

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Malcolm Blair a resident at Wilton Place Approved Premises on 9 January 2019

A report by the Prisons and Probation Ombudsman

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*



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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Blair was found hanged in his room at Wilton Place Approved Premises in Oldham on 9 January 2019. He was 40 years old. I offer my condolences to Mr Blair's family and friends.

Mr Blair had lived at Wilton Place following his release from HMP Kirkham on 11 November 2018. He had a significant history of substance misuse, including the use of cocaine and alcohol in the community. The conditions of his licence included regular testing for alcohol and drug use. Mr Blair's death occurred after he had consumed substantial quantities of alcohol. Wilton Place must develop a clear substance misuse strategy.

Staff left Mr Blair largely unsupported and unmonitored during the hours leading up to his death. Although it would not have affected the outcome for Mr Blair, I am concerned that the two agency staff who were on duty during the evening of 9 January were ill-prepared to respond to an emergency situation. This placed an unfair burden on the only other member of staff who was an experienced residential service worker.

I am pleased to note that the current manager at Wilton Place has identified some of the issues raised in this report and has already taken some actions to address them. More work remains to be done, however, to ensure that a similar tragedy does not happen again at Wilton Place.

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

Sue McAlister CB
Prisons and Probation Ombudsman

November 2019

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Summary

Events

1. On 29 November 2016, Mr Malcolm Blair was sentenced to four years imprisonment for robbery and possession of a bladed article. He spent time in different prisons. Mr Blair did not have a significant history of suicide and self-harm.
2. On 11 November 2018, Mr Blair was released on licence from HMP Kirkham. Mr Blair's licence conditions required him to live at Wilton Place Approved Premises (or AP) in Oldham. His licence conditions also included regular tests for alcohol and drugs.
3. During his time at Wilton Place, Mr Blair presented with excellent behaviour and raised no concerns. He told staff that he wanted to rebuild his relationship with his wife and daughter and was determined to do so.
4. Between November and December 2018, staff tested Mr Blair for cocaine and opiates several times. Staff tested Mr Blair for alcohol every day between his arrival on 11 November and 10 December but thereafter on only three further occasions. All test results for both alcohol and drugs were negative.
5. Between 24 and 27 December, Mr Blair went on his last period of home leave. This was the third of three during his stay at Wilton Place. Although his wife did not raise any concerns with staff, it appears that Mr Blair spent the Christmas period alone. His wife suspected that he had started to drink alcohol and take drugs again but, again, raised no such concerns.
6. On 8 January, Mr Blair broke up with his wife. He was very sad and told his key worker about his relationship breakdown. He also said that he was very concerned that he could become homeless as a result. The key worker reassured Mr Blair that she would assist. She sent an email to his offender manager, asking her to consider Mr Blair's accommodation plan. The key worker did not take any other action or check Mr Blair's state of mind.
7. On 9 January, Mr Blair exchanged at least 11 text messages with his wife and spoke to her over the phone. Mr Blair asked her to meet him, but she refused. She terminated the call because he appeared to be drunk. At 8.59pm, Mr Blair sent his last text message saying to his step-son and daughter that he would always be around them. Staff were not made aware of these messages.
8. At around 11.09pm, two residential service workers found Mr Blair hanging from the top of the shower in his room. One pressed his alarm, removed the ligature, called an ambulance and started cardiopulmonary resuscitation (CPR). At around 11.16pm a police officer attended Mr Blair's room and, seconds later, paramedics also arrived. They continued with CPR until 11.42pm, when Mr Blair was pronounced dead.
9. The post-mortem examination identified alcohol in Mr Blair's blood. The pathologist said that the level of alcohol found could be associated with notable drunkenness, an exaggerated emotional response and a degree of disinhibition.

