior probation officer telephoned Lancashire police to ask if the contingency plan was available. The senior probation officer was told that it had just been completed and would be emailed to her. The plan would then be circulated to all staff and managers of other Approved Premises in the area.
37. The man settled in at the hostel, but initially was forgetful of his curfew times. On the morning of 8 October, he left the hostel at 9.15am, fifteen minutes before the curfew time of 9.30am. Non compliance meant breaching the conditions of his licence. He was reminded of the need to abide by the curfew and given an informal warning. His response to staff was that this particular requirement had slipped his mind.
38. Later that day the man met a homeless outreach drug worker for the Stockport Substance Misuse Service (SMS). The substance misuse worker provides

outreach drugs services and works with the Criminal Justice Intervention Team. She provides substance misuse (including alcohol) support to the Approved Premises residents every Monday and Wednesday. The premise of this work is to offer residents advice, support and refer them to other services. In the man's case, this meant alcohol support groups.

39. During her session with the man, the substance misuse worker conducted a basic screening assessment called a drug interventions record. The assessment is the same for both alcohol and drug interventions. After the man's personal details were taken down, the substance misuse worker briefly noted his risk assessment details. She wrote:

“Probation risk assessment – high risk offender – bears grudges. Suffers histrionic personality disorder [and] narcissistic personality order.....Drinks heavily linked to anxiety and depression.”

40. The substance misuse worker noted that the man needed a doctor's appointment as he had problems sleeping, adjusting, a dust allergy and a problem with his eyes. In the section on legal details, she outlined the conditions of his licence relating to alcohol. These were to address alcohol use as it has been identified as a trigger for his offending behaviour. The man would have to adhere to alcohol testing and sign an alcohol compact of abstinence. With regard to alcohol use, the man told the substance misuse worker that he had received help from a doctor on two occasions in the past for his heavy drinking. He had also received counselling for a year. The man said that he had not touched any alcohol since his release from prison and found it easy to abstain. Prior to his offence, the man said that he did not drink regularly, but had done so heavily on the night it happened.
41. The substance misuse worker established a care plan for her contact with the man, which included weekly sessions for a month, to be reviewed after a month. She identified his immediate needs as a doctor's appointment and to continue support with his supervising officer (the man's offender manager) and key worker. The man signed and agreed to the plan.
42. On 9 October, the man had a meeting with the man's offender manager and the senior probation officer. The meeting was to discuss the man's progress and find out how he was coping with life at the hostel. The man said that he was pleased and relieved to be at the Approved Premises. However, he had some trouble sleeping over the weekend and felt unable to rest. It was noted that he had a doctor's appointment at a local Healthcare Centre.
43. The senior probation officer explained to the man the importance of demonstrating willingness to progress and address his offending behaviour. For example, working with his alcohol support worker (the substance misuse worker), keeping appointments and complying with hostel regulations. Meeting this target would be considered during future risk assessments and benefit him in terms of normalising his life. They also discussed the man's time in prison custody. The senior probation officer noted that the man spoke intensely about

his experiences at prison. He said that staff had been dismissive to him at Risley.

44. The man saw a doctor who prescribed Amitriptyline (an antidepressant) at 25mg twice daily for anxiety and Loratadine (an antihistamine) for his allergies. The man told staff that the doctor said he would not have to take the tablets for a long period of time.
45. On 13 October, the man went to the staff office to enquire about home leave. The Approved Premises staff member explained the process to the man and told him that in order to apply for home leave he would need MAPPA approval. She also explained that residents have to be at the Approved Premises for six to eight weeks before they can apply. The man told the member of staff at the Approved Premises that he wanted to spend some time at his mother's house sorting his belongings. They discussed the option of asking MAPPA to relax his signing in times so he could do so. The man suggested that he could report to the police station at his signing time.
46. The member of staff at the Approved Premises said that he would still need to wait for six to eight weeks before the request could be made. She explained the MAPPA process to him and that demonstrating progress under supervision would lend to a positive report. In addition, it could possibly lead to a relaxation in his licence conditions. The man acknowledged this. The staff member advised him to take one day at a time and noted in his contact sheet that the man thanked her for talking to him.
47. The substance misuse worker held a one to one session with the man on 15 October. They talked about his mental state. The man described highs and lows in his mood. He said that the highs were "fruit bat" behaviour and his lows were when he hated himself, the world and everything. By "fruit bat" he meant very bubbly and sociable. The man disclosed that sometimes before going to sleep at night he had suicidal thoughts, which he described as thinking "what is it all for?" The substance misuse worker probed the man further on this comment and he said that he did not have those thoughts at the time. She wrote in her notes "no suicidal ideation at present or today". The man said he mentioned it to demonstrate his highs and lows, and to explain that this was normal behaviour for him. He said that antidepressants helped stabilise his mood and limited the extremes.
48. They also talked about alcohol. The man said that he had not really been to many pubs since his release, but he refrained from drinking alcohol when he did. He considered it to be low on his list of priorities. The substance misuse worker raised the possibility of referral to support groups such as the Alcohol and Drugs Services (ADS) or the Alcohol and Drugs Abstinence Services (ADAS). The man said that he would consider it. The substance misuse worker asked the man if he could identify the periods in his life when he drank heavily. He said that there were two occasions, due to the stress of an unfulfilling job and the death of his father. The substance misuse worker asked the man about more positive areas of his life. He told her about his plans to finish his OU degree before looking for a job. He described himself as

academic and good at everything he did. They set the date for the next session, which was 10.00am, 22 October.

49. The following day, the man had a risk management plan meeting with the deputy manager and the man's offender manager. The purpose of the meeting was to draw up a hostel intervention plan and discuss his progress. They discussed curfew times and the contract to abstain from alcohol. It was suggested that the contract could be reviewed during the next MAPPA meeting with the aim of reintroducing social drinking on a gradual basis. The agreed overall plan was that the man would:

- attend the morning meetings
- attend group work
- attend all appointments made by hostel staff
- adhere to all hostel rules
- attend alcohol support sessions
- address his low mood by talking to staff if anxiety arose
- take his prescribed medications.

The man agreed to this. The plan would be reviewed four weeks later.

50. Later that day, the man had a keywork session with both the residential service officers at the Approved Premises. The man said that he felt settled and was associating well with other residents. He had registered for income support and with City College. He had also received his OU forms, which needed to be completed and returned by 7 November. The man told them that he was not happy to participate in the Employability group work as he felt he was being pushed to get a job. The residential service officer explained that the point of the group work was not to push people into employment, but to equip them with the skills for having a job.

51. They discussed the man's medication and sick note. The man stated that he had been told by the doctor that he would not be taking his antidepressant in the long-term. He also told the residential service officer that he had suffered from stress whilst in prison but felt he had coped because he was a strong person.

52. On 17 October, the man went to the staff office and asked to telephone Wigan Magistrates' Court regarding an outstanding fine for damage to the property of his mother's neighbour's property. He had been charged for causing damage prior to his prison sentence. A compensation order was in place and the man would have money deducted weekly from his benefits. Lancashire Police were informed of this contact.

53. Two days later, a Detective Sergeant from Lancashire Police contacted the man's offender manager regarding the compensation order for the damage. Although Lancashire Police was primarily concerned with making sure the man did not attempt to contact his victims, they closely monitored all areas of concern. The Detective Sergeant also asked about the man's antidepressant medication as she was concerned that the man had access to medication

without full supervisory control. She wanted to know how he collected his medications and whether staff controlled the quantity he was taking. The man's offender manager explained that a doctor from the local surgery, used by all residents, had prescribed his antidepressants. The Detective Sergeant said that she knew this, but had been led to believe that the man was collecting his own prescription. She subsequently spoke to the hostel and was assured that this had been an oversight and his prescriptions would be sent directly to the Approved Premises. It is not clear where the Detective Sergeant got this information, however she told my investigator that the police were running ongoing surveillance and intelligence checks on the man's movements whilst he was at the Approved Premises.

54. There was further concern on the Detective Sergeant's part that the medication, in conjunction with alcohol, was thought to trigger the man's offending behaviour. The man's offender manager told the Detective Sergeant that in his opinion the medication should not be viewed in isolation as a trigger and that probation risk management and monitoring is based on a series of factors. The man's offender manager assured the Detective Sergeant that the man was being closely monitored and, when required, measures would be taken to minimise risk. No specific incidents or measures are referred to in the man's offender manager's notes.
55. At 10.00am on 22 October, the man had his one to one session with the substance misuse worker. He told her that he had not had any alcohol, but wanted to discuss reintroducing social drinking. The man said that he would like to be able to do this when he went out with his mother and her partner. The substance misuse worker made a note to ask the member of staff at the Approved Premises if the man's no alcohol contract had been or could be lifted by MAPPA. They then moved on to discuss his medication. The man said that he was now feeling the benefit of taking his antidepressant and had not felt anxious for seven days. He said that he was starting to feel more settled at the Approved Premises. The substance misuse worker again mentioned a referral to alcohol and drugs support agencies. The man said that he was happy at present and did not need such contact.
56. The man's offender manager went to the Approved Premises for a planned appointment with the man on 23 October. They discussed his relationships with other residents. The man said that he was exercising appropriate caution and had different levels of trust and contact with residents. He was aware of the need to keep away from any trouble. This was a general conversation and there were no particular concerns about any specific relationships or residents. The man's offender manager spoke to the man about the compensation order brought against him. The man was unhappy with the amount he had to pay and was seeking advice about its reduction.
57. The next one to one meeting with the substance misuse worker was held on 29 October. The man told her that he had been out to a pub socially, but had refrained from drinking alcohol. He said that he had drunk a non-alcoholic beer and felt fine in doing so. He also reported that he felt settled at the hostel. The substance misuse worker reduced the sessions to fortnightly. The next

meeting was scheduled for 12 November. During interview with my investigator, the substance misuse worker explained that this was a typical approach to managing clients. They would initially be seen on a weekly basis and this would reduce to fortnightly, then monthly as the client settled.

