

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Bolton, released on licence to Rookwood Approved Premises, on 3 July 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 I oversee can improve their work in the future.

On 3 July 2019, Mr Raymond Bolton was found hanged in Pearson Park, Hull a few hours after being released from HMP Hull on licence. He was 64 years old. I offer my condolences to Mr Bolton's family and friends.

Mr Bolton had no history of self-harm or attempted suicide. He was briefly managed under suicide and self-harm procedures (known as ACCT) in January 2019, after his wife told him that she wanted to end their relationship, although she said she would continue to support him while he was in prison. I am satisfied that it was reasonable for staff to have thought that Mr Bolton had come to terms with this in the months before his release.

Mr Bolton was due to live at Rookwood Approved premises as part of his licence conditions. His wife collected him from outside HMP Hull at 9.45am as arranged and told Mr Bolton that their relationship was over. She then took him to Hull Probation Office for his appointment with his probation offender manager, but he did not go in. At 12.45pm, Mr Bolton was found hanging from a tree in Pearson Park, Hull.

The events of 3 July were sudden and unexpected, and I am satisfied that no one could have predicted Mr Bolton's actions.

I am, however, concerned that Mr Bolton's key worker did not meet him sufficiently frequently and did not see him at all in the month before he was released from prison. This may have been a missed opportunity to assess how he felt about his marriage.

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

Sue McAllister, CB
Prisons and Probation Ombudsman

January 2020

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Summary

Events

1. On 4 July 2016, Mr Raymond Bolton was remanded into custody at HMP Hull charged with sex offences. On 23 December, he was sentenced to three years in custody. Mr Bolton had no history of or self-harm or attempted suicide while in custody.
2. On 9 January 2019, staff opened suicide and self-harm procedures (known as ACCT) as Mr Bolton was feeling 'down' about relationship problems with his wife and said he might 'do something' to himself. The ACCT was closed the following day, after Mr Bolton had spoken to his wife on the phone.
3. On 17 January, an ACCT post-closure review was held and Mr Bolton told staff that his wife was going to leave him, although she had said she would continue to support him while he was in prison. Mr Bolton said he had no thoughts of suicide or self-harm and would speak to staff if he needed support.
4. Mr Bolton remained in frequent telephone contact with his wife during the remaining six months of his sentence and she also visited him.
5. On 3 July 2019, Mr Bolton was released on licence from Hull to live at Rookwood Approved Premises, Rotherham.
6. At 9.53am, Mr Bolton's wife collected Mr Bolton from the prison and told him that their relationship was over. She took him to the Probation Service office in Hull for his appointment with his offender manager, but he did not go in and walked away saying he was going to kill himself. His offender manager informed the police.
7. At approximately 12.45pm, Mr Bolton was found hanging from a tree in Pearson Park, Hull. Emergency services were called but Mr Bolton was pronounced dead at the scene.

Findings

Assessment of risk

8. We found that prison staff appropriately assessed Mr Bolton's risk of suicide and self-harm in line with national instructions. He had no history of self-harm or attempted suicide in custody, and when he was low in mood in January 2019, he was appropriately managed under ACCT procedures. Mr Bolton's wife told him that their marriage was over six months before his release and it was not unreasonable for staff to think he had come to terms with this. We are satisfied that prison staff could not have foreseen that Mr Bolton would take his own life on 3 July.
9. Mr Bolton did not discuss his marital problems with his key worker. This may have been because they did not meet frequently enough to establish a meaningful relationship.

10. Although Mr Bolton's offender manager knew the day before his release that his wife intended to end the marriage, we are satisfied that the events of 3 July were sudden and unexpected and we do not consider that she could have predicted his actions.
11. The offender manager acted appropriately in calling the police when Mr Bolton did not attend their appointment.

Clinical care

12. The investigation identified no concerns with Mr Bolton's treatment while in custody and the clinical reviewer concluded that the healthcare provided to Mr Bolton was equivalent to that he could have expected to receive in the community.