Findings

Management of risk of suicide and self-harm

10. Mr Blair's risk factors for suicide and self-harm included his significant history of drugs and alcohol misuse in the community and his relationship instability. He was determined to regain the trust of his wife but failed to do so. Mr Blair's relationship breakdown was a significant cause of his decline and possibly the main reason for his tragic outcome.
11. Mr Blair's presentation on 8 January was so uncharacteristic that staff should have been more cautious. They missed an opportunity to carry out a thorough investigation of his risk factors and triggers as a means of assessing his risk of suicide and self-harm. As a result, staff were ineffective and left Mr Blair broadly unsupported and unmonitored during the hours leading up to his death.
12. Wilton Place did not have a local suicide and self-harm prevention strategy at the time of Mr Blair's death that could be used to guide staff actions. Staff have not been trained in suicide and self-harm prevention.

Drug and Alcohol

13. We are concerned that the lack of alcohol testing during the 11 days before Mr Blair's death, and immediately following his absences on home-leave, enabled Mr Blair to relapse. Although the pathologist was unable to confirm Mr Blair's state of mind, the amount of alcohol he consumed on 9 January could have influenced his decision to kill himself.
14. Mr Blair's room was never searched while he was at Wilton Place and the AP does not have a local substance misuse strategy. These are both contrary to national policy.

Emergency Response

15. Agency staff did not receive adequate induction to the premises and were ill-prepared to deal with the emergency response. They did not know where basic equipment, such as the defibrillator, was kept, and their input on 9 January left much to be desired.

Recommendations

- The manager at Wilton Place should ensure that:
 - a local suicide and self-harm prevention strategy to guide staff actions is developed at Wilton Place and is in line with the National AP Manual 2014 and the National Probation Service AP Strategic Action Plan 2018-2021, "Reducing Self-inflicted Deaths";
 - staff thoroughly investigate all risk factors when determining a resident's level of risk of self-harm and suicide; and
 - staff take appropriate action to address known risk factors, such as by doing additional welfare checks on residents.

- The Head of the National Probation Service and the manager of Wilton Place Approved Premises should ensure that comprehensive training on suicide and self-harm prevention is available to Wilton Place staff, to assist them in the identification and management of residents with risk factors for suicide and self-harm.
- The Approved Premises manager should develop a clear local substance misuse policy in line with PI 32/2014 and ensure that frequent substance misuse testing and searches take place.
- The Approved Premises manager should ensure that agency staff are made aware of basic health and safety information and of building lay out. This should include awareness of where the defibrillator, emergency bags and fire exists are located.

The Investigation Process

16. The investigator issued notices to staff and residents at Wilton Place, informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
17. The investigator visited Wilton Place on 24 January 2019. He obtained copies of relevant extracts from Mr Blair's records, and interviewed one member of staff and two residents.
18. The investigator interviewed five further members of staff, via skype, in April, June and July 2019.
19. We informed HM Coroner for Greater Manchester North District of the investigation. The coroner gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
20. One of the Ombudsman's family liaison officers contacted Mr Blair's father to explain the investigation and to ask whether he had any matters the family wanted the investigation to consider. Mr Blair's father did not raise any matters.
21. We sent a copy of the initial report to Mr Blair's father. He did not make any comments.
22. We also sent a copy of the initial report to the National Probation Service. They did not raise any factual inaccuracies.

Background Information

Wilton Place Approved Premises

23. 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. Each resident is allocated a key worker or offender supervisor both to oversee his progress and well-being, and to ensure that a resident adheres to licence conditions and the premises' rules.
24. Wilton Place Approved Premises is a large house in Oldham, Greater Manchester, providing accommodation for up to 29 men. All rooms at Wilton Place are single rooms. There are communal lounges, laundry facilities, a dining room and other areas used for group work. Staff are available at Wilton Place 24-hours a day (with at least two members of staff on duty overnight). Residents are responsible for their own health and are expected to register with a local GP surgery. Medication is held by each resident in his room, subject to a risk assessment.

Previous deaths at Wilton Place

25. Mr Blair's death was the first self-inflicted death to occur at Wilton Place. There have been three other deaths, from natural causes, in 2004, 2006 and 2012. There are no similarities between the circumstances of the previous deaths and that of Mr Blair.

