Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Walker, a resident at The Grange Approved Premises on 16 November 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

I carry out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr Anthony Walker was found hanged in his room at The Grange Approved Premises on 16 November 2017. He was 66 years old. I offer my condolences to Mr Walker's family and friends.

Mr Walker had lived at The Grange following his release from HMP Winchester on 3 November. He suffered from asthma and depression and was prescribed appropriate medication. He was distressed that, because of the nature of his offence, his licence conditions prevented him from returning to live near his family.

While staff at The Grange supported Mr Walker as far as they could and encouraged him to seek the medical help he needed, I do not consider that the options available to them and the policy framework on which they relied were sufficient to address his emerging and dynamic risks of suicide and self harm effectively.

Although it would not have affected the outcome for Mr Walker, I am concerned there was a delay of seven minutes before staff called an ambulance after he had been found hanging. I am also concerned that staff did not cut the ligature when they found Mr Walker, but left him hanging until the paramedics arrived. I consider that this was undignified and inappropriate.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman August 2018

Contents

Summary

Events

1. On 3 November 2017, Mr Anthony Walker was released on licence from HMP Winchester to live at The Grange Approved Premises (AP), Portsmouth. Mr Walker was serving a nine-month prison sentence for assault and actual bodily harm. The victim of his offence was his wife. Mr Walker had a history of asthma, alcohol abuse and depression. His licence conditions prevented him from travelling to his family home on the Isle of Wight.

2. The day after he arrived at The Grange, Mr Walker breached his licence conditions by turning up at his family home under the influence of alcohol, threatening to harm himself. He was returned to The Grange by family members and, on 6 November, he was given a Licence First Warning by the National Probation Service. On his return to the AP he gave conflicting accounts of whether he had intended to harm himself.

3. Over the next few days Mr Walker saw his offender manager (probation officer) and his keyworker at the AP and was prescribed anti-depressant medication by a local GP. He was described as presenting with a "hopeless" outlook. He was concerned about not having accommodation arranged when his placement at The Grange was due to end on 8 December and about not being able to return home, and he said that he was thinking of stopping his anti-depressant medication because he thought it was making him feel unwell.

4. At 5pm on 15 November, Mr Walker had a telephone conversation with his offender manager, who told him that it was unlikely that he would be allowed to return to the Isle of Wight when he had to leave The Grange on 8 December. Later that night, Mr Walker had a telephone conversation with his wife. Another AP resident said that Mr Walker was very emotional during the call. That night, staff checked Mr Walker at midnight, 2am and 4am.

5. On 16 November, at 9.32am, a member of staff found Mr Walker hanged in his room and requested an ambulance. Staff did not begin cardiopulmonary resuscitation as it was clear that Mr Walker had been dead for some time. The paramedics arrived at 9.47am and Mr Walker was pronounced dead at 9.52am.

Findings

Management of suicide and self-harm

6. We found that staff at The Grange assessed Mr Walker's risk of self-harm in line with national instructions and did their best to support him. However, we do not consider that the national instructions provided AP staff with sufficient guidance or tools to address Mr Walker's emergent and dynamic risks of suicide and self-harm.

Enforcement of licence conditions

7. When Mr Walker breached his licence conditions on 4 November, the Probation Service reviewed his licence, added additional conditions and issued him with a

warning, rather than recalling him to prison. Mr Walker did not breach his licence conditions again during his time at The Grange.

8. We found that that probation staff made the decision not to recall Mr Walker to prison with the intention of supporting him and giving him every chance of making a success of his licence period. We do not consider that it is possible to say that this decision was inappropriate or that it contributed to Mr Walker's death.

Clinical care

9. Mr Walker had registered with a local GP practice and was prescribed appropriate medication for his conditions. We are satisfied that staff at The Grange took appropriate decisions about which medication Mr Walker should be allowed to have in his possession and supervised the dispensing of his other medication each day.

Emergency response

10. Although it would not have affected the outcome for Mr Walker, the staff at the Grange did not call an ambulance as soon as Mr Walker was found hanged. We are also concerned that AP staff did not cut the ligature when they found Mr Walker, but left him hanging until the paramedics arrived. This was undignified and inappropriate.

Recommendations

- The Head of the National Probation Service should ensure that, as part of the current review of the Approved Premises Manual, guidance is available to Approved Premises staff to assist in the identification and management of dynamic risks of suicide and self-harm.