58. Later that day, the man spoke to the member of staff at the Approved Premises about bringing his computer (a stand alone PC and not a laptop) into the hostel so that he could complete a computer course that he had purchased. The member of staff at the Approved Premises explained that this question would have to be dealt with by the managers as she was unable to make a decision. A risk assessment would need to be completed as residents are not usually permitted to have personal computers. The man also asked whether a request for home leave could also be submitted as he wanted to go home for Christmas. He was told that this would have to be decided by MAPPAs. The man was not happy with this. He told the member of staff at the Approved Premises that he was unhappy with his MAPPAs category Level 3. The man said he had understood Level 3 to be the lowest level of risk and not the highest. The member of staff at the Approved Premises told the man that if he wanted a fuller explanation of MAPPAs and the categorisations she could arrange for him to be given this information. The member of staff at the Approved Premises noted that the man seemed happy with this response.
59. When the man's offender manager met the man for a supervision appointment on 30 October, the man told him that he had several points he wanted to discuss – alcohol, home leave and his curfew. He told the man's offender manager that his sessions about alcohol with the substance misuse worker had been going well. They had discussed a strategy for reintroducing responsible drinking and the man wanted the opportunity to prove that he could do it. The man then re-stated that he would like to apply for home leave. He added that he would like his curfew hours adjusted to allow more freedom during the day time to spend longer at the library or visit his mother. The man's offender manager said that these requests would all need to be put to the MAPPAs panel. He told the man that his positive engagement to date was encouraging and he should continue as this should help support his requests.
60. The man's offender manager explained the MAPPAs Level 3 category to the man. He said that if the man could demonstrate a reduced risk to the public, his rating level might be reduced. The man's offender manager told the man that a significant factor in the level attributed to him was the lack of remorse or empathy shown toward his victim. The man did not like this and said that this was a historical fact and no longer true. The man's offender manager wrote in the contact notes that he thought the man was becoming more open to exploring the victim's perspective.
61. The man also approached the deputy manager on the subject of moderate alcohol consumption. He said that he did not feel that alcohol was an issue for him and he wanted to be able to have a drink when he went out. The man wanted to join a gay and lesbian focus group that met in a pub on the second Wednesday of each month. The deputy manager discussed the issue of moderate drinking with the man's offender manager, who in turn discussed it

with the MAPPA Chair. It was agreed that because of the man's good progress it would be safe to allow him a moderate drinking contract. On 2 November, the man received a letter from the deputy manager confirming that the MAPPA Chair had agreed. The new contract meant that he could be breathalysed at any stage, but if the reading was over the legal drink/drive limit (35 micrograms of alcohol per 100 millilitres of breath or 80 milligrams of alcohol per 100 millilitres of blood) then the man would be in breach of the contract. The deputy manager told my investigator that the reason for this limit was to encourage the man to approach drinking sensibly without binge drinking. The man's offender manager said that this was a further opportunity for him to demonstrate his progress and that he could be trusted.

62. The same day, the man was told that he would be allowed to bring his computer to the hostel. The computer could be kept in the group work room on the ground floor on the proviso that the man would work on it at times convenient to staff. He would not be allowed the computer in his room. The man agreed to these conditions.
63. Four days later (6 November), the man had another supervisory session with the man's offender manager. The man reported that he was pleased with the new alcohol contract. He had talked about it with the substance misuse worker and she had agreed that it would be a positive step for him to start socialising in the community. The man's offender manager agreed.
64. They discussed the man's request for home leave. The incident of criminal damage to the neighbour's car was a possible barrier to his application for leave. There was concern that if the man came into contact with the neighbour it could possibly set him back. The man told his offender manager that whilst he still felt aggrieved by the situation, he acknowledged that his previous behaviour had been inappropriate. The man's offender manager said he felt this demonstrated a positive shift in the man's attitude and thinking. He was becoming more aware of the consequences of his actions and this could act in his favour with the MAPPA panel at the next meeting – 15 November.
65. On 9 November, the Approved Premises manager gave the man a letter that confirmed he had been given permission a week earlier for limited use of his computer in the group-work room on the ground floor. A member of staff gave another copy of the contract to him. The man declined the conditions of the contract, saying that he did not want to work alone in the group-work room in the basement. He said that he needed to be able to use the computer at any time and would prefer it in his room. The man added that he would rather wait until he could do what he wanted in a couple of months. The staff member did not know what he meant by this statement. The man asked that she tell the Approved Premises manager that he was grateful for the offer, but he would not accept it.
66. Later on in the afternoon at 4.45pm, the man told the staff member that he had put his name in an internet search engine to see what information he could find. The man was very upset to find some news reports which referred to him being sexually abused and contained information about his offence that he

considered to be incorrect. He was not happy for the information to be public knowledge. The man said that he wanted to change his name. He said that he felt emotional and wanted to see a doctor. The staff member reported in the man's contact notes that he wanted an appointment before he self-destructed. An appointment was not available until 6.15pm, so the man went for a walk instead. The staff member later reported that he had calmed down on his return and said he no longer needed to see the doctor.

67. The staff member informed the deputy manager of his conversation with the man. They decided to contact the Detective Sergeant and let her know about the man's reaction to finding the information. The Detective Sergeant said that she was concerned and would share this information with her colleagues.
68. At 10.15am on 12 November, the man had a one to one session with the substance misuse worker. He presented as fed up. The man said this was because he was being denied full access to his computer to do his OU assignments. He said that he would probably defer his course until the following year. The man also talked about wanting home leave so that he could sort through some of his belongings at his mother's house. The substance misuse worker noted that the man appeared unsettled during this session and was worried that if he was becoming unhappy that this may lead to an increase in alcohol consumption. She decided to arrange an appointment for the following week on 19 November.
69. On 14 November, the day before the MAPPa panel meeting, the Approved Premises manager spoke to the man. The manager, who was attending the panel meeting on behalf of the Approved Premises, had not had a great deal of direct contact with the man as he had been on leave. The man requested that the manager ask the MAPPa panel to withdraw his 12.30pm signing time so that he could start to look for work. He wanted to have more time to explore Stockport as he would not be under pressure to return to the hostel when he left in the morning. The manager noted in the man's contact sheet that this was a brief but positive meeting and that he appeared to be making good progress.
70. The MAPPa panel sat the following morning. There were four representatives from Lancashire Police (including the Detective Sergeant), one from Greater Manchester Police (GMP), four from the Probation Service (including the Approved Premises manager and the man's offender manager), an administrative officer and a chairperson. The Approved Premises manager was not present at the start of the meeting. He told my investigator that although he was in the building, he was not notified when the meeting began. Consequently he did not join the discussion until the panel was deciding on what action to take. He was however able to provide an update.
71. All MAPPa meetings have a confidentiality protocol that participants must adhere to. Information from the meeting was not to be disclosed to other parties without the Chair's permission. The meeting was called to review the man's risk following his release from prison, address any arising matters and updates.

72. The man's offender manager gave the panel an update. He said that he had visited the man six times since his release, and although it was early in his licence, the man's resettlement had so far been positive. He had been compliant and was receptive to staff interventions and guidance. The panel discussed his engagement with the alcohol support services and the recent change in his contract to allow moderate drinking. The man's offender manager told the panel that although this plan was in place, the man had not returned to drinking alcohol at this stage and all breath tests for alcohol use had been negative. The man's medication was also been discussed. The man's offender manager said that the man's anxiety levels were high at the time of his release and he had since been prescribed an antidepressant. His medication was dispensed in accordance with hostel rules; it was kept in staff possession and dispensed as prescribed.
73. The issue of a home visit was discussed. The police were concerned about the man's conviction for damaging property belonging to his mother's neighbour. The man's offender manager explained to the panel that, although the man previously disputed the compensation order, he accepted his behaviour was inappropriate and the neighbour was entitled to compensation. The Detective Sergeant voiced concerns regarding the risk of a home visit, particularly whilst the compensation order was still active. A suggestion was made that the man could have a police supervised visit. The panel rejected the idea of both an unaccompanied and a police supervised visit and the request was therefore denied. The man was expected to obtain his belongings from his mother's house by other means.
74. When the Approved Premises manager joined the meeting he told the panel that the man had made progress at the Approved Premises and requested a relaxation of his signing in times. The panel did not support the request at that time, but considered that it could be a possibility in the longer term. Until then, his curfew and signing times would remain the same.
75. The panel's conclusion was that no evidence had been given to support the view that his current curfew and times restricted the man's attempt to gain employment. It was decided that his risk and conditions of licence would not be altered until the next MAPPA panel meeting. At the next meeting, set for 3 January, the man's offender manager would update the panel on the relaxation to the man's alcohol contract. The man was to be informed of the panel's decisions by his offender manager immediately, followed by an official letter. The man's offender manager informed the man by telephone the next day.
76. On 16 November, the man had a key worker session in which he told his key worker, the residential service officer, that he was very unhappy with the MAPPA decision. He felt that all the positive progress to date had been wasted. The man elaborated on this disappointment and said he was at a loss as to what to do in order to get recognition for his compliance. He had hoped for some relaxation of his signing times and was upset that this had not been granted. The residential service officer explained that MAPPA decisions are not just based on his behaviour and progress at the Approved Premises. Other

risk factors had also been taken into consideration, and in this instance had taken precedence.

77. The man did not fully accept this and said that he felt let down by the Probation Service and other authorities. He told the residential service officer that he believed that the Probation Service had altered his OASys score [his previous complaint] and this had affected the decision. The residential service officer wrote in the man's contact sheet that he appeared to be a defeated man and he became quite upset during the session. The man said on several occasions how he was beyond disappointment and did not know what to do next.
78. The man had a one to one session with the deputy manager during the afternoon. She noted in his contact sheet that he was upset about the MAPPA decision. The deputy manager told him that she was unable to explain the MAPPA decision process to him, but the man's offender manager would be able to do so more fully in their next session. The man said that he regarded the MAPPA decision as a conspiracy and it was a test to see how he would cope with bad news. He told the deputy manager that she only empathised with him because she was trained to and that he did not know who he could trust.
79. Two days later, the man spoke with the residential service officer again. The residential service officer noted that the man had been in a very low mood over the weekend and that he and other staff had tried to engage him in conversation to no avail. The man had spoken very little and had been seen by the hostel chef sitting on a wall outside staring into space. The residential service officer tried to speak to the man but he said that he did not want to talk. He just wanted to watch the cars go by. The residential service officer said that this had been typical of his mood in the days after the MAPPA meeting.
80. The man had his one to one meeting with the substance misuse worker on 19 November. He told her that he was unhappy with the MAPPA decision not to relax any of his licence conditions. He said that he now drank two pints of shandy when he went to a pub. The man said that he felt bullied by the system and disclosed that a resident had asked to buy a urine sample from him. He raised this matter by asking if he could tell the substance misuse worker something confidential. She told him that it would be fine to, however there were limits on what could remain in confidence if it could compromise hostel security. The man said that he was happy for the substance misuse worker to speak to staff about the incident. The substance misuse worker told my investigator that the man did not appear under pressure from this resident, he just found it bizarre that someone would want to purchase his urine. The substance misuse worker did not think that he was being bullied.
81. The substance misuse worker considered the man's behaviour to be strange during this meeting. He asked her whether a member of the community drugs team had been sent to check on him as he had seen someone from the team whilst at the pub with his friends. The substance misuse worker told my investigator that she reassured the man that it had been a coincidence.