Key Events

26. On 29 November 2016, Mr Malcolm Blair was sentenced to four years imprisonment for robbery and possession of a bladed article. He was sent to HMP Forest Bank and then transferred to HMP Hindley. On 13 June 2017, Mr Blair transferred to HMP Kirkham. Mr Blair's NOMIS (the electronic records system) shows that he had no recent history of suicide and self-harm and while in prison had not been subject to ACCT monitoring. (Assessment Care in Custody and Teamwork procedures are known as ACCT.)
27. On 1 November 2018, Mr Blair was released on licence from Kirkham, where he had held the status of enhanced prisoner. Mr Blair's licence conditions required him to live at Wilton Place Approved Premises (AP), Oldham, with a curfew between 9.00pm and 9.00am every day. Mr Blair also had to provide oral samples for drug testing, and to comply with any requirement of his offender manager to address his alcohol-related behaviour problems.
28. At around 3.00pm, Mr Blair arrived at Wilton Place. He was told about, and issued with, copies of the AP rules, details of the facilities, regime and fire, health and safety procedures and the support available from AP staff. Mr Blair's *Resident AP management plan* specified that Mr Blair was going to be tested daily for alcohol, and twice-weekly for drugs. This was not Mr Blair's first time at Wilton Place. He had stayed there for one day in July 2018 and two days in August 2018, so he was familiar with the environment.
29. Mr Blair signed a receipt to confirm he understood and had received copies of the AP rules and policies. Staff recorded in the induction documents that Mr Blair had no healthcare issues, was not taking any medication and that there had not been any self-harm or suicide concerns raised. The AP manager confirmed to the investigator that staff at Wilton Place did not receive any documentation indicating that Mr Blair was at risk of suicide and self-harm. Mr Blair was allocated room 18.
30. On 13 November, Mr Blair told his offender manager, that he was doing well at Wilton Place. He said that he wanted to work to support his wife and daughter. Mr Blair was trying to rebuild his relationship with his family as it had broken down after he had committed robbery and used money (which his wife had saved to start a business) to buy drugs. The same day, staff tested Mr Blair for drugs including cocaine and opiates. He was tested again on 22 November, 5 December and 24 December. All tests showed negative results.
31. On 22 November, Mr Blair repeated to his offender manager that his wife and daughter were very important to him and that he wanted to support them. The offender manager and Mr Blair discussed the possibility of Mr Blair working as a floor tiler (his speciality) and spoke to a contractor who agreed to employ him. Mr Blair said that he was trying "hard" to make his relationship work but recognised that his wife still did not trust him. Four days later, Mr Blair started working on a construction site. His offender manager agreed to reduce his curfew so that it ended at 6.00am rather than 9.00am.

32. On 6 December, the offender manager spoke to Mr Blair's wife who did not raise any concerns. She agreed that Mr Blair could have home leave, staying at his wife's address.
33. After his arrival, and until 10 December, staff tested Mr Blair for alcohol every day. They then did so on only three occasions: 17, 18 and 29 December 2018. All tests showed negative results.
34. On 11 December, Mr Blair was granted home leave for a period of three nights. His wife agreed to this, and to a further period of leave between 19 and 21 December. After both periods of leave, Mr Blair returned to Wilton Place and raised no concerns.
35. Between 24 and 27 December, Mr Blair took another period of home leave at his wife's address. His offender manager had authorised this because Mr Blair's wife had told her that she was going to be at home over that period. Mr Blair's wife and his daughter did not spend this time at home, however, so Mr Blair was at the address alone.
36. Mr Blair's wife subsequently told the police that when she returned to her house, she had spoken to friends who told her that Mr Blair had been drinking and using cocaine. It does not appear that Mr Blair's wife informed his offender manager or staff at Wilton Place about this. The offender manager said that she was not aware that Mr Blair had spent this time on his own otherwise she would not have authorised his leave.
37. On 28 December, Mr Blair spoke to his key worker, at Wilton Place. Mr Blair told her that he had had a "nice" Christmas and had been busy at work. He did not go into any detail and raised no concerns. Mr Blair repeated that he was still working on "rebuilding his relationship" and that "things were going ok". Mr Blair told his key worker that he did not need any support from staff but knew that he could approach them if he needed.
38. On 29 December, staff at Wilton Place tested Mr Blair for alcohol for the last time. The test showed negative results. We are not certain why no further tests were carried out, but the offender manager, told the investigator that as Mr Blair's behaviour and presentation was always good he consequently required only random, rather than daily, alcohol testing at Wilton Place.
39. On 7 January, Mr Blair, his wife and their daughter went out for a family day. Mr Blair's wife did not raise any concerns with staff.
40. On 8 January, at around 3.00pm, Mr Blair asked to speak to his key worker. He handed her an appointment letter for a homelessness assessment on Friday 11 January. Mr Blair started to cry and told her that his wife did not want to be with him anymore. He said that "they were now two different people" and "things were not working". Mr Blair was very concerned about his accommodation after his placement at Wilton Place finished on 25 January. Mr Blair had also recently struggled to get more work as a tiler because his van had broken down so was very stressed.
41. The key worker told the investigator that she was shocked at Mr Blair's presentation. She told Mr Blair that she would help him and reassured him that