- The Manager of The Grange Approved Premises should ensure that:

  - there is appropriate cover at all times by staff who are fully trained in first aid and the use of emergency equipment; and
  - staff follow the emergency procedures when an attempted suicide is discovered and ensure that an ambulance is called immediately an emergency incident has occurred.

The Investigation Process

11. The investigator issued notices to staff and residents at The Grange informing them of the investigation and asking anyone with relevant information to contact him. Two residents responded.

12. The investigator visited The Grange on 21 November. He obtained copies of relevant extracts from Mr Walker's probation records.

13. The investigator interviewed four members of staff and two residents at The Grange in December.

14. We informed HM Coroner for Portsmouth and South-East Hampshire of the investigation. He gave us the results of the post-mortem examination and toxicology results and we have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Walker's family to explain the investigation and to ask whether there were any matters they wanted the investigation to consider. Mr Walker's family raised a number of concerns, including how often staff checked on him, whether he should have been recalled to prison custody and whether residents at The Grange had access to the internet. Mr Walker's family received a copy of the draft report. The solicitor representing Mr Walker's family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

The Grange Approved Premises

16. Approved Premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own health and are expected to register with a GP.

17. The Grange, in Portsmouth, is managed by HM Prison and Probation Service (HMPPS). It has 22 single rooms. Evening meals are provided and there is a communal area for dining and socialising and areas for group work. Each resident is allocated a key worker/offender supervisor to oversee their progress and well-being, and to ensure that residents adhere to licence conditions and the premises' rules. Probation Service employees are on duty at The Grange 24 hours a day.

Previous deaths at The Grange

18. Mr Walker's death was the second death at The Grange since 2004. The previous death took place in 2015, and was from natural causes. There are no similarities with the circumstances of the previous death and that of Mr Walker.

Key Events

19. On 27 July 2017, Mr Anthony Walker was convicted of assault and actual bodily harm and was sentenced to nine months imprisonment. Mr Walker's victim was his wife. He was sent to HMP Winchester. Mr Walker had a history of depression, asthma and alcohol abuse.

20. On 3 November, he was released on licence from Winchester. Mr Walker's licence conditions required him to live at The Grange Approved Premises (AP), Portsmouth. He was required to be at The Grange between 7.00pm and 7.00am every day, and to report to AP staff at 1.00pm each day. Mr Walker was not permitted to visit the family home on the Isle of Wight.

21. Mr Walker arrived at The Grange at 12.17pm and received an induction from AP staff. He was told about, and issued with, copies of the AP rules, details of the facilities, regime and fire, health and safety procedures, the alcohol and substance misuse policy, and the support available from AP staff. Mr Walker signed a receipt to confirm he understood and had received copies of the rules and policies. Mr Walker was also informed of his specific licence conditions, restrictions and signing/curfew times and the medication policy.

22. AP staff recorded that Mr Walker was prescribed mirtazapine (an antidepressant), cetirizine (an antihistamine), seretide (inhaler for asthma), salbutamol (inhaler for asthma), ventolin (inhaler for asthma), tiotropium bromide (inhaler for asthma), omeprazole (for gastric reflux), paracetamol (mild to moderate pain relief), ibuprofen (anti-inflammatory) and anusol cream (haemorrhoid relief). Arrangements were made for Mr Walker to register as a patient at a nearby surgery.

23. The offender supervisor (and Mr Walker's keyworker) said that due to the limited availability of accommodation at The Grange, Mr Walker only had a room there until 8 December. The Probation Service would arrange alternative accommodation for him after that.

24. The offender supervisor completed a self-harm information sheet as Mr Walker said he had attempted suicide by taking an overdose in March 2017. Mr Walker said he took medication for depression but had no thoughts of self-harm or suicide. The offender supervisor recorded that excessive alcohol use was a trigger for Mr Walker's risk to others and himself.

25. The offender supervisor assessed that Mr Walker posed a high risk of harm if allowed all his medication in his possession, and he was therefore only permitted to have his inhalers and anusol cream in his room. All Mr Walker's other medication would be issued to him by AP staff and he was required to take it in their presence. Mr Walker signed and dated the resident's medication contract.