82. The man continued to decline the offer of referral to an alcohol support group. This worried the substance misuse worker as he had now progressed from drinking low alcohol lager to pints of lager shandy. As the man was unhappy with his conditions, the substance misuse worker was concerned this might impact upon his drinking. She told him that he might find it a useful exercise, but he continued to refuse. The next appointment was set for 3 December.
83. The following day (20 November), the man's offender manager attended the Approved Premises for his supervisory meeting with the man. The man remained disappointed with the MAPPA decision and said he was equally disappointed that he had to wait so long for the next meeting. The man's offender manager explained to the man that the period in between would be important as his progress would continue to be monitored. The man's offender manager stressed that as the monitoring and reviewing was an ongoing process, his continued positive engagement was crucial. The man's offender manager noted that the man's motivation had taken a setback. However, the man said that he was feeling a little more positive after their conversation.
84. The man appeared to settle over the next week and concentrated on his computer course, using the hostel computer. However, he suffered a panic attack on 26 November during a group work session. The man left the session saying he needed a comfort break and did not return. Instead he went to speak to the deputy manager. The man told her that he felt uncomfortable with the number of residents in the session. He said that he found it difficult to cope with a large crowd and also made the assumption that members of the group were sex offenders. The man explained that sex offenders made him feel uneasy and frightened because he had been abused in his past. After discussing the issue, the man agreed to see if he could cope with smaller group work sessions.
85. The deputy manager informed the Approved Premises manager of the man's panic attack. He said that the man could be removed from the group on the understanding that he engaged in other work and made constructive use of his time. For example, continuing with his computer based education. When a smaller group activity was next scheduled, the man would be expected to participate. The deputy manager said that she would take this up with him.
86. The next evening (27 November), the man went to the staff office at 8.30pm. He complained of chest pains and had another panic attack. Another member of staff was working that evening. He spoke to the man, who became more agitated. The staff member told the man to lie down on the floor and an ambulance was called. The paramedics arrived at 8.40pm. They calmed him down and took him on board the ambulance to be medically assessed.
87. The Approved Premises manager was the duty manager that evening. He was contacted at 9.00pm and informed of the situation. The Approved Premises manager instructed staff at the Approved Premises to keep a close watch on the man, checking him every 15 minutes whilst he was awake and periodically throughout the night. This is an example of good practice.

88. When the man came out of the ambulance, staff said he seemed calmer and in a better frame of mind. The paramedics advised the man to see a doctor as soon as possible to discuss his anxiety. It was noted that the man already had an appointment booked for the next day. The man went to bed at 11.00pm and staff checked him throughout the night.
89. At 11.00am the following morning, the man spoke to the deputy manager about his anxiety. He said that his panic attack had been triggered by the stress placed upon him by the Probation Service and gave the following reasons for his stress:
- He was being made to live in a place for high-risk offenders when he believed he was not high-risk.
 - He attributed his offending to a reaction to his medication. Therefore he was not responsible for those actions and not high-risk.
 - He felt that living at the Approved Premises exposed him to potential danger from other individuals who are high-risk.
 - He felt that he should not be exposed to group work as it increased his anxiety.
 - Not having access to the internet in the hostel meant he could not send emails, which restricted contact with his family.
 - He said that the substance misuse worker had told him that it was his offender manager who could adjust his signing times and not MAPPAs.
 - He mistrusted probation staff as they were conspiring against him.
90. The man told the deputy manager that his mother and sister supported him on these points. He said that he was going to exercise his right to privacy and would no longer engage with staff at the hostel. The deputy manager tried to empathise with his frustrations and told the man that his concerns would be raised during the next MAPPAs meeting. She explained that the substance misuse worker was not a probation worker and consequently would not be familiar with licence conditions and MAPPAs procedures. The deputy manager later took the matter up with the substance misuse worker, who stressed that she had not given the man any reason to believe that his supervising officer had the authority to remove a signing time. The substance misuse worker confirmed this when she spoke to my investigator.
91. The deputy manager telephoned the man's offender manager and expressed concern that the man seemed to have taken a step back. He was no longer accepting personal responsibility for his offending behaviour. She told the man's offender manager of the man's assertion that external events had been to blame for his situation. The deputy manager attributed this shift in his mood to the outcome of the recent MAPPAs meeting. The man's outlook and willingness to trust staff had deteriorated when MAPPAs did not relax his licence conditions in recognition of his progress.
92. The man attended his medical appointment the next day. The doctor prescribed Zopiclone (sleeping tablets) and Propranolol (medication used for the associated symptoms of anxiety, i.e. tremor, sweating and dry mouth). The man started the sleeping medication that night and Propranolol two days later.

93. On 29 November, the deputy manager sent an email to the man's offender manager, copied to the manager, again saying that she was becoming increasingly concerned about the man's deteriorating mood. She said that her two major concerns were:
- The man now regarded all probation staff as having a hidden agenda. He said that staff were deliberately putting stress upon him to see how he coped. This made him difficult to work with on a day to day basis.
 - The man's mood was such that she believed there could be potential for self-harm or otherwise self-destructive behaviour.
94. The deputy manager said that she believed there would be therapeutic value in relaxing his restrictions, namely the 12.00pm signing time. She recognised this would be a risk, however the current way of working was increasing his resentment which could heighten his risk. As both she and the Approved Premises manager would not be available for the next MAPPA meeting on 3 January, she asked whether there was any flexibility on the date.
95. The manager forwarded the deputy manager's email to the representative from the Greater Manchester Area Office who Chaired the MAPPA meeting on 15 November together with a supporting email of his own. He reminded the Chair that he had not been present for the majority of the MAPPA discussion as no one had informed him it had started until the panel were discussing the action points of the agenda. The Approved Premises manager said that he was concerned that his staff were not aware of any police intelligence to suggest that the man's risk was increasing. He wrote that the man had made progress since arriving at the Approved Premises which was not recognised.
96. The Approved Premises manager asked that as the panel would not reconvene until early January, a compromise be reached over relaxing the man's afternoon signing requirements for some of the days of the week. He suggested that Lancashire Police be made aware so that surveillance could be organised if required. He asked the Chair to give the man something positive to work towards to prevent the possibility of a difficult licence recall. The Approved Premises manager believed there needed to be some sort of offer in order to rebuild a working relationship with the man. These requests were not met by the Chair at this time, but remained on the agenda for discussion at the panel meeting set for January. The date of the meeting was changed to 10 January to enable representatives from the Approved Premises to attend.
97. The man was six minutes late for his evening curfew on 29 November because the taxi driver who brought him back did not know where the Approved Premises was located. The driver came into the hostel with the man and explained to the residential service officer (who was on duty that night) what had happened. The man did not speak as the driver was talking to the residential service officer, but went straight to his room. He did not appear to receive a warning, formal or informal for his late arrival.

98. The following day, the District Manager for Wigan/Atherton Probation Area and the man's offender manager conducted a review of the man's case as a high-risk offender. This type of review can be held at the request of the offender manager, if there are concerns, or as part of a standard review for a MAPPA case. In addition to the man's offender manager's input, the District Manager considered supporting information from the manager and the deputy manager at the Approved Premises, both of whom detailed the man's deterioration in mood since the MAPPA meeting. The District Manager said that she did not think it appropriate to reconsider the man's conditions at this time and they should wait for the next MAPPA meeting in January. A proposal was made to bring forward the MAPPA meeting, but the District Manager did not think that there were strong enough reasons. In the meantime she asked that:

- The man's behaviour continue to be monitored.
- The offender manager tell the man that it would be in his interest to start engaging with staff as MAPPA would be reconsidering his signing times during the next meeting. This decision would take into account recent behaviour.
- Hostel staff brief MAPPA in writing if they were unable to attend the meeting in early January.

99. Later that day, the Approved Premises manager issued a notice to the staff on weekend duty, by email. He requested that the man be breathalysed if he went out, particularly as it was known that the man had started consuming low levels of alcohol when visiting the pub. This request was in keeping with his alcohol contract. The Approved Premises manager said:

"Please be careful when asking him for a sample of breath, but ensure that this is done. Please also ensure that staff on shift from this evening [Friday night] know that he needs to be treated with care, concern and with some degree of caution too. He is disappointed by the decisions of the MAPP panel not to relax any of his signing times and whether he has a point or not is irrelevant – this is how he sees things and this might make him a danger to staff and his risk may now be increasing. It is his stated reason for withdrawing his cooperation and not engaging with staff as well as was doing previously."

There are no entries in the man's contact sheet for that weekend.

100. On 2 December, the residential service officer wrote in the man's contact sheet that the man had continued to withdraw from life at the hostel. The man went to the office several times during the day to talk to staff. On one occasion he told the residential service officer that he had decided not to contact a former prisoner he knew who had come to Stockport. The next occasion he asked why the police had contacted his solicitor for a report. The man said his solicitor told him that the police were snooping around. He went on to say that the man's offender manager must have known but was hiding information from him. The residential service officer asked the man why he thought that the Probation Service were party to police enquiries. The man replied saying that everyone was conspiring against him.

101. The man continued this line of conversation when he came to collect his medication during the afternoon. He explained to the residential service officer that he felt like he was being attacked from all sides and likened it to “being scratched with nine inch nails”. He said that leaving prison should have been a happy time, instead he had been placed in a high-risk offenders’ hostel, which had put him in danger due to the nature of the other offenders. The man said that he believed he was medium-risk, so did not know why he was labelled high-risk. He said that people would have to apologise to him once it was found that he did not have a personality disorder. He alluded to an independent report that he would use when his solicitor said it was appropriate.
102. The man repeated that he felt the Probation Service was conspiring against him. He told the residential service officer that he would no longer eat at the hostel. The residential service officer noted in the contact sheet that the man kept changing his clothes that night and had mood swings.
103. The residential service officer told my investigator that during the beginning of December he the man sorting through some clothes in his room. The man said he had got them from his mother’s house. It is not clear whether he had collected them or they had been brought to the hostel. The man told the residential service officer that he wanted to sort things out. The residential service officer told my investigator that although there was nothing significant about this conversation, he was concerned that the man was feeling troubled. This event is not documented in the man’s contact sheet and is an event that the residential service officer recalled during his interview.
104. At 9.15am on 3 December, the man had a one to one session with the substance misuse worker. She noted that he had a negative presentation, but attributed this to the fact that he had only just woken up and was still drowsy. The man told her it was because of his sleeping tablets (Zopiclone). They talked about how he was feeling. The man said that he felt like “he had given his all and got nothing in return”.
105. They discussed his low-level alcohol use. The man said that he had been to a pub last week for a curry and drinks with friends. The man also said that he had met one of the residents and a previous friend from his time in prison. On this occasion he had consumed four pints, three of them lagers. The substance misuse worker noted that his drinking was increasing. The man told the substance misuse worker that he would not meet his friend from prison again as he did not think it would be a good idea.
106. The man said he had not spoken to his supervising officer for two weeks about changing his licence conditions. The substance misuse worker noted that his demeanour had improved by the end of the session and she had no further concerns about his presentation. The next appointment was scheduled for 12 December. (This session did not take place because the substance misuse worker was on sick leave.)