he was not going to become homeless. She told the investigator that she did not want to “probe the issues any further”, however, as she did not want to upset him more. She told the investigator that Mr Blair was fine after they spoke and Mr Blair thanked her.

42. At 3.52pm, Mr Blair’s key worker sent an email to his offender manager, copying in all staff at Wilton Place, including the AP manager. The key worker was not working the next day, so she wanted to ensure that everybody was aware of her interaction with Mr Blair. The key worker wrote that she spoke to Mr Blair who had broken up with his wife. She wrote that he was very concerned that he did not have anywhere to go after leaving the AP. The key worker asked the offender manager to speak to Mr Blair about a new accommodation plan as soon as possible.
43. At 4.02pm, the offender manager (who was away from work, preparing for an inquest) forwarded the email to another offender manager, who was looking after her caseload. The offender manager asked her to call Mr Blair on her behalf. At around 5.00pm, the other offender manager, briefly spoke to Mr Blair. She told the investigator that he did not appear to be concerned or stressed during their conversation. Mr Blair agreed to attend her office on Friday 11 January to discuss his new accommodation plan and did not raise any concerns. She did not take any action other than arranging the meeting.

Events of 9 January

44. The investigator reviewed CCTV footage, AP logs, ambulance service records, the audio record of the telephone call to the ambulance service, and police disclosure. The investigator found no significant discrepancies between these sources but was told that the time recorded in CCTV footage was 30 seconds behind real time. He took that into account. The investigator also considered Mr Blair’s text messages which the police had retrieved from Mr Blair’s phone.
45. At around 9.40am, Mr Blair sent a text message to his wife asking her to meet him in a café at around 1pm. Mr Blair’s wife responded that she did not want to see him. At 11.45am, Mr Blair left Wilton Place and returned at 12.00pm.
46. At around 3.00pm, Mr Blair spoke to a residential service worker, in the AP’s office before leaving the premises again. He told the investigator that he asked Mr Blair about the state of his van and was told that it was still broken. He told the investigator that Mr Blair appeared “not to be himself” in the days leading up to his death and was “very down”. He said that Mr Blair did not mention any issues about his relationship but was concerned that he could not work because of his van.
47. At 6.15pm, Mr Blair returned to Wilton Place and went to his room. Around ten minutes later, he sent a text message to his wife asking her to “please pick up the phone”. Mr Blair also wrote “can’t believe you think I’ve had a drink ring me please” - and - “this is it I love you”. Mr Blair also asked his wife to tell their daughter that he loved her.
48. At around 8.00pm, Mr Blair phoned his wife from his mobile phone. Mr Blair’s wife told the police that Mr Blair used abusive language towards her, so she

thought that he had been drinking. She ended the call immediately. It appears that Mr Blair's wife did not inform anybody at Wilton Place that Mr Blair was drunk.