Recommendations

- The Governor should ensure that key workers are allocated sufficient time for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

The Investigation Process

13. The investigator issued notices to staff at HMP Hull and Probation Service informing them of the investigation and asking anyone with relevant information to contact him. This investigation is recorded as an Approved Premises death as our case management system currently is unable to record it more accurately.
14. The investigator obtained copies of relevant extracts from Mr Bolton's prison, medical and probation records.
15. NHS England commissioned an independent clinical reviewer to review Mr Bolton's clinical care at the prison.
16. The investigator interviewed one member of staff from the Probation Service in July.
17. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. Our family liaison officer contacted Mr Bolton's wife and his next of kin, to explain the investigation and to ask whether there were any matters they wanted the investigation to consider. Neither Mr Bolton's wife or his next of kin raised any concerns and they did not request a copy of this report.

Background Information

Rookwood Approved Premises

19. 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.
20. Rookwood, in Rotherham, is managed by the National Probation Service. It has 25 single rooms. All 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 his progress and well-being, and to ensure that residents adhere to licence conditions and the premises' rules. Probation Service employees are on duty at Rookwood 24 hours a day.

Previous deaths at Rookwood

21. Mr Bolton was due to live at Rookwood but he never arrived at there. There has only been one other death at Rookwood of a resident who died on 15 February 2019, from mixed drug toxicity.

HMP Hull

22. HMP Hull HMP Hull is a local prison holding a maximum of 1,036 men on remand, convicted or sentenced. The prison serves the courts of Hull, Grimsby and York. City Health Care Partnership CIC provides health services, including mental health.
23. In August 2018, Hull was selected to be part of the "10 Prisons Project", which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

24. HM Inspectorate of Prisons (HMIP) carried out an inspection of Hull in March 2018. Inspectors found reception procedures properly assessed prisoners' risk and induction arrangements were adequate. Hull had many experienced staff but also a significant number of newer staff, all of whom received good mentoring and support. Prisoners with the greatest mental health needs were supported well, but the range of interventions and staffing resources did not meet all low-level needs.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report, published in December 2018 the IMB were very

concerned about the levels of self-harm and violence and of the ready availability of Psychoactive Substances (PS).

Assessment, Care in Custody and Teamwork (ACCT)

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.
27. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

The key worker system

28. The key worker system is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS's *Manage the Custodial Sentence Policy Framework*. This says:
 - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
 - Key workers must have completed the required training.
 - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
 - Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

Key Events

29. On 4 July 2016, Mr Raymond Bolton was remanded into custody at HMP Hull charged with sex offences. He was later convicted and on 23 December, he was sentenced to three years in custody. Mr Bolton had a been in prison before, having served several custodial sentences dating back to 1974. He had last been released from Hull in April 2015.
30. Mr Bolton had no history of attempting suicide or self-harm at any time while in custody. While at Hull, Mr Bolton worked as a wing cleaner and was also a Listener (a prisoner trained by the Samaritans to support other prisoners).
31. On 22 December 2018, an officer introduced himself to Mr Bolton as his new key worker. Mr Bolton said he had no issues.
32. On 9 January 2019, at 2.45pm, a member of the chaplaincy team opened suicide and self-harm procedures, known as ACCT, as Mr Bolton said as he was in low mood because he had been unable to contact his wife. He was emotional and when asked if he might 'do something' to himself, he said he might.
33. At 3.30pm, a Supervising Officer (SO) saw Mr Bolton under the ACCT procedures and completed an immediate action plan. He assessed Mr Bolton as being at raised risk of suicide or self-harm. His level of observations were set at hourly throughout the day and night until the first case review. Later that evening Mr Bolton spoke to his wife.
34. On 10 January, at 9.30am, a member of the chaplaincy team assessed Mr Bolton as part of ACCT procedures. Mr Bolton said he had spoken to his wife, they were talking and there were some family issues which he was dealing with. Mr Bolton said he had no thoughts of suicide or harming himself.
35. At 11.00am, a SO held the first ACCT case review. Also present was a nurse, a member of the mental health team, and Mr Bolton. The member of the chaplaincy team provided verbal input to the SO before the review. Mr Bolton told the SO he had been worried about his wife, they had spoken on the phone and it had been a tearful conversation. He said he had no thoughts of self-harm or suicide. The SO recorded that Mr Bolton had no history of self-harm, was a trained Listener and worked as a wing cleaner.
36. The SO and the nurse assessed that Mr Bolton was at low risk of suicide and self-harm and agreed to close the ACCT. A post-closure interview was set for 17 January.
37. On 17 January, a SO held the scheduled ACCT post-closure interview with Mr Bolton. Mr Bolton said his wife was going to leave him but they were talking and she would continue to support him while he was in prison. He thanked the staff and chaplaincy for the support they had given him. Mr Bolton said had no thoughts of suicide or self-harm and would speak to staff if he had any concerns or wanted support.
38. On 21 January, a member of the chaplaincy team, recorded that she had had "a good conversation" with Mr Bolton about his difficulties with his wife. She noted