26. The offender supervisor told the investigator that there is a national curfew of 11.00pm to 6.30am which all residents of approved premises must observe. At The Grange, all residents are checked at 11.00pm. Residents must be in their rooms by midnight when staff conduct a further check of all residents. There are then two physical welfare checks of each resident around 2.00am and 4.00am,

where the night staff open resident's doors and check for any concerns. In addition, staff conduct two walk-round checks of the building during the night.

27. The offender supervisor also told the investigator that residents at The Grange do not have access to the internet. Residents are permitted to have a basic mobile phone that can only make and receive calls and send and receive texts. Mobile phones with internet and camera functionality are not permitted. On his arrival at The Grange, Mr Walker had his mobile phones confiscated as they were internet-enabled. He was advised to purchase a basic phone from a local supermarket.

Events of 4 November

28. During the early hours of 4 November, staff checked Mr Walker at 2.21am and 4.24am. He appeared to be asleep on each occasion and there were no concerns. Staff recorded that Mr Walker reported for his 1.00pm check, and he then left The Grange at 2.35pm to go into Portsmouth.

29. At 7pm, Mr Walker failed to return for his evening curfew. AP staff informed the on-call AP manager that Mr Walker had not complied with his curfew. Mr Walker's wife telephoned The Grange and said that Mr Walker was at the family home on the Isle of Wight and was threatening to harm himself. Mr Walker had allegedly made an attempt at suicide near the family home. Mr Walker's wife said she had tried to call the mental health team but there were no crisis workers on duty. Mr Walker's wife said she would not call the police because Mr Walker would not cope with being recalled to prison.

30. AP Staff informed the on-call AP manager what had happened. It was agreed that Mr Walker had to be back at The Grange in time for the 11pm curfew, otherwise he would be recalled to prison. One of Mr Walker's daughters and his wife agreed to bring him back to The Grange. The on-call manager put in place an additional sign-in time for Mr Walker of 5pm each day. Mr Walker's son-in-law (the husband of another of Mr Walker's daughters) also contacted The Grange to say the family were concerned about Mr Walker's wellbeing. He said Mr Walker had turned up at the family home, was under the influence of alcohol and had attempted suicide in a brook near the family home.

31. At 10.35pm, Mr Walker arrived back at The Grange. He apologised to staff, said he had drunk too much and had fallen into the brook. When specifically questioned by staff about the incident, Mr Walker was adamant that he had lost his footing and fallen into the brook and that it was not a suicide attempt. Staff checked on Mr Walker at 11pm, and he was in his room. Staff checked Mr Walker again at midnight, 1.10am, 2.02am, 3.05am and 4.03am, and each time he was in bed and appeared to be asleep.

32. On 6 November, a senior probation officer spoke to Mr Walker on the telephone. He told Mr Walker that his behaviour was considered to be wilful non-compliance with his licence conditions which undermined the purpose of his supervision and placed his wife at risk. He gave Mr Walker a Licence First Warning. Mr Walker said he was fully aware of the consequences of any further non-compliance with his licence conditions. He told Mr Walker he had a meeting scheduled with his offender manager later in the week.

33. On 8 November, Mr Walker's offender manager visited him at The Grange. She discussed the incident in which Mr Walker had breached his licence conditions. Mr Walker said his solicitor had given him the details of witness statements provided by family members about his conviction. These had upset him, along with not being allowed to return home, and he had had a "meltdown". Mr Walker told her he had decided to go to his home after consuming an excessive amount of alcohol, with the intention of killing himself.

34. The offender manager encouraged Mr Walker to see a GP to get help with his mental health and emotional control, and to speak to the AP staff if he had any problems or concerns. She reiterated to Mr Walker that he did not have permission to go to his home address on the Isle of Wight and that he was required to sign in with AP staff at 1pm and 5pm each day. She gave Mr Walker a Licence First Warning Letter written by the senior probation officer. She also told Mr Walker he had to leave The Grange on 8 December. Other addresses would be considered for him, including a move to another hostel. She agreed with Mr Walker that she would telephone him every Wednesday at 5pm.

35. On 9 November, the offender supervisor met with Mr Walker for a keyworker session. He recorded that Mr Walker consistently presented with a "hopeless" outlook on his current and future situation and resisted any alternative suggestions about the way forward. He made it clear to Mr Walker that he needed to see a GP about any mental health support and a review of his medication. He contacted the GP surgery, obtained an appointment for Mr Walker at 11.20am that day and booked a taxi to get him there. Following his appointment with the doctor, Mr Walker was prescribed fluoxetine (an anti-depressant) in addition to mirtazapine, with the quantity of mirtazapine to reduce gradually over time.