107. On the same day, 3 December, a member of staff at the Approved Premises noted in the man's contact sheet that staff were aware that the man had started to drink a few pints of alcohol. However, there were concerns as he was taking various medications – Zopiclone (sleeping tablets), Amitriptyline (antidepressant) and Loratadine (antihistamine, non-drowsy). Each of these medications gave instructions to avoid alcohol.
108. Two days later (5 December), the man's offender manager wrote to the Approved Premises manager and the deputy manager by email on the issue of the man's medication guidance. He emphasised that as part of their duty of care to the man, the Approved Premises (and he) should take steps to ensure that the man was not being exposed to a preventable risk by drinking whilst taking medication. The man's offender manager wrote:
- “It is my view from a health and safety perspective that we need to ensure that the man is avoiding alcohol in accordance with his medication guidance. We are to all intents and purposes administering his medication so we need to take steps to ensure that we are not exposing the man to a risk that is preventable. I don't view this as harsh rather something that we are compelled to do under health and safety legislation and as a duty of care.”
109. The man's offender manager had a supervisory session with the man that afternoon. He noted the man appeared more resistant to engaging with staff and less motivated towards his offence focused work. The man's offender manager said that he found the man to be preoccupied with the idea that the police were interfering, as they had asked his solicitor for access to psychiatric assessments. He asked the man how he was coping with his anxiety. The man said that nothing had changed since their last meeting. He still attributed his stress to the MAPPA decision. The man did say that he had been to his doctor in the interim and had been advised to continue taking his antidepressant.
110. The man's offender manager took the opportunity to raise the issue of drinking whilst taking medication. He reminded the man about being careful with his prescribed medication if he was going to drink. The man said that his doctor's guidance was not to drink to excess and not take more than his prescribed dose of medication. He told his offender manager that it was not really an issue, as he did not feel the need to drink. The man's offender manager asked the man about the use of the breathalyser test. Again, the man said this was not a problem as he did not want to drink and was complying with hostel rules. After their meeting, the man's offender manager sent a further email to the Approved Premises manager and the deputy manager informing them that the man was being sensible regarding his alcohol contract and prescribed medications.
111. During the evening, the man went to the office to provide information about his forthcoming appointments. He told two members of staff that one of the appointments was with his solicitor in Merseyside and asked how long it would take to get there. She asked where in Merseyside and noted in his contact

sheet that he replied “Merseyside, Merseyside” in a sarcastic manner. He then went on to say that his family had come to the decision that he should return to live at home and asked who he would need to speak to about this. The staff member said that he would need to talk to the man’s offender manager and the deputy manager, but that ultimately the decision would lay with MAPPA. She noted that the man was adamant this was not the case and that the Probation Service wanted him at this mother’s address in the first place. The staff member noted in the contact sheet that the conversation was icy and awkward.

112. On 6 December, an entry in the man’s contact sheet noted that he had been acting strangely with staff. He was not forthcoming with conversation and came out with flippant comments when asked questions. At 2.00pm the next day, the deputy manager managed to speak with the man at length. They talked about his anxiety, frustrations and psychiatric reports. The man told the deputy manager that he did not need another opinion regarding his diagnosis of personality disorder as he already had one. A report had been written by a consultant psychiatrist, which vindicated the man from responsibility for his offence. The man said that this report was with his solicitor and was not ready to be released to other parties. He said that the report said he had committed his offence due to:

- an underlying state of anxiety (not personality disorder)
- a build up of stressful events (loss of his father, job and sexual abuse)
- overdose of medication in combination with alcohol.

113. The man said that this report would help him appeal his sentence. The deputy manager suggested that if these circumstances were the case the man should try not to shut people out, but should explore his anxiety with his offender manager and keyworkers. The man said that he had decided to withdraw his cooperation with staff and exercise his right to silence. He told her that he thought if he spoke he would be misinterpreted by the authorities and recalled to prison. His only current anxiety related to his signing times. He felt confined by them and the rigid framework. The deputy manager stressed that he needed to comply in order to fulfil his licence and for MAPPA to relax his conditions. She advised the man to write a list of advantages and disadvantages for engaging more positively with staff and his situation.

114. Later that evening, it was brought to the deputy manager’s attention that the man had collected his own medication from the pharmacy for the second time that week. Although he handed the unopened medication to hostel staff, the deputy manager told him that it could not happen again as it was against hostel policy and prescribed medication was a listed risk factor for the man.

12 December 2007

115. On 12 December, the man was 30 minutes late for his midday signing time. He argued with the member of staff that he was in a City College session taking place within the building. The man said that staff knew he was inside the hostel and so he did not see why he should have to write that he signed in at 12.30pm

instead of 12.00pm. The staff member reminded the man of the importance of meeting his conditions and noted that he reluctantly signed the book.

116. The man's offender manager was in the office when this conversation took place. He was due to have a supervisory session with the man at 12.30pm. They talked about his argument with the member of staff. The man's offender manager told him that he needed to maintain some discipline. The man attempted to deflect this by saying there were times where he had been delayed in signing because staff were not in the office at the required time. The man's offender manager wrote in the man's contact sheet that, in his view, the man was testing the boundaries in response to his signing times not being relaxed by MAPPA.
117. The only positive point that the man raised was that his mother and her partner had visited him over the weekend. He said that they had talked about him moving home once his licence allowed. The man said that they had only considered it as he had not been granted home leave and had therefore been unable to spend sufficient time with his family. The man told his offender manager that he was being tortured and it was similar to when he was kept in prison beyond his parole eligibility date. During the meeting, the offender manager gave the man a letter from the MAPPA Chair which re-stated the decision made in November. Whilst he had received verbal feedback from the meeting on their decision, this was the written confirmation. The man was unhappy with the letter, screwed it up and put it in the bin. He told his offender manager that, whilst he was not going to breach his conditions, he could not see any point in engaging when good behaviour was not rewarded. The man's offender manager reminded him that the conditions and requests for home leave would be reviewed at the January meeting.
118. The man's offender manager concluded from the session that the man's approach to their sessions had shifted and he was mistrustful. At several points during the session, the man referred to MAPPA decisions as the man's offender manager's decisions. The man's offender manager wrote:

"His narrative also suggests that he now views myself as an agent of control, making comments that there is no point in our meetings as all they are about is telling him what he cannot do so what is the point in meeting as he knows what he cannot do. The man asked if the meeting could be concluded as he did not feel able to go any further as he was upset by finding out that he wouldn't be able to go home for Christmas. Whilst it was anticipated that the man would adversely react to not being given granted home leave and a constructive outcome was not envisaged, it is of greater concern that the man's resistance is becoming more entrenched, with it becoming increasingly difficult to re-engage him in constructive offence focused work."
119. The man's offender manager found the man to be frustrated by this situation and unwilling to engage. He told my investigator that, although the man was upset and angry, he was not concerned about him being at risk of any harm.

120. After this meeting, the man went to the office to take his medication. The man's offender manager was with him. The member of staff noted in the hostel log book that the man appeared very annoyed and did not want to take his medication in front of his offender manager so he left the office whilst the man took them.
121. The man left the hostel that evening to go to the pub with some friends. My investigator received an account of his time at the pub from police witness statements after his death. The man met his friends at 5.30pm. He had asked them to meet him earlier as he wanted to see them prior to a monthly social meeting they all attended, which started at 7.30pm. His friends told the police that the man had spoken about his earlier issue with hostel staff concerning his 12.00pm signing time. They said that he had been concerned about this and that staff had not listened to him. His friends told the police that they had a few drinks, but the man said he had restrictions about how much he was permitted to consume.
122. The man was seen speaking to the bartender at the second pub where the social group met. The police also interviewed this man as part of their investigation. The man told the police that he and the man chatted for a short while before exchanging telephone numbers and agreeing to meet at the weekend. The man told the police that the man had not appeared drunk and he had only served him one, to one and half pints of lager that evening.
123. The friends told the police that the man appeared anxious that he might miss his curfew and asked how long it would take to get back to the hostel in a taxi. They told him that if a taxi arrived on time he would get back before his curfew. The man left the second pub at 8.45pm. His friends did not see him get into a taxi, but assumed that he had done so. They said that he had been in good spirits that evening and did not present as a cause for concern. After the man had left the pub, the bartender noticed that he had a missed call from the man. He sent the man a text message asking if he was okay, but did not receive a reply.
124. At 8.55pm, the man telephoned the hostel and spoke to the member of staff at the Approved Premises (one of the RSOs on duty). He explained that he had just left the pub and had been trying to get a taxi, but had been dialling the wrong number for the last 15 minutes. The man gave her the telephone number that he had been using and she tried to call on his behalf. It came to light that the number was incorrect. The member of staff at the Approved Premises spoke to the man and told him to get back to the hostel as quickly as possible as he was going to be late for his curfew. The man sounded concerned and estimated that it would take 25 minutes to walk there. He succeeded in contacting the taxi firm and rang the member of staff at the Approved Premises at 9.00pm to say that he was on his way. My investigator asked the member of staff at the Approved Premises if the man had sounded drunk on the phone. The member of staff at the Approved Premises said "not overly, no".