that Mr Bolton seemed “to have done all he could do on his part to bring a resolution to the situation” and was aware that ongoing pastoral support was available when he needed it.

39. On 31 January, the keyworker saw Mr Bolton for the second time. Mr Bolton had questions about his parole date. He spoke to him again on 8 and 19 February, 22 and 28 March and 23 April. He also spoke to wing staff about Mr Bolton in his absence on 16 February, 18 April and 2 and 15 May. He spoke to Mr Bolton for the last time on 30 May when Mr Bolton said he was looking forward to his release on 3 July, although he still did not have confirmed accommodation in the community.
40. Mr Bolton did not discuss his marital difficulties with his keyworker and there is nothing in the entries the officer made in Mr Bolton’s electronic record to show that he was aware that Mr Bolton had been on an ACCT in January. On 22 March, his keyworker recorded, “Wing staff informed me that he has had some recent personal issues but he did not mention this to me. He told me that he is fine.”
41. Prison records show that Mr Bolton was in frequent telephone contact with his wife and she also visited him. Her last visit was on 26 May.
42. On 2 July, Mr Bolton’s telephoned his wife, sister and mother. The investigator listened to each of these calls. Mr Bolton said he was looking forward to being released the next day and that his wife would collect him from outside the prison.

Events of 3 July 2019

43. On 3 July, Mr Bolton was released on licence from Hull. Mr Bolton’s licence conditions required him to live at Rookwood Approved Premises (AP) in Rotherham. He had a curfew requiring him to be at Rookwood between 8.00pm and 7.00am every day. He was required to report to AP staff at 11.00am and 2.00pm each day. He was excluded from a specific area of Hull and was not permitted to have any contact with three named individuals. On his release Mr Bolton had an appointment with his offender manager (probation officer), at 12.00pm, at the Hull Probation Office.
44. At 8.09am, Mr Bolton telephoned his wife. The investigator listened to this call which lasted for four minutes and 26 seconds. Mr Bolton said he expected to be released between 9.30am and 9.45am, and he would wait outside the prison for her to collect him. Mr Bolton talked about his licence and contact with the police and ended the call saying, “Love you babe, give you a big kiss soon, love you sweetie.”
45. The offender manager told the investigator she had spoken to Mr Bolton’s wife the day before he was released. She said Mr Bolton’s wife told her that she had agreed that Mr Bolton could ring her in the morning and the evening, and she would visit once a week to offer him support while he was in prison, but she said that she had made it clear to Mr Bolton that their relationship was over and she wanted to get on with her life without him in it. Mr Bolton’s wife said she planned to put Mr Bolton’s belongings into her car, she would meet him outside the prison, give him the car with his belongings and she would get into her next of kin’s car

and leave. The offender manager said both Mr Bolton and his wife knew he had an appointment with her at 12.00pm.