36. On 11 November, Mr Walker told staff he felt unwell and could not stop shaking. AP staff contacted the NHS 111 telephone advice service, which advised that Mr Walker should go to the local hospital and take his medication with him. AP staff arranged, and paid for, a taxi to take Mr Walker to hospital at 9.15am. At 12.45pm, Mr Walker returned from hospital with his medication. There were no concerns with Mr Walker's health and he had been discharged without the need for treatment.

37. On 14 November, the offender supervisor saw Mr Walker for another keyworker session. He recorded that Mr Walker was taking his prescribed fluoxetine and was on a decreasing dose of mirtazapine. Mr Walker said he did not feel physically well. He had considered not taking the anti-depressant medication as he believed it was this that made him feel unwell. The offender supervisor advised Mr Walker to continue to take his medication as it would only work if taken regularly and because there could be a period of adjustment between one and another. He advised Mr Walker to consult the doctor for advice and not simply stop taking the medication of his own accord.

38. The offender supervisor recorded that Mr Walker could take care of his personal issues and he spent much of his time in the hostel watching TV and completing puzzles in his room. Mr Walker would go out to local shops as and when the need arose.

39. The offender supervisor noted that Mr Walker had a telephone appointment arranged with the offender manager the following evening. Mr Walker told him he intended to ask about his housing situation as he felt there was not enough time to arrange alternative accommodation before he was due to leave The Grange on 8 December. Mr Walker said that if the offender manager felt it unlikely that he would be allowed to return to his home address, he would ask if he could start looking for alternative accommodation himself.

40. AP records show that Mr Walker was tested for alcohol on 11, 12 and 14 November, and on each occasion the test was negative.

15 November

41. At 5pm, on 15 November, the offender manager spoke to Mr Walker by phone as arranged. Mr Walker said he was okay and felt he was doing well at the hostel. She told Mr Walker that, as he was due to leave The Grange on 8 December, the Probation Service was seeking rented accommodation for him in the Portsmouth area and he might have to live in another hostel initially. She said that he could provide alternative addresses himself for consideration by the Probation Service if he wished.

42. Mr Walker said his wife was looking for rental properties for him on the Isle of Wight. The offender manager told him that the senior probation officer would be unlikely agree to this at this stage. She explained to Mr Walker that when he left The Grange he would have less support, and safeguarding measures therefore needed to be in place at his wife's address before he could return to the Isle of Wight. Mr Walker said he believed he could be trusted to return to the Isle of Wight as he would not jeopardise his marriage, licence or want to return to court. She told Mr Walker that because he had breached his licence, the Probation Service had to exercise caution. She said, however, that he had made progress, had demonstrated he could comply with this licence, and that the expectation was he would be allowed to return home in due course.

43. Mr Walker said he could see nothing positive, that he was vulnerable and could not cope unless he was on the Isle of Wight with family support. He also asked about having access to his car. Mr Walker said he would ring his wife and tell her he could not return home. The offender manager assured Mr Walker that living in Portsmouth would only be temporary, however she would raise his concerns directly with the senior probation officer and would call Mr Walker back the next day at 1pm. She advised Mr Walker to discuss any concerns with AP staff.

44. AP staff recorded that Mr Walker had spoken to the offender manager and had been advised to speak to his keyworker the next day. The night manager recorded that she had issued Mr Walker with his medication at 8.53pm, and that he was in his room and awake at the curfew check at 11.00pm. His mood appeared normal.

45. A fellow resident told the investigator that Mr Walker was a quiet man who kept himself to himself and spent a lot of the time in his room. He said he would usually see Mr Walker at meal times. He said that Mr Walker appeared his usual self on the evening of 15 November. Another fellow resident told the investigator

that he lived in the room next to Mr Walker. He said that after the 11pm curfew check he could hear Mr Walker on his mobile phone. He said that he could not hear what was being said but could tell that Mr Walker was very emotional.

16 November

46. CCTV footage of the landing shows that the night manager checked Mr Walker at midnight, 2.06am and 4.01am. She said that on each occasion she opened Mr Walker's door and looked in and that he was in bed and appeared asleep. She went off duty at 7am, and handed over to a relief keyworker. There were no concerns about Mr Walker.