125. The member of staff at the Approved Premises telephoned a senior probation officer (SPO) who she thought was the duty manager, to let them know that the man was a little late for his curfew but was on his way. Unfortunately the member of staff at the Approved Premises had read the duty roster incorrectly and telephoned a SPO who was not on duty. In the meantime, the taxi arrived and the man came into the hostel with the taxi driver at 9.10pm. The driver confirmed that he had only just picked the man up and had driven him straight to the hostel.
126. The man asked the member of staff at the Approved Premises if she had change for a £10 note. She said that she did not. The taxi driver said that he would get some change. The member of staff at the Approved Premises said this was okay, thinking the driver would get the money from his car, but noticed that the man got back into the car and the taxi drove off. The car returned a few minutes later and the man explained that they went to the petrol station across the road to get some money.
127. On speaking to the man, the member of staff at the Approved Premises said that she could smell alcohol on his breath. She asked him to take a breathalyser test. The man replied "Oh today of all days. I have had a drink and will be over the limit.... This close to Christmas". The member of staff at the Approved Premises told my investigator that she said "well there's no problem, but for health and safety I just need to do the test to see how much alcohol you have had". Whilst the member of staff at the Approved Premises prepared the test, the man stood up and said, "I tell you what, I can't be bothered" and walked out of the office.
128. The member of staff at the Approved Premises went to telephone the duty manager to let her know that the man had been a few minutes late, had been drinking and would not take the breathalyser test. Before she was able to do this, the man returned to the office. He smiled, waved to the staff on duty and said, "See ya". The man then walked out of the hostel carrying his rucksack and ran down the driveway in the direction of Stockport. The two members of staff at the Approved Premises called after the man telling him to come back. One of the members of staff at the Approved Premises pursued him to the end of the driveway and repeatedly called after him but the man ignored her calls. The member of staff at the Approved Premises was unable to continue after him as two members of staff are required to be on the premises at all times for the safety and security of the hostel and other residents.
129. The member of staff at the Approved Premises contacted the duty manager at 9.20pm and informed her that the man had absconded. The duty manager remembered the police contingency plan and two hour emergency recall that had to be urgently put into action should he abscond. She instructed the member of staff at the Approved Premises to inform the police to implement the contingency plan.
130. At approximately the same time, the man contacted his mother. In her police statement, the man's mother described the phone call as frantic. The man's mother said that her son told her he believed hostel staff were about recall him

to prison for breaching his licence conditions. It is not clear where the man got this information. The member of staff at the Approved Premises told my investigator and the police that she did not say this to the man when he had returned late for his curfew. The man told his mother that he was standing outside the petrol station near the hostel. He asked her to come and see him for one last time before going back to prison. The man's mother told the member of staff at the Approved Premises that she had telephoned her son straightaway. She said that she could tell he had been drinking, which was influencing his actions. The man's mother told her son not to do anything stupid and to go back to the hostel, go to bed and apologise to staff in the morning. The man ended the conversation and switched off his mobile phone.

131. The man's mother received a text message at 9.42pm from the man's second mobile (he carried two) which said "Mum pick me up now at [petrol] garage, would be nice to see you tonight at home before I go to jail". His mother tried to telephone her son on his second mobile, but she was directed straight to his answering service. This was the last she heard from the man.
132. According to the police enquiries made after the man's death, he had purchased a large bottle of vodka from a local off licence after leaving the hostel. The shop keeper told the police that the man had £6.87 in his possession. The vodka cost £6.99. The man gave the money he had and left two music CDs with the shopkeeper to make up the difference in cost. (A bottle of vodka was found near the handrail close to the point where the man fell from the bridge over the motorway.)
133. At 10.00pm, the man's mother telephoned the hostel and spoke to the member of staff at the Approved Premises to tell her that her son had been in contact and she was worried. The member of staff at the Approved Premises told my investigator that the man's mother sounded upset and said that she could not believe what he had done. The member of staff at the Approved Premises telephoned the police and gave relayed this information. The police went to the petrol station but found no trace of the man.
134. Coincidentally, the man's friends tried to telephone him at 10.00pm. They later told the police that they made several efforts but got no reply. One of the women said that she was concerned by his lack of response, as it was unusual for him not to reply.
135. The duty manager called the member of staff at the Approved Premises at 10.20pm. She said that the emergency recall paperwork had been initiated. It was made clear to the member of staff at the Approved Premises that, should the man return to the hostel, he should be allowed in and encouraged to go to bed. If he did return, the police should be immediately notified. The duty manager made her way to the hostel. Ten minutes later, the man's mother telephoned the hostel to see if there was any news. She had been trying to contact her son but he was not answering his phone, which kept going straight through to his voicemail.

136. Stockport Police telephoned the hostel at 10.50pm to report that someone had fallen from the motorway bridge near the hostel. They believed it to be the man, but could not confirm at that stage. The person who had fallen had been taken to hospital and was in a critical condition. The police requested that a photograph be taken to the hospital in order to identify the person and asked for the man's mother's contact details.
137. The police telephoned again at 11.00pm and asked what the man was wearing when he left the Approved Premises. Given the description, the police said they believed that it was the man and that he had died. The police requested that the hostel did not pass any details to his mother until someone had formally identified the man's body.
138. The man's mother telephoned the hostel at 11.06pm. She asked whether there was any news. No information was given at this stage. Lancashire Police were given an update of the situation at 11.15pm. Fifteen minutes later Stockport Police telephoned the Approved Premises to ask if a member of staff could go to the hospital to identify the man's body. The duty manager and one member of staff at the Approved Premises attended, whilst two members of staff remained at the hostel. Staff were asked to identify his body, rather than the man's mother, to prevent any undue trauma if it was not her son.
139. At 12.30am, the man's mother telephoned again. She said that she was worried and apologised for calling. The member of staff told her that she need not apologise and it was understandable. Again, no information was given. Ten minutes later, the duty manager and the member of staff returned to the hostel and confirmed that it was the man who had died. It is not clear at what time the police told the man's mother, but there is a note in the contact sheet at 1.35pm the following afternoon indicating that the man's family were aware of his death. The procedure is that the police initially notify the next of kin after the death of a resident at Approved Premises. Once this initial contact has been made the hostel contact the family.

After the man's death

140. The next day, 13 December, the deputy manager called a meeting of the residents to explain about the man's death and offer support. The deputy manager ensured that residents not present at the meeting were also informed. Flowers were placed around the hostel in remembrance and a sympathy card was sent by the residents to the man's family. Staff provided support to each other and to the man's offender manager. Two members of the senior management team from the Area Office visited the Approved Premises that morning to offer support to both staff and residents.
141. The deputy manager rang to speak to the man's mother at 4.20pm that afternoon, but his sister answered the phone. His sister told the deputy manager that the man had been scared of all the "bag heads" (slang term for drug users, particularly heroin) at the Approved Premises. The deputy manager told her that this was not the case and residents and staff had genuinely liked the man. She said that the residents were shocked and

distressed by the news of the man's death. There had never been any indication to staff that other residents had bullied the man. Likewise, my investigator found no evidence to suggest that the man had been bullied or had any issues with drug users at the hostel.

142. The man's sister arranged to come to the Approved Premises the following day to see his room. The deputy manager prepared the room by tidying a little, but did not remove any property. The room was declared out of bounds to everyone apart from the Coroner and the man's family.
143. The following day the man's mother came to the hostel with her partner to collect his belongings. The deputy manager gave details of a bereavement counselling service, along with some sympathy cards from staff and residents. The Approved Premises manager, deputy manager and the man's offender manager offered ongoing support as well as providing information about the man's time at the Approved Premises and the night he died to his family as and when required.

ISSUES

Confidential review of a drug related death (including alcohol)

144. After the man's death, Pennine Care National Health Service Trust produced a review of a drug related death report. This type of review is routinely conducted if the deceased is a client of the area's substance misuse services (SMS). The review replaces a serious untoward incident report that is produced when the deceased has had some other form of contact with a clinical organisation. The review was undertaken because the man had received support from the SMS.
145. The Acting Team Manager of Stockport SMS, produced the report. Its findings are based on the substance misuse worker's notes of her support sessions with the man whilst he resided at the Approved Premises. Pennine Care Trust provided a copy of the records kept by the substance misuse worker to my investigator. A full copy of the review is at Annex A.
146. The review found that the SMS protocol for outreach work at the Approved Premises had been followed. The substance misuse worker had appropriately recorded details of her interventions with the man. Basic and relevant information from the sessions were recorded in the logbook kept at the Approved Premises for probation staff to see. The book is kept the main office and is easily accessible. The substance misuse worker would read the logbook prior to any one to one sessions to see any entries that had been made by staff and for updates on the man. She also liaised with the staff to see if any significant or relevant changes had been made to the man's licence conditions. All future appointments made were recorded in the hostel diary.
147. The review highlighted concerns around the sharing of information on client risk assessments between the Probation Service and other services, including SMS. She noted that from the risk assessment documentation it was difficult to see how the assessment was formulated and then shared with key partner agencies. The Trust recommends that consideration be given to the quality and nature of information sharing regarding risk assessment for contact with clients at the Approved Premises. The substance misuse worker did not raise this as a problem in relation to her work at the hostel during her interview with my investigator. During the course of her investigation, my investigator did not find this to be a concern that had impacted upon the man's care at the Approved Premises. Although it had not direct bearing upon the man's situation, I agree that importance should be placed on transparency and information sharing between the services.
148. The Trust has drawn up a local action plan to address the issue of information sharing. The action plan was initially discussed with the substance misuse worker, her line manager and the Approved Premises manager on 31 January 2008. My investigator has not been informed of the outcome of this meeting.
149. A second action point was to review and amend the protocol for the homeless outreach worker at the hostel based on the findings of the Ombudsman's report. I have found no need to suggest a review of the protocol.

Alcohol

150. When the man first went to the Approved Premises one of his licence conditions was that he could not drink alcohol. This condition was relaxed on 2 November, after discussion with his alcohol worker, his offender manager, the deputy manager at the hostel and finally with the MAPPA Chair. The purpose of relaxing the condition to a moderate alcohol contract (permitting him to have alcohol to the drink/drive limit) was to reward his good progress and encourage sensible drinking habits. I am not convinced that this was the most obvious or sensible of his conditions to relax, given alcohol was a known risk-factor for the man, but I do see the initial motivation for providing a concession. In addition to the alcohol risk, it was known that the man's offence was committed under the influence of a large quantity of alcohol and antidepressant medication.
151. Whilst at the Approved Premises the man was prescribed three types of medication by his doctor – an antihistamine, an antidepressant and, later on, sleeping tablets - all of which advise against drinking alcohol whilst medicated. The member of staff at the Approved Premises brought this caution to management's attention on 3 December. In addition, the police raised concerns about the man drinking whilst taking prescribed medication because it had been cited as a trigger for his previous offending behaviour. The side effects of drinking alcohol whilst taking Amitriptyline are drowsiness, possible lack of coordination and increased effects of alcohol consumption (could make a person drunk quickly on smaller amounts of alcohol).
152. During her interviews, my investigator asked staff at the Approved Premises how they reconciled these concerns with permitting him to drink. The decision had been taken by his offender manager after discussion with the deputy manager and the substance misuse worker. The deputy manager told my investigator that she was not absolutely certain when his prescribed medication started or what they were, but thought it started when he moved into the Approved Premises. She said that distributing medication was not one of her particular duties and she would not routinely be aware of a resident's prescription. The deputy manager said that this would be something a residential service officer (RSO), who would work more on a one-to-one basis, would know.
153. The RSOs are responsible for arranging repeat prescriptions, making medical appointments, booking in medications and dispensing. The deputy manager said that if she was aware of a resident's prescription this would not necessarily mean she would know the possible side effects. So in the man's circumstances, she was not aware that there was a caution against drinking with these medications until it was raised by the member of staff at the Approved Premises - several weeks after the moderate contract had been signed.
154. My investigator asked whether any consideration was given to revising the contract once this information came to light. The deputy manager told my

investigator that the matter was discussed with the man's offender manager in the first instance and then again during his weekly visit to the Approved Premises on 5 December. It was decided between them not to revoke the contract as the man was already in a low mood after the MAPPA meeting on 15 November. It was thought that removing the contract would take away the leeway given to the man to reward his progress. Doing so might have caused a further negative response from the man. Their main priority was rebuilding the man's confidence with staff after MAPPA had declined to relax any of his licence conditions.