49. At around 8.03pm, Mr Blair left his room again but did not leave the premises. Mr Blair returned to his room at around 8.12pm. A residential service worker told the investigator that during this time Mr Blair went to the office and spoke to him briefly. He asked Mr Blair whether he was well. Mr Blair did not raise any concerns.
50. At 8.59pm, Mr Blair sent his last text message addressed to his step-son and grandchildren saying that "I will always be round them". There is no evidence that any concerns related to these messages were raised with staff at Wilton Place.
51. At around 9.45pm, the residential service worker left the premises and another residential service worker arrived. Two agency staff also arrived at the premises to start their night shifts. They were the only staff present at Wilton Place at that time. The residential service worker said that both agency staff were not experienced, and it was the first time that one of the agency staff had attended Wilton Place. The residential service worker said that the agency staff did not know "where anything was" and had no access to any electronic system or network.
52. At around 11.02pm, the residential service worker locked the main door, set up the general alarm and went with an agency staff to carry out the residents' welfare check. The agency staff took the emergency bag with her, as is usual practice at Wilton Place. The other agency staff remained at reception.
53. At around 11.09pm, the residential service worker and agency staff arrived at Mr Blair's room. The residential service worker opened the door and saw Mr Blair suspended from the top of the shower in his bathroom. Mr Blair had used a bedsheet as a ligature. He pressed his alarm key, attached to his key chain, which triggers a call to the police. He then took the scissors from the emergency bag. The resident living opposite Mr Blair, also attended.
54. The residential service worker removed the ligature, placed Mr Blair on the floor and started CPR. He then used his personal mobile phone to ring the ambulance service. He put his phone into loud-speaker mode so he could provide instructions to the ambulance service while continuing to perform CPR.
55. At around 11.10pm, the agency staff left the room and returned a minute later with the other agency staff. At around 11.12pm, the residential service worker instructed an agency staff to fetch the defibrillator from the office, and the other agency staff to open the front door to allow police and paramedics access.
56. At around 11.13pm, an agency staff returned to the room with another emergency bag but not the defibrillator. She told the investigator that she could not find the defibrillator which had been moved to another office, something of which she was unaware. The other agency staff went to the office but could not find the key so was unable to open the door.

57. At around 11.14pm, the residential service worker returned to the reception area while an agency staff and a resident continued with CPR. He found the keys, opened the front door and took the defibrillator from the top of a cupboard in the main office. He asked an agency staff to remain at the front door and wait for the paramedics and police to arrive. At around 11.16pm, a police officer arrived and went up to Mr Blair's room. Around 30 seconds later paramedics arrived. They continued with CPR until 11.42pm, when Mr Blair was pronounced dead.

Post-mortem report

58. The post-mortem examination found that Mr Blair died of hanging. The toxicology examination identified alcohol in Mr Blair's blood sample. The pathologist said that the level of alcohol found could be associated with notable drunkenness and exaggerated emotional response and a degree of disinhibition. However, the pathologist said that it was not possible to determine the exact effect the alcohol consumption would have had on Mr Blair's state of mind.

Contact with Mr Blair's family

59. On 10 January, at around 8.50am, in line with National Probation Service guidance, the police visited Mr Blair's wife at her home address and informed her of Mr Blair's death. At 11.41am, the acting AP Manager, contacted Mr Blair's wife by telephone and offered her condolences and support. In the days that followed, she maintained contact with Mr Blair's family.
60. In line with national guidance, the Probation Service offered a contribution to the costs of the funeral.

Support for prisoners and staff

61. After Mr Blair's death, the acting AP Manager, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff we interviewed told the investigator that they felt well-supported after the event by their managers.

Findings

Management of risk of suicide and self-harm

62. 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.
63. 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 which achieves the same aims.