47. The relief keyworker told the investigator that he began the required 9.30am resident check and reached Mr Walker's room at 9.32am. When he opened the door, he saw Mr Walker hanging from the window by a ligature made from a T-shirt. He said, based on his 30 years' service as a police officer, it was clear that Mr Walker had been dead for some time and that beginning cardiopulmonary resuscitation (CPR) would have been futile. He told the investigator he closed and locked Mr Walker's door to preserve the scene as he had found it.

48. The relief keyworker went to the AP office and informed the offender supervisor that he had found Mr Walker hanged in his room. Both he and the offender supervisor returned to Mr Walker's room and the offender supervisor agreed that Mr Walker had been dead for some time. They returned to the office to call the emergency services.

49. South Central Ambulance Service records confirm that the 999 call was received from The Grange at 9.39am, and paramedics were despatched at 9.42am. Paramedics arrived at The Grange at 9.47am. They cut the ligature and lowered Mr Walker to the floor, recorded the presence of rigor mortis and blood pooling, and pronounced Mr Walker dead at 9.52am.

50. The investigator has liaised with Hampshire Police who have confirmed that Mr Walker's mobile phone records show that the last call he made was to his wife. The investigator has not had access to the content of that call. Hampshire Police have also confirmed that Mr Walker did not leave a suicide note.

Contact with Mr Walker's family

51. In line with National Probation Service guidance, the police visited Mr Walker's wife at her home address and informed her of Mr Walker's death. Later that morning the acting AP Manager contacted Mr Walker's wife by phone and offered her condolences and support. In the days that followed, the offender supervisor maintained contact with Mr Walker's family and, in line with national guidance, the Probation Service offered a contribution to the costs of the funeral.

Support for residents and staff

52. The offender supervisor held a meeting with residents following the incident to inform them that Mr Walker had died and offered them support. The acting AP Manager offered support to all staff, including those staff not on duty at the time of the incident.

Post-mortem report

53. A post-mortem examination confirmed that the cause of Mr Walker's death was hanging. The toxicology results showed that Mr Walker was not under the influence of alcohol or any illicit drugs at the time of his death.

Findings

Management of risk of suicide and self harm

54. Probation Instruction (PI) 32/2014 *Approved Premises Manual* sets out the National Probation Service framework for delivering safer procedures. It lists a number of risk factors and potential triggers for suicide and self-harm. These include previous self-harm, recent monitoring in prison custody under Assessment Care in Custody and Teamwork procedures (known as ACCT), conviction of a violent offence and a history of alcohol or drug abuse. Staff should interview new residents as part of the induction process to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by residents with these risk factors and should act appropriately to address any concerns. PI 32/2014 states there is no absolute requirement for an AP to adopt the ACCT process, provided the AP has a coherent strategy that achieves the same aims.

55. When Mr Walker arrived at The Grange on 3 November, his offender supervisor correctly completed a Self-Harm Information Sheet after Mr Walker said he had taken an overdose in March 2017. He assessed that Mr Walker was at raised risk of self-harm if he had access to all of his medication and therefore this was not allowed. We consider this assessment was appropriate.

56. When Mr Walker was brought back to The Grange on 4 November by his family, he told AP staff that he had had no intention of suicide or self-harm. However, we consider that AP staff correctly increased the number of physical welfare checks on Mr Walker that night. We also consider that it was appropriate to impose the additional sign in time of 5pm each day for Mr Walker. This meant that in the days that followed Mr Walker was physically seen by staff a minimum of eight times in each 24-hour period.

57. However, in the days that followed, there were signs that Mr Walker's risk of suicide or self-harm was high and possibly increasing. Mr Walker told his offender manager that he had gone to the Isle of Wight with the intention of killing himself (although it is not clear if this information was passed on to AP staff), presented as feeling "hopeless" about the future, was prescribed additional anti-depressant medication by a GP, and showed signs of anxiety.

58. The evening before his death, Mr Walker's offender manager told him that it was unlikely that he would be able to return home to the Isle of Wight as quickly as he wanted. His offender manager recorded that he said he could see nothing positive and that he could not cope without the support of his family. Again, it is not clear whether this information about Mr Walker's state of mind was passed on to AP staff.