155. The man's offender manager sent an email to the Approved Premises manager and the deputy manager on 5 December asking for guidance about the man's medication. He was concerned that, in having a duty of care for the man, the Approved Premises should ensure that he was avoiding alcohol in accordance with the medication guidance. He said that to all intents and purposes the Approved Premises was administering the man's medication, so steps should be taken to ensure that the man was not exposed to an avoidable risk. The man's offender manager's view was that this was something they were compelled to do under health and safety legislation and a duty of care.
156. The man's offender manager took the matter forward by speaking to the man at length about his drinking during their meeting that day. The man's alcohol consumption since the new contract was signed had not been a problem, however the man's offender manager wanted to discuss drinking with his medications. The man told the man's offender manager that he was aware of the advice on possible side effects. The man's offender manager and the man agreed during their session that there was no need to change his contract. The man said that he was aware that he should not drink whilst taking his prescribed medication and told the man's offender manager that he was not going to drink.
157. The man's offender manager and the deputy manager decided to trust the man and not retract his contract. The deputy manager told my investigator that to revoke the contract might have been perceived as patronising to the man who was an adult and aware of the consequences of drinking with prescribed medicines. She added that the man's behaviour and attitude towards alcohol did not present as an issue as it had in the past (referring to his offending behaviour). They agreed to monitor the situation.
158. I am relatively content with this reasoning, however I consider it would have been better for the discussion to have taken place prior to the contract being changed. This might have influenced the decision to grant a moderate drinking contract in the first instance. I do not agree that part of a reason for not changing a contract with a resident should be based on whether it could be construed as patronising. However, it is not certain whether changing the contract would have made any difference to the eventual outcome.
159. I would like to commend the staff member's vigilance in noticing the risks from the man's medications and bringing them to her managers' attention. Her example should be followed and staff responsible for dispensing prescriptions

to residents should familiarise themselves with any overt warnings and appropriately share this information.

160. No one interviewed for this investigation could offer any insight as to why the man decided to drink above the drink/drive limit on 12 December. There was nothing significantly different about his behaviour that day. He was noticeably annoyed after his session with his offender manager, but neither the man's offender manager nor anyone else felt that the man was a risk to himself that day.

Mental health

161. Whilst in custody, the man had been diagnosed with a histrionic and narcissistic personality disorder. Antidepressants were prescribed to help stabilise his mood and anxiety. At the Approved Premises he registered with the local surgery like all other residents. The doctor prescribed Amitriptyline as the man reported feeling anxious. During his sessions with the substance misuse worker, the man told her that he felt these tablets stabilised his moods.
162. Initially, the doctor told him that he could only take the tablets for only a short period. However, after the man's panic attacks on 26 and 28 November, the man informed staff that the doctor had advised him to stay on them for a while. My investigator did not ask to see the man's NHS medical notes, as she did not consider it necessary to comment any further on his prescription.
163. It is noted in the Pennine Care Trust review that the man appeared to display some elements of paranoia in the weeks before his death. For example, he enquired as to whether a SMS member of staff who had been in the same pub had been sent there to check up on him. This example, coupled with the man's two panic attacks and occasionally reported odd behaviour at the hostel, suggest deterioration in the man's mood.
164. My investigator asked staff and the man's offender manager during interviews whether they thought the man's behaviour suggested paranoia. All interviewees said that they did not feel informed enough to make that judgement, but acknowledged that his behaviour and mood were markedly different after the MAPPA meeting on 15 November.
165. The Approved Premises does not specialise in working with offenders with mental health disorders. Accordingly, staff are not specifically trained to work residents with mental health issues and the Approved Premises has no specific mental health advisor or worker. The deputy manager told my investigator that there had been one or two workshops for staff, given by the MAPPA support unit (MSU) forensic psychologist, regarding personality disorders and other issues. It was understood by staff that the man was considered to have a personality disorder rather than a mental disorder.
166. During her interview, the deputy manager explained that if a resident required mental health care they are referred in the first instance to the local doctor in the first instance, who would refer them to a community mental health team

(CMHT). Residents who are already existing clients of a CMHT would continue to receive care. In addition, the MSU forensic psychologist can assess and treat highest risk offenders if required. Referral to this psychologist is decided by the MAPPA panel and is not something that hostel staff would directly take forward. If staff thought an urgent referral was necessary, the MAPPA Chair could be approached rather than waiting for the next panel meeting.

167. The deputy manager told my investigator that, prior to the man's release she was aware that part of the MAPPA panel's plan was to encourage him to see the MSU forensic psychologist for further insight into his personality disorder. However, the panel had speculated that the man would not be compliant or would be suspicious of the motive behind asking him to do this. It was decided that once he had been released and begun working with probation staff that the forensic psychiatrist would then be asked to see him.
168. The deputy manager said that when the man's engagement and mood deteriorated after the panel's meeting on 15 November, she had thought about arranging for the forensic psychologist to see him and discussed this with the man's offender manager. The offender manager's response was that until they were able to secure the man's full compliance, this would be fruitless and counterproductive.
169. On 7 December, the man spoke at length with the deputy manager. He raised the fact that several psychiatric and psychological reports had been compiled about him. The deputy manager told my investigator that this information was offered without prompting the man to discuss his mental health or asking if he would speak to the MSU psychologist. It was during this conversation that she considered raising the issues. However, in spite of his comment, he stipulated that he would not cooperate with another psychiatrist or psychologist. He believed that the existing reports were not accurate reflections and were prejudiced, based on his offence. The man said he had a new report that he had commissioned himself, which was with his solicitor. This report is said to state that the man did not have a personality disorder. His offence was said to be committed due to anxiety triggered by traumatic events and an accidental overdose of his prescribed medication. The deputy manager suggested that the report be made more widely available. The man refused on the grounds that it was for him and his solicitor to decide what to do with the document. (My investigator did not have sight of the new psychiatric report as it was not relevant for her investigation.)
170. The deputy manager said that, given the direction of their conversation, she did not raise seeing the MSU psychiatrist with the man. Whilst the deputy manager's record of the session is comprehensive, she makes no reference to her decision not to raise a referral to the MSU psychiatrist. I would like to have seen that any additional discussion was documented. I accept that the concern the man might not engage was not without reason, particularly in the light of his conversation with the deputy manager on 7 December. However speculation is not sufficient when there is a duty of care. The matter could still have been raised with him, perhaps at an earlier stage when he showed signs of withdrawing and anxiety. It is not possible to determine whether an

appointment with MSU psychologist would have prevented his death, but it would have given the man the opportunity to discuss his mental health with a professional if he wanted to.

171. My investigator has not seen any documentation relating to the earlier MAPPA plan or a record of the conversation between the deputy manager and the man's offender manager. Given the nature of the conversation I would have expected to see a record in the man's contact sheet.

The Manager at the Approved Premises should remind staff to record all significant conversations and decisions regarding a resident.

Self-harm or suicide risk

172. The National Probation Service requires all Approved Premises to have in place a strategy for preventing self-harm and suicide. The Approved Premises, like other Approved Premises in the north-west, use a process for observing and monitoring risk based on that used by the Prison Service. If any resident is identified as at risk of self-harm or suicide a document called an Assessment Care and Teamwork (ACT) document is opened. This form can be initiated and used by any person responsible for the resident's care. The purpose of the form is to better manage the resident's risk. This is done by documenting interactions, observations and assessments, in addition to detailing care plans. Any care plan has to be agreed to by the resident. The document is accessible to all involved, making care transparent and sharing responsibility.
173. My investigator asked the man's keyworker, the residential service officer, whether he had considered the man to be at risk to himself at any time. The residential service officer described the man as being a bubbly and happy person in his first few weeks, but also very private. He said that the man was demonstrably frustrated by his licence and MAPPA restrictions, but adhered to them nonetheless and showed signs of progress.
174. My investigator asked the residential service officer if he ever saw the man upset or low in mood. The residential service officer said that the man was unhappy with his licence conditions and his time in prison. He said that the only time that he became a little concerned was at the beginning of December when the man was sorting through some clothes he had got from his mother's house. When he asked the man why he had the clothes, he replied that he wanted to sort things out. The residential service officer told my investigator that whilst there was nothing significant about this conversation he had a gut feeling that the man was troubled. This was compounded by the man's strange behaviour on 2 December when he went to the staff office on a number of occasions during the day to ask why the police were asking for information about him. The man changed his clothes a number of times that evening and told staff that he would no longer eat at the hostel.
175. The residential service officer said that the man withdrew from staff. He told the residential service officer that he might as well give up trying, as he was not being treated with leniency for his progress. The residential service officer said

that, on occasion, during the last few weeks before his death the man would not speak to him. Staff would have to cajole the man into conversation when he went to the office to collect his medication. The man's mood was variable, one day he would be friendly and the next moody, with no apparent trigger other than the MAPPA panel decision.

176. Despite his impression that the man felt troubled, the residential service officer told my investigator that he did not think the ACT process was needed. He thought that the most appropriate approach was to keep a close watch on the man. The residential service officer recorded that he had, on several occasions, attempted to talk to the man about how he was feeling, but the man had not wanted to discuss the matter.
177. My investigator asked the same of the substance misuse worker, particularly in reference to her conversation with the man on 15 October when he spoke of his mood swings and occasional suicidal thoughts. The substance misuse worker explained that, despite the depressive nature of some of their conversation, in her view the man displayed no current or significant suicidal thoughts or intent. My investigator asked the substance misuse worker what she would have done had she been concerned. The substance misuse worker said that it depended on the level of concern. If the man had presented as acutely suicidal she would have taken him to the Accidents and Emergency department of a hospital to see a doctor as she would with any client if the need arose. Alternatively, she would have suggested a doctor's appointment.
178. Anything of concern would be raised with the resident's key worker and either the manager or deputy. The substance misuse worker said that she would also record it in her logbook, which remains at the hostel for staff to read. This book is also used for summarising the key points arising from any meeting with her clients, for staff information. In such circumstances, the substance misuse worker is permitted to break client confidentiality and ensure that all key people responsible in providing care are aware of the situation.
179. The substance misuse worker stressed to my investigator that she did not think that the man presented as a risk to himself and she would have made staff aware of any concerns. She said that the man did not refer to having suicidal thoughts again after their meeting on 15 October.
180. My investigator asked the deputy manager whether she had been concerned that the man might be a risk to himself. She told my investigator that he was low in mood during a session on 7 December. However, it was not unusual as his mood had been changeable for some weeks. She did not consider him then, or any other time, to be at risk of self-harm. The deputy manager described the man's temperament and statements of not wanting to engage or eat his meals at the hostel as reactionary rather than a sign of risk. She explained that the man had an impulsive character.
181. My investigator asked whether these changes in his mood could have been attributable to a deterioration in his mental health. The deputy manager said that, with hindsight, it could be possible to argue that this had been the case.