Assessment of risk

64. Mr Blair's risk factors for suicide and self-harm included his significant history of drugs and alcohol misuse in the community and the instability of his relationship. Although Mr Blair was determined to re-gain the trust of his wife he failed to do so. He did not, however, have a recent history of suicide and self-harm and was not on ACCT monitoring when he was released to Wilton Place.
65. From his arrival at Wilton Place on 11 November until 8 January 2019 (the day before he died), staff said that Mr Blair did not raise any significant concerns for them. He arrived as an enhanced prisoner with an excellent record and good presentation. At Wilton Place he continued to present and behave well, spent most of his time working and never failed a drug or alcohol test. Staff and peers respected him and spoke to him regularly. We consider that staff managed Mr Blair's risk factors during this period satisfactorily. There was no reason for them to put in place any suicide and self-harm prevention measures to support him.
66. On 8 January, however, Mr Blair's presentation changed dramatically. When he approached his key worker that afternoon, Mr Blair was crying, anxious, and felt hopeless and stressed. A residential service worker told the investigator that Mr Blair appeared "not to be himself" and was "very down" in the days leading up to his death because his van had broken down and he was unable to work. The key worker told the investigator that she was shocked at Mr Blair's presentation.
67. We consider that on 8 January, Mr Blair disclosed to staff a degree of distress so uncharacteristic of him, that they should have been more worried and more risk-averse in their approach. We are concerned that when Mr Blair approached his key worker and informed her, in tears, that his relationship had broken down she did not explore his feelings and state of mind more thoroughly. She did not ask any questions intended to ascertain whether he had any suicidal thoughts.
68. Although it is not always likely that residents or prisoners with a suicidal intention will disclose that they feel suicidal, we consider that asking whether they have such thoughts is an obvious and necessary step in assessing their risk.

69. The key worker said that she did not ask any more questions because she did not want to upset Mr Blair any further. We acknowledge that this was well-intended. She also said that as Mr Blair had never presented as suicidal in the past, she did not think she needed to explore anything else. We consider that this was an error of judgement.
70. The key worker provided Mr Blair with good keyworker sessions and we commend her positive input and commitment. This was evident in her thorough case notes and in interview with the investigator. However, the key worker missed a clear opportunity on 8 January to explore and better understand the full scope of Mr Blair's risk factors and distress. She was probably the member of staff best placed to do so, as Mr Blair appeared not to have been as candid with anybody else.
71. The AP manager told the investigator that one of the lessons that could be learned from Mr Blair's death was that staff should not take at face value residents' good presentation, in assessing their risk. She said that staff should explore residents' comments and behaviours thoroughly. We welcome the manager's insight.

Actions and resident checks

72. We are concerned that on 8 January staff actions were largely ineffective and nobody, including a residential service worker, considered carrying out additional welfare checks on Mr Blair. Staff therefore left Mr Blair broadly unmonitored and unsupported during the hours leading up to his death.
73. A residential service worker told the investigator that at Wilton Place "there should normally be a welfare check of all residents at 8.30pm every evening". He said that the check should involve ensuring that residents are in their rooms and responsive. On 9 January, the 8.30pm check was not carried out for any resident.
74. The AP manager told the investigator that different managers at Wilton Place have adopted different practices, so staff were not clear as to whether the 8.30pm check was compulsory. She also said that she has now clarified the matter with staff and has formally re-instated the practice. We welcome this measure but consider that staff should also use their discretion and judgement to make further welfare checks on residents if necessary, to protect them. This should particularly be the case if a resident's risk of suicide and self-harm is believed to have increased.

Suicide Prevention Strategy

75. IP 32/2014 stipulates that all APs must have a strategy for reducing incidents of self-inflicted death. If there is more than one AP in a trust's area, the plan should be common to all of them, including any establishments run by non-probation bodies. Plans that are agreed on a wider basis are also acceptable. As part of their strategies, APs must ensure that their staff are suitably trained and developed. Each strategy must also include a system for monitoring and recording deaths and significant instances of self-harm, and a process for

reviewing all such incidents and identifying possible changes to procedure and practice.

76. We are concerned that at the time of Mr Blair's death, staff at Wilton Place did not have a local suicide and self-harm prevention strategy to guide their actions.
77. The AP manager told the investigator that she is currently in the process of implementing a probation service strategic action plan on suicide and self-harm prevention - *The National Probation Service AP Strategic Action Plan 2018-2021 – "Reducing Self-inflicted Deaths"*. The plan includes, among others, the following objectives:
- to develop AP staff confidence and competence in assessing and managing issues related to risk to self and ensuring staff wellbeing, resilience and support are promoted;
 - to ensure that all APs have in place an effective system for the identification, assessment and management of residents who may pose a risk to themselves; and
 - to ensure that self-inflicted death prevention is continually promoted within each AP.

