

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gareth Hutchinson a resident at Withington Road Approved Premises on 23 March 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 Gareth Hutchinson was found hanged in his room at Withington Road Approved Premises, Manchester on 23 March 2016. Mr Hutchinson was 35 years old. I offer my condolences to Mr Hutchinson's family and friends.

I am satisfied that staff at Withington Road could not have predicted that Mr Hutchinson would take his life. When staff did not see Mr Hutchinson during a routine check on the morning he died, they should have tried to find him. Had they done so, they may have found him sooner. We do not know if this might have prevented his death.

The healthcare and mental healthcare team at HMP Wymott failed to support Mr Hutchinson's continuity of care in the community by releasing him without a discharge letter for his community GP and responding inadequately to requests from community mental health services for his records.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

December 2016

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Summary

Events

1. In February 2011, Mr Hutchinson was remanded to HMP Liverpool for a serious sexual offence. He was transferred to HMP Wymott in November 2012. He had depression and staff monitored his risk of suicide and self-harm many times. Despite this, he settled into prison life and had no contact with the mental health team from April 2015 until January 2016 when he asked for their support. Mr Hutchinson was anxious about his forthcoming release, and saw a psychotherapist until just before his release.
2. On 8 February, Wymott released Mr Hutchinson to Bowling Green Approved Premises in Carlisle. They did not give him a discharge letter for his community GP, which would have outlined his mental health history and needs. He registered with a GP who noted he was slow to respond, appeared socially isolated and struggled with his memory. Mr Hutchinson denied thoughts of suicide or self-harm. At his GP's suggestion, the manager of the approved premises referred Mr Hutchinson to the community learning disability team but they would not see him as he did not meet their criteria.
3. On 26 February, Mr Hutchinson was moved to Withington Road Approved Premises in Manchester. Staff noted he appeared subdued and anxious. He said he was worried other residents would find out about his offence. On 1 March, Mr Hutchinson saw a clinical psychologist who said he did not appear to have a personality disorder or psychosis. Mr Hutchinson continued to deny thoughts