46. Prison records show that Mr Bolton was released from Hull with a rail travel warrant to Rotherham, £2.20 in bus fare, £207.29 from his personal prison account and the £46 discharge grant (which is paid on release to all prisoners who have served a sentence of more than 14 days).
47. At 9.42am, prison CCTV footage shows Mr Bolton walking out of the prison and sitting on the front wall at the front of the prison entrance. At 9.53am, Mr Bolton's wife picked him up in her car and drove away four minutes later with him in the car.
48. At 11.00am, Mr Bolton's wife contacted the offender manager to say she had ended their relationship in the car. Mr Bolton's wife told her she had taken Mr Bolton to the probation office at approximately 10.15am. Mr Bolton had said he was going to kill himself and he had walked off. She contacted the police and went to look for Mr Bolton in Hull city centre herself.
49. Humberside Police confirmed to the investigator that the offender manager had contacted them. At 11.30am, Mr Bolton's wife also contacted the police to say Mr Bolton had called her from a public telephone and said he had bought a rope and was going to kill himself. Humberside Police began a search for Mr Bolton.
50. At 12.46pm, Mr Bolton's wife contacted the police to say she had found Mr Bolton hanging from a tree in Pearson Park, Hull. Humberside police confirmed that Mr Bolton was pronounced dead at the scene.

Post-mortem report

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

Contact with Mr Bolton's family

52. In the days that followed, the offender manager maintained contact with Mr Bolton's wife to offer support and, in line with national guidance, the Probation Service offered a contribution to the costs of the funeral.

Findings

Assessment of risk

53. There is no evidence or intelligence to indicate Mr Bolton used drugs in prison before his release. Mr Bolton had no history of attempting suicide or self-harm at any time while in custody.
54. We consider that staff at Hull correctly opened an ACCT on 9 January 2019, when Mr Bolton expressed possible suicidal thoughts briefly as a result of relationship difficulties with his wife. We consider the decision to close the ACCT a day later was not unreasonable as Mr Bolton had spoken to his wife and it appeared that his period of crisis had passed. It is clear that members of the chaplaincy team continued to provide him with support after this.
55. The last record of a discussion with Mr Bolton about his marital difficulties was on 21 January, although Mr Bolton's key worker recorded on 22 March that wing staff had told him that Mr Bolton had had "some recent personal issues". There is no evidence that Mr Bolton raised the issue with staff after 21 January. We consider that it was reasonable for staff to assume that Mr Bolton had either resolved his problems or that he had come to terms with the end of his marriage in the months before his release.
56. We do not, therefore, consider that prison staff could have predicted Mr Bolton's actions on 3 July.
57. It is worth noting, however, that although the key worker model is intended to help reduce self-inflicted deaths among prisoners, Mr Bolton did not discuss his marriage problems with his key worker. This may simply have been because Mr Bolton was a private person, or because they were not personally compatible, but it may also have been because they did not see each other frequently enough to have established the kind of relationship where personal matters could be discussed.
58. His Keyworker saw Mr Bolton only eight times in the five months between 22 December (when they met for the first time) and 30 May (when they met for the last time), and they did not meet at all in the month before Mr Bolton's release. Even when they did meet, Mr Bolton was sometimes "busy with his cleaning duties" and very little discussion took place.
59. We do not criticise the keyworker, but we are concerned that they met less often than we would have expected because Mr Bolton was sometimes not on the wing when the keyworker went to see him and because the officer's other duties (as an officer in the Segregation Unit) sometimes kept him too busy. We do not suggest that Mr Bolton's death would have been prevented if the keyworker had seen him more frequently, but we are concerned that the key worker model was not working as effectively as it should have done. This may have been a missed opportunity to understand Mr Bolton's feelings about his marriage and to assess his risk of suicide and self-harm. We, therefore, recommend:

The Governor should ensure that key workers are allocated sufficient time for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

60. We have also considered the role of Mr Bolton's offender manager given that she knew the day before his release that Mr Bolton's wife intended to end their marriage on the morning of 3 July. We accept, however, that the offender manager knew that Mr Bolton's wife had already told him that their marriage was over while he was in prison and she, therefore, had no reason to think that Mr Bolton would react as he did. We consider it was reasonable for her to think that she would be able to assess whether Mr Bolton posed a risk of suicide or self-harm at her appointment with him a couple of hours later.
61. We also consider that she acted promptly and appropriately in calling the police when Mr Bolton's wife told her how he had reacted.

Clinical care

62. The clinical reviewer found that the care that Mr Bolton received in HMP Hull was of a good standard and equivalent to what he could have expected to receive in the wider community. She commented that there were no concerns about Mr Bolton's mental health.

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