We annex the action plan to this report.

78. The strategic action plan asks AP managers to carry out a number of actions in their locations to comply with these objectives. We do not repeat all the actions in this report but the following are particularly relevant to Wilton Place:
- AP to have in place written policies for identifying and dealing with issues that vulnerable resident raise; and
 - AP to have in place a process for identifying, assessing, monitoring and managing residents who may pose a risk to self (equivalent to the ACCT prison process) and contribute to the development of national guidance.

79. We make the following recommendation:

The manager at Wilton Place should ensure that:

- **a local suicide and self-harm prevention strategy to guide staff actions is developed at Wilton Place and is in line with the National AP Manual 2014 and the National Probation Service AP Strategic Action Plan 2018-2021, "Reducing Self-inflicted Deaths";**
- **staff thoroughly investigate all risk factors when determining a resident's level of risk of self-harm and suicide; and**
- **staff take appropriate action to address known risk factors, such as by doing additional welfare checks on residents.**

Training

80. We are concerned that a residential service worker told the investigator that he had not received any suicide and self-harm prevention training since he started to work at the Approved Premises in 2014. An agency staff also told the investigator that she had never received any training on suicide and self-harm prevention.
81. The AP manager said that only one member of staff at Wilton Place had received any relevant training on suicide and self-harm prevention at the time of Mr Blair's death. Staff training is a cornerstone of any successful prevention strategy. We make the following recommendation:

The Head of the National Probation Service and the Manager of Wilton Place Approved Premises should ensure that, comprehensive training on suicide and self-harm prevention is available to Wilton Place staff to assist them in the identification and management of residents with risk factors for suicide and self-harm.

Drugs and alcohol

Testing

82. PI 32/2014 stipulates that evidence of alcohol consumption on the premises should lead to appropriate enforcement. It makes a provision for testing residents for alcohol either on reasonable suspicion or at random those residents who have a history of alcohol-related offending. The frequency of drugs and alcohol testing will be defined by the licence conditions and the judgement of the offender manager.
83. The evening of Mr Blair's death, the police found two bottles of vodka in his room. The toxicology report showed that Mr Blair had taken considerable amounts of alcohol on 9 January.
84. In Mr Blair's *AP Management Plan*, agreed on his arrival, Mr Blair was to be tested for alcohol daily while at Wilton Place. He was tested every day until 10 December. The offender manager told the investigator that, given Mr Blair's excellent presentation and behaviour, she decided that Mr Blair was to be tested for drugs and alcohol on a random basis.
85. Given Mr Blair's significant history of alcohol and drugs, and the extent to which this impacted on his offending behaviour, we are concerned that after 10 December staff only tested Mr Blair for alcohol on three further occasions, all the same month. He was therefore not tested at all over the remaining 11 days before he killed himself.
86. We consider that the lack of alcohol-testing during this period (and immediately following his return from periods of home-leave) and the relaxation of the monitoring of his substance misuse, gave Mr Blair the opportunity and encouragement to relapse. Although his thought processes could not be confirmed by the pathologist, the amount of alcohol Mr Blair consumed on 9 January was so great that it could have influenced his decision to kill himself.

Room Searches:

87. PI 32/2014 stipulates that periodic room searches (authorised by the manager or the deputy) should be completed regardless of whether there is any suspicion that the resident is taking any illicit substances. Room searches should be carried out regularly, although not at pre-set intervals.
88. Staff never searched Mr Blair's room while he was at Wilton Place. The AP manager recognised that this was unacceptable. She told the investigator that the staff's perception was that searches should only be carried out if there was any suspicion that a resident was misusing drugs or alcohol. This was a clear mistake.
89. The AP manager told the investigator that, in January 2019, she directed staff to carry out regular searches of all rooms in line with national policy. She said that residents with security risk levels such as that of Mr Blair, should have their rooms searched fortnightly. A residential service worker was vague on the subject and told the investigator that currently there is no expectation that every room is to be searched but that as many as possible should be. We are therefore not persuaded that the manager's instructions have been fully embraced by staff at Wilton Place.