However, she stressed that at the time this did not seem a possibility as his behaviour was more challenging than concerning.

182. Similar answers were given by all interviewees. Although the man appeared withdrawn and had a changeable mood, no one thought that he was a risk to himself. There was greater concern that he could impose an increased risk to others instead of to himself. For example, the manager of the Approved Premises issued a notice to staff on 30 November, reproduced earlier in this report. He advised caution in their contact with the man as his disappointment regarding the MAPPA decision might lead to an increased risk to staff. There are no entries in the man's contact sheet for that weekend. I am concerned by this and would have expected to see at the least a daily entry noting that contact had been made with the man. Even if there was no contact this should have been recorded.

The Manager should remind staff that, particularly when careful monitoring has been requested, records of contact are kept.

183. During the police interviews, the man's friends said that it had been apparent that he was unhappy about his licence conditions and the restrictions imposed on his life at the hostel. However throughout the time they had known him, the man had never given the impression that he was depressed or suicidal.
184. Given that the man did not present as an active risk of self-harm or suicide, it was reasonable for staff to consider the ACT document to be inappropriate. The man was subject to closer observation due to his change in mood and engagement, likewise he received considerable staff attention and opportunities to discuss his feelings. The deputy manager and the man's offender manager encouraged him to be more open with staff, however he increasingly chose not to engage. When he did engage it was mostly to vent frustration.

The question of bullying

185. The man's mother told my investigator they were concerned a resident had bullied her son as he had told his family that a resident had approached him and asked him to provide a urine sample. My investigator looked into this issue. She confirmed that this event had taken place but could find no evidence to suggest that the man had been bullied.
186. The reason for the resident's approach was that he knew the man was not a drug taker and could provide a clean sample. The man refused and told his alcohol worker, the substance misuse worker, during their session on 12 November. The substance misuse worker reported the incident to hostel staff, who noted it in the man's contact sheet. As a result of the information, the procedure for drug testing was changed from urine samples to oral swabs.
187. The resident who approached the man was drug tested using the oral swab which gave a positive result for Class A drugs. The resident admitted that he had asked the man for a urine sample. There were no further reported

instances of him approaching the man for samples. There was nothing in the hostel records or from staff accounts to suggest that the man was bullied.

MAPPA

188. The man was disappointed with the MAPPA panel decision on 15 November. He made it clear to staff that he was unhappy with this outcome and said that he saw no point in positive engagement if it was not going to be recognised. The man told the deputy manager, his offender manager and other members of staff that the negative response from MAPPA was a conspiracy by the authorities to put him under stress and make him crack under pressure. All parties tried to reassure the man that this was not the case and that continuing to positively engage might influence the panel's decision at the next meeting.
189. The deputy manager told my investigator:
- “The man was somebody who was quite challenging, quite demanding and incidents seemed to attach themselves to him... He was somebody who was very questioning and sometimes quite tortured in his thinking and in his response and sometimes in his behaviour. But there was a definite shift in his mood after 15 November. He was questioning, he wanted to know about the MAPPP process and how it had come about.”
190. Staff at the Approved Premises and the man's offender manager, told my investigator during interview that they thought the decision not to relax his conditions was counterproductive and a definite turning point in his engagement with staff. Soon after the MAPPA meeting the man noticeably withdrew and staff found it difficult to work with him.
191. I am satisfied that staff at the Approved Premises, the substance misuse worker and the man's offender manager tried to motivate the man and keep him engaged. The contact notes demonstrate that at every meeting with the man the importance of his engagement was discussed, as was the MAPPA process.
192. It is not within my remit to comment on whether the MAPPA decision was fair or appropriate. The man was a high-risk offender with a detailed contingency plan in place. The decision was based on many factors and not just those presented by the Approved Premises staff or the man's offender manager. His progress at the hostel was taken into account, but it was thought that he needed to be monitored for a longer period before any relaxation of signing times could be considered. The panel intended to revisit the issue at the January meeting.
193. The man's mother asked why she was not able to appeal to the MAPPA Chair. The MAPPA panel meetings are confidential as is the identity of its members. Therefore the man's mother would not have been given any contact information to lodge an appeal. In addition, her son was an adult and therefore it would have been his responsibility to lodge an appeal.

Staffing

194. The man's family asked my investigator to provide information about the staff who were on duty the night that he absconded. In particular, they have asked if there were any agency staff on duty. The Approved Premises manager and the deputy manager and told my investigator that there were no agency staff on duty that night. There was a member of staff from another Approved Premises providing leave cover. Using staff from another hostel is the first preference for providing cover, but in the event that this is not possible, agency staff are used.
195. Another member of staff providing cover for the night shift that evening would have arrived to take over from the member of staff at the Approved Premises when she finished her shift at 10.00pm. However, given the circumstances, the member of staff at the Approved Premises did not leave. The other member of staff was familiar with working at the Approved Premises, but might not have known the man very well. The two other members of staff on duty at the time the man absconded both knew the man well.
196. Stockport Police asked if a member of staff from the Approved Premises could go to the hospital to identify the man's body. This request was made to prevent the man's mother from suffering any undue trauma should the body found not have been her son. I appreciate that this was a difficult task for the member of staff at the Approved Premises, particularly as she was one of the last people to see the man. She should be commended for volunteering to do this.

Breaching conditions of licence

197. During the induction process at the Approved Premises residents have their licence conditions explained to them, including what constitutes a breach. Offenders released on licence know that if they do not comply with the conditions attached to their licence they risk being recalled to prison. The man had been made aware of this during his induction.
198. There is no formal policy at the Approved Premises setting out how to tell a resident if they have breached licence conditions or may be recalled. However, according to the Approved Premises manager, there is an informal practice which all staff are aware of. The custom is to defuse the situation first. In the event that a resident is late for curfew they would be told to return to the hostel as soon as possible. If a resident was intoxicated on their return, they would be encouraged to go to bed and sleep it off.
199. The Approved Premises manager told my investigator that staff would not mention a breach or recall to a resident because of the increased risk of absconding which could present a danger to the resident or the public. He told my investigator that a resident might surmise the outcome of their breach and abscond anyway. It was the Approved Premises manager understands from conversations with the member of staff that the man may have reached this conclusion. The member of staff stressed to the manager and the police that

the man was not told that he had breached his licence or that he might be recalled.

200. I would judge that there may be some merit in formalising guidance on how to deal with residents in breach of licence conditions. In response to the initial draft of this report, the Director of Intervention and Support Services at Greater Manchester Probation Trust has suggested that this could be discussed within the Greater Manchester Trust or nationally.
201. The National Offender Management Service (NOMS) Approved Premises policy lead was also asked for his opinion on formalising guidance. He warned of the danger in creating a blanket policy, as each situation should be assessed on its own merits. The policy lead said that discussing action to be taken following on from a breach might alleviate anxiety if the sanction is to be minor, e.g. a warning. However, there would be times when saying nothing until the following day would be beneficial. He explained that reasons will vary, and deciding upon a course of action is all part of the ongoing risk assessment and risk management that hostel staff undertake on a regular basis. The policy lead said that consideration could be given to formalising guidance, but not necessarily along the lines of the informal practice used by the Approved Premises. He said that it would first be necessary to canvass the Approved Premises estate to ascertain customary policy and practice.
202. I welcome the suggestion by both parties that this issue could be discussed more broadly to consider agreeing guidelines for all staff across the Approved Premises estate.

NOMS should evaluate common practice across the Approved Premises estate for dealing with a resident in breach of licence conditions, with a view to formalising guidance.

203. The member of staff at the Approved Premises repeated what the manager had said to my investigator during her interview. She confirmed that she had not mentioned a breach of licence or given any warning to the man. The member of staff also told my investigator that the man was not aggressive when she asked him to take the breathalyser test, he simply said that he did not want to do it. My investigator asked the member of staff if the man had appeared anxious or frightened. She said that he did not. The man was calm when he left the office and also when he came down from his room and left the hostel. My investigator asked whether the man would have overheard the member of staff tell her colleague that she was going to ring the duty manager. The member of staff said that it was unlikely and stressed that her words were nothing more than "I'm going to have to contact the duty SPO".
204. The member of staff had not telephoned the duty manager before the man left the hostel. She said that if the man had stayed in his room she would have made the duty manager aware that he had missed his curfew, but that he had let staff know he was on his way and would only be a little late. The member of staff explained to my investigator that this is not uncommon as public transport is not always reliable. As long as the resident lets them know and is only a few

minutes late that it is not generally a problem. However, lateness would always need to be noted and the SPO or duty SPO would always be informed. Under these circumstances, the duty SPO would leave it to the manager or deputy manager to decide what action to take when they started their shift in the morning. My investigator was satisfied with the member of staff at the Approved Premises accounts of events and found no reason to disbelieve her.

205. The SPO can make a recommendation to recall an offender. During normal working hours, the decision has to be approved by either the relevant Area or District Manager and by the senior manager 'out of hours'. The hostel staff (The member of staff at the Approved Premises in the man's case) inform the SPO (the duty manager) of the breach. Depending on the circumstances, the SPO then decides whether or not to make the recommendation to the Early Release and Recall Section (ERRS) at the National Offender Management Service (NOMS). In the man's case, once he had absconded there was no option but to initiate an emergency recall and the police contingency plan.
206. The SPO (hostel manager or duty manager), or the district manager, is responsible for making the decision on the next steps. The SPO is required to consult with their line manager to ratify the recall. (In the man's case the duty manager contacted an Assistant Chief Officer, and discussed the recall.) The Recall Officer at the ERRS, who has the power to action or reject the recall, is then contacted. The Approved Premises manager said in his police interview that overturning the decision is rare and, in his experience, had only happened once in four years. Once the Recall Officer agrees the decision, the police are informed."
207. The decision to recall depends on the breach. A warning can be issued in place of the recall. In the event that a resident is subject to a recall, they are not informed until the police arrive to escort the resident back to prison.
208. Some breaches of licence are dealt with by the Approved Premises – for example, by issuing a warning letter. More serious breaches result in a recall to prison to serve the remainder of a sentence. There are two types of recall, emergency and standard. Standard is for lower risk cases which are processed within 24 hours. Emergency recalls are dealt with within two hours. The man was subject to an emergency recall as he was on Level 3 MAPPA.
209. If a resident subject to emergency recall absconds out of hours, staff contact the on-call duty manager by telephone. The duty manager would then initiate the recall process by contacting the Home Office. This involves telephoning the Recall Officer² at the Home Office who then telephones the duty manager back, takes details and revokes the resident's licence. A revocation form is completed and faxed to New Scotland Yard and the resident is added to the Police National Computer as a 'wanted' offender.