59. Although Mr Walker's immediate concerns were in the process of being addressed by the Probation Service, his broader risk factors were not fully considered or adequately addressed. We recognise that it is not possible or appropriate to apply the same kind of suicide and self-harm prevention measures in APs as in prisons. We are, however, concerned that the guidance in the AP Manual on suicide and self-harm focusses on historic behaviours, and does not

adequately support AP staff in identifying and managing dynamic and emerging risk. We make the following recommendation:

The Head of the National Probation Service should ensure that, as part of the current review of the Approved Premises Manual, guidance is available to Approved Premises staff to assist in the identification and management of dynamic risks of suicide and self-harm.

Enforcement of licence conditions

60. National Probation Service standards state that where an offender fails to comply with a community order, suspended sentence order or post-sentence supervision period and has not given an acceptable explanation, an offender manager should issue a warning or take appropriate enforcement action within six working days of the last failure to comply. They say that when residents do not comply, staff should respond in a way that is proportionate to the level of risk presented, and that they should investigate the issue, focusing on indicators of increased risk of re-offending likely to cause serious harm. They say that staff should exercise professional judgement to determine whether a reason provided for non-compliance is reasonable, taking into account factors such as a resident's pattern of compliance and their overall response to their sentence.

61. PI 32/2014 states that the overriding responsibility of offender managers and staff of APs is to manage the resident in a way that reduces the risks of reoffending and serious harm to the public, as well as harm to the resident. APs need to manage their internal warning and sanction system in a way that ensures that any breach is appropriate and justified.

62. Mr Walker breached his licence in a significant way by going to the family home on the Isle of Wight on 4 November. Probation staff responded by issuing Mr Walker with a warning and adding additional conditions to his licence, rather than recalling him to prison as they could have done. We recognise that they did so with the intention of supporting Mr Walker, in order to give him every chance of completing his licence period successfully. We also recognise that Mr Walker did not breach his licence conditions again during his remaining 10 days at The Grange.

63. It is possible that Mr Walker might not have killed himself if he had been recalled to prison since he could have been subject to closer supervision in prison. However, it is also possible that Mr Walker would have been at greater risk of suicide if he had been recalled.

64. In these circumstances we cannot say that the decision not to recall was inappropriate or that it contributed to Mr Walker's death.

Clinical Care

65. Mr Walker had depression and asthma. Shortly after his release on licence, he registered with a local GP surgery and was prescribed medication. Staff at The Grange ensured Mr Walker received it.

66. Mr Walker was independent and, as with anyone else in the community, was responsible for managing his own health and attending medical appointments.

Nevertheless, staff at The Grange supported Mr Walker in managing his conditions and encouraged him to make and attend appointments.

Emergency response

67. PI 32/2014 provides guidance for AP staff on what to do in the event of an incident of serious self-harm or death. The relief keyworker found Mr Walker hanging in his room at 9.32am and went to the office to raise the alarm with the offender supervisor. The PI requires AP staff to call an ambulance immediately when an emergency incident occurs. However, according to Ambulance Service records, staff at The Grange did not call an ambulance until 9.39am. While this did not affect the outcome for Mr Walker, such a delay could be crucial in other emergencies, and we are concerned that staff did not follow a mandatory national instruction.

68. PI 32/2014 also requires that all AP staff must be trained in first aid and CPR, and that at least one member of staff with up-to-date first aid training must be on duty at all times. In addition, AP first aid kits must contain two ligature cutters and an automatic external defibrillator and AP staff should know how to use this equipment. The PI says that every possible effort must be made to save life in cases of suicide or serious self-harm and that staff should not leave the resident unattended in such circumstances.

69. We are concerned that AP staff did not cut the ligature when they found Mr Walker and that they left him hanging until the paramedics arrived. We consider that they should have cut him down, both to check for signs of life and because this would have been more dignified for Mr Walker.

70. However, we are satisfied that the decision taken by staff not to try to resuscitate Mr Walker was appropriate as there were no signs of life and blood pooling was evident. European Resuscitation Council (ERC) Guidelines for Resuscitation 2015, Section 11 state, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile”. The guidelines define examples of futility as including the presence of blood pooling and rigor mortis. Attempting CPR when someone is clearly dead is distressing for staff and undignified for the deceased.

71. We make the following recommendation:

The Manager of The Grange Approved Premises should ensure that:

- **there is appropriate cover at all times by staff who are fully trained in first aid and the use of emergency equipment; and**
- **staff follow the emergency procedures when an attempted suicide is discovered and ensure that an ambulance is called immediately an emergency incident has occurred.**

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