Local Substance Misuse Policy

90. PI 32/2014 mandates that staff should be familiar with the local AP substance misuse policy, which should contain clear procedures and instructions on how to deal with situations they will commonly face, such as residents in possession of or using substances, or found unconscious or with breathing difficulties, and room searches. It is important to keep a written record of any self-harm incidents that occur within the AP, both on the resident's case record and on an incident file. This includes substance misuse incidents.
91. The National Probation Service AP Strategic Action Plan 2018-2021, *Reducing Self-inflicted Deaths* asks AP managers to ensure that AP staff understand substance misuse, including psychoactive substances (PS) and have the competencies needed to deal with residents who misuse drug and alcohol in residential settings.
92. Wilton Place did not have a local substance misuse policy at the time of Mr Blair's death and has no plans to develop one. The AP manager acknowledged that staff would benefit from having such a plan. We make the following recommendation:

The Approved Premises manager should develop a clear local substance misuse policy in line with PI 32/2014 and ensure that frequent substance misuse testing and searches take place.

Emergency Response

93. PI 32/2014 provides guidance for AP staff on what to do in the event of an incident of serious self-harm or death. 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. The PI states 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.

94. The National Probation Service AP Strategic Action Plan 2018-2021 – “*Reducing Self-inflicted Deaths*”, asks AP managers to ensure that staff are familiar with defibrillators and are competent in their use. It also stipulates a number of actions for AP managers to enable staff to respond effectively to emergencies involving a ligature and the provision of first aid.
95. On 9 January, a residential service worker dealt with almost every aspect of the emergency response - from cutting the ligature and performing CPR, to calling the ambulance and allowing access to the police and paramedics. He told the investigator that the other two service workers on duty with him “did not know where anything was, so he had to do most of the work on that day”. We commend his extraordinary efforts on this occasion. He did everything he could to save Mr Blair’s life.
96. Agency staff tried to assist the residential service worker, but she panicked when Mr Blair was discovered hanging. The residential service worker asked her to fetch the defibrillator from the office, but she was unable to find it. This caused a significant inconvenience because he, who she described as “being in charge of the situation”, had to leave the room and arrange for another resident to continue CPR for some two minutes. This may not have made a difference in this case but it could be crucial in other emergencies.
97. Before the incident, the defibrillator had been moved from its original place and re-located to the top of a cupboard in the main office. The agency staff told the investigator that because she did not work at Wilton Place regularly, she was not aware that the defibrillator had been moved. It is unacceptable that nobody informed her where it was when she arrived at Wilton Place.
98. The AP manager and agency staff told the investigator that before Mr Blair’s death, agency staff did not receive any basic induction at the premises. They were not even provided with simple guidance on where important equipment – such as the defibrillator, emergency bags or fire exits - were located. The AP estate varies widely in building layout, accessibility and state of repair, it is therefore important that agency staff are made aware of health and safety information and the unique features of the locations they are working in. We make the following recommendation:

The Approved Premises manager should ensure that agency staff are made aware of basic health and safety information and of building lay out. This should include awareness of where the defibrillator, emergency bags and fire exists are located.

Keyworkers allocation

99. Although Mr Blair had regular and meaningful contact with his key worker while he was at Wilton Place, we are concerned that Mr Blair’s allocated key worker did not appear to have contacted Mr Blair at any point. Another resident told the

investigator that his allocated keyworker had never spoken to him or proactively tried to contact him at Wilton Place.

100. The AP manager told the investigator that under a previous manager, keyworkers could work with any resident, regardless of whether they were allocated to them. Such approach could have meant that staff had an unbalanced caseload. For example, the key worker told the investigator that she was more structured in her work than other keyworkers and ended up “keyworking a lot of people” that had not been allocated to her. This placed an unfair burden on her.
101. It could also have meant that some residents would not have received the same amount, and quality, of keyworker sessions.
102. The AP manager told the investigator that she has now changed the approach since Mr Blair’s death. The ad hoc approach is no longer used, and all keyworkers should work with their allocated residents. We welcome her actions and will follow them up in subsequent investigations.

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