² Note the Recall Officer is part of the Offender Management Service, which is part of the National Probation Service.

210. A resident would not be told they were going to be recalled in any other circumstances. To do so would increase the possibility of the resident absconding or reacting badly to the news. It would cause undue stress for the resident and staff alike.

Security

211. For security reasons, there is a requirement at night for at least two members of staff to be on duty and present in the hostel at all times. When the man decided to leave the hostel after returning for his curfew, the member of staff followed him to the end of the driveway and called for him to come back. Due to the security requirements relating to staff presence, she was unable to continue following the man. The only action that the member of staff at the Approved Premises could take at this time was to ring the duty manager, and the police to inform them that the man had left the premises after curfew.

Post-mortem and toxicology

212. A forensic pathologist performed the post mortem on Friday 14 December. He concluded that the injuries to the man's body were consistent with trauma caused by a fall from a motorway bridge. Though some of his injuries could have been caused by contact with traffic, there was no evidence he had been run over in the conventional sense. From a pathological perspective, the forensic pathologist was unable to determine exactly how the man fell from the bridge. His cause of death was the result of head injuries.
213. A toxicology report produced by a consultant clinical biochemist dated 19 March 2008 found ethanol (alcohol) to be present in the man's system:

“at a blood concentration that may be associated with slight impairment of mental acuity and motor-coordination. The legal blood ethanol limit for driving is 800mg/l. As indicated by the urine concentration [1850mg/l], the blood ethanol concentration [1280mg/l] has probably been higher than reported here a few hours before death.”

This confirms that the man had been drinking before his death, above the level agreed to in his moderate alcohol contract.

CONCLUSION

214. Whilst I understand the importance of finding a way to reward the man for his initial positive progress and provide further motivation during his first few months the Approved Premises, I find it difficult to reconcile that the one concession given and permitted by the MAPPa panel was related to his alcohol contract. This is particularly pertinent given the reason for not relaxing any other licence condition was firmly weighted on the man's potential high risk to others and alcohol had been cited as a trigger for his offending behaviour. However, the onus was on the man to demonstrate that he was able to enjoy this moderate privilege sensibly and not exceed the limit. As an adult, the man was responsible for his own decisions. It would be unfair to apportion any blame for his death on the relaxation of this licence condition.
215. It is clear that the man chose to refuse the breathalyser test after returning late for his curfew and to abscond from the Approved Premises. The man had made it clear to staff, his offender manager, the substance misuse worker and his family that he did not want to go back to prison. It seems that he assumed that he would be recalled, despite staff at the hostel giving no indication that this would be the case. All offenders on licence know that they risk recall if they breach their conditions; however recall is dependent on circumstances and is not an automatic penalty.
216. Absconding is a serious breach of conditions, particularly for a high-risk offender. Although the man will have been unaware of the two-hour emergency recall or the existence of the police contingency plan, he knew that by absconding he would have been liable to recall. This is highlighted by his conversation with his mother shortly after running away.
217. As with the police investigation, I have no evidence to conclude whether the man intended to fall from the motorway bridge or if it was an accident. Like all the self-inflicted deaths investigated by my office, the man's was a sad and unnecessary death.

RECOMMENDATIONS

1. The Manager at the Approved Premises should remind staff to record all significant conversations and decisions regarding a resident.
2. The Manager should remind staff that, particularly where careful monitoring has been requested, records of contact are kept.
3. NOMS should evaluate common practice across the Approved Premises estate for dealing with a resident in breach of licence conditions, with a view to formalising guidance.

RESPONSE TO THE DRAFT REPORT

Probation Service

The Director of Interventions and Support Services for Greater Manchester Probation Trust, commented on the draft report on behalf of the Probation Service. In addition to highlighting some factual inaccuracies, The Director commented on the third recommendation. This referred to developing guidance for the Approved Premises staff on how and when to inform a resident of a licence recall. The Director said that the recommendation should be directed to the whole Approved Premises estate and just at the Approved Premises in isolation. This would enable a discussion at the District Management Team level to agree guidelines for all staff in the division.

The Head of Approved Premises, responsible for Approved Premises policy in NOMS, was also asked to comment on the recommendation. He said that consideration could be given to formalising guidance, but not necessarily along the lines of the informal procedures used in the Approved Premises. The Head said that the Approved Premises estate would need to be canvassed to ascertain customary policy and practice. The initial view from a policy perspective would be that there are instances where discussing what action will be taken following a breach might alleviate anxiety when the sanction is likely to be minor, e.g. a warning. On the other hand, there will be times where simply saying nothing until the following day is the best course of action. The Head said that reasons will vary and deciding on what course of action to take is part of the ongoing risk assessment and risk management that hostel staff regularly undertake. He stressed that a blanket policy (either to never discuss or always discuss) would probably be unwise.

I have accepted both the Director of Interventions and Support Services for Greater Manchester Probation Trust, and The Head of Approved Premises's advice and have amended the recommendation accordingly.

In response to the section regarding the man's alcohol consumption on page 40 of the report, the Probation Service has stressed that the Chair of the MAPPP was unaware of the discussions that had taken place about the importance of not drinking alcohol whilst taking prescribed medication. I acknowledge that this information would have been useful to the Chair in agreeing to relax the no alcohol contract. However, no comment has been offered by the Chair as to whether this would have made any difference to the man being permitted moderate alcohol consumption. I am disappointed to learn that this important series of discussions was not fully shared with the Chair.

The Director highlighted that the process for initiating the recall decision making process had not been accurately explained in the draft. She said that whilst the SPO can make a recommendation for recall, it is the Area or District Manager who provides the approval. 'Out of hours' the senior manager needs to approve the recommendation. Also a SPO has to consult with their line manager to ratify the recall. The SPO can make a recommendation to recall an offender. I have incorporated these comments into paragraphs 210 and 211.

The Director's final point was on the time taken by my office to conduct this investigation. I appreciate that delays in issuing death in custody reports can be stressful for both the deceased's family and staff. Again, I reiterate my apology for any undue distress this may have caused. I hope that staff at the Approved Premises will understand that part of the delay in issuing the final was to afford the man's family adequate time to respond to the draft. I am sure that they will appreciate that this will have been an upsetting process for the man's family. Their full comments were provided shortly before Christmas. I appreciate that there has been a further significant delay. This was attributable to the investigator responsible for the report leaving the Fatal Incidents Team. I offer my sincerest apologies for this additional delay and any further distress this may have caused all parties.

The family's response

The man's mother provided a thorough response to the draft report. I recognise that this was a difficult and emotional undertaking and thank the man's mother for her time taken. I have addressed each of her questions in turn below.

The man's mother's primary concern is the apparent discrepancy between staff statements and accounts during interview. She has asked why it is that staff had differing opinions of her son's behaviour on both the months prior to and the night of his death. Specifically, she asked:

- Why the Deputy Manager said that no alcohol was found in the man's room, but the Approved Premises manager said a bottle of vodka was found.
- The duty manager said she was told the man became "stropky and argumentative and stormed out of the hostel". Whereas in a member of staff at the Approved Premises's account she said that the man smiled, waved and said "see ya" on leaving the hostel. The member of staff at the Approved Premises also said that the man was not aggressive when he refused to take the breath test.

Where there are discrepancies between staff accounts and there is no supporting evidence to resolve the matter either way I have not drawn any conclusion. What is clear regarding the alcohol is that the police investigation confirmed the man bought a bottle of vodka from a shop after walking out of the Approved Premises. My investigator was unable to establish for definite whether or not there was a bottle, but did not think it was pertinent to the investigation to pursue the issue.

I appreciate that that the duty manager's account during her interview differed to the member of staff at the Approved Premises's. However, the member of staff at the Approved Premises's was a first-hand account and the duty manager was offering an interpretation of events sometime after the man's death. Despite these discrepancies, the fact of the matter is that the man refused to take the breath test and walked out hostel when his curfew was in place. The man was subject to a very stringent police contingency plan and emergency recall due to his high level of risk to others. He seriously breached his licence in leaving the Approved Premises and immediate action had been taken, regardless of whether he was or was not aggressive in doing so.

It should be recognised that it minor discrepancies between staff accounts and statements are not exceptional during an investigation. People recall events in different ways or can have varying perceptions of a person's presentation. This is why investigators do not solely rely upon singular verbal accounts in undertaking an investigation. On occasions when there are contradictory accounts of pertinent events, the investigator will do their utmost to identify any corroboratory evidence.

The man's mother asked for clarification on why a question regarding her son selling his urine had been asked. My investigator asked the Deputy Manager what she knew about this matter because she wanted to establish whether the man had been under any pressure or had been bullied by any of the residents at the Approved Premises. There were references in his records about the man having told his drugs worker that he been approached by a resident to sell his urine for the purpose of drug testing. The Deputy Manager told my investigator that this concern had been brought to the attention of staff by the drugs worker. However it never amounted to anything beyond suspicion because despite enquiries (through random testing and speaking to the man) there was no evidence to support the claim.

Concerns were raised regarding the residential service officer's understanding of the man's family situation. The man's mother was upset to read that the residential service officer thought there may have been a rift between herself and her son. She was also disappointed that the residential service officer did not know that the man's father had died. He had referred to her partner as her son's father during his interview. The man's mother thought that these comments indicated that the residential service officer did not know her son very well, despite him being her son's keyworker. Although I appreciate that this was a mistake on the residential service officer's part, my impression is that this was not intentional. The residential service officer knew the man well enough to have an effective keyworking relationship.

In addition, she found the residential service officer's comments about her son displaying "strange" behaviour to be vague and odd. The residential service officer did have difficulty qualifying what he meant in using the word "strange" to describe the man's behaviour on the day when he was sorting through his clothes. What he was attempting to convey was that the man's was behaving differently and there was something odd about it that he could not put his finger on. My investigator did try to get the residential service officer to elaborate on this point, but he could not put into words. I am confident that the residential service officer had sufficient previous contact with the man to make a judgement about his demeanour and to identify when he was behaving any differently.

The man's mother asked for clarification on the manager of the Approved Premises statement that "if a resident was intoxicated on their return, they would be encouraged to go to bed and sleep it off." She asked why her son was not privy to this procedure on the night of his death. The man would have been encouraged to do so after taking the breath test. He was aware of the requirement to have random breath tests as part of his alcohol compact. The man chose not to engage and then left the hostel. There is nothing to suggest that the man would not have been afforded this opportunity once he had complied. Indeed, all staff interviewed said

that this would have been the case and his breach of licence conditions would have been dealt with the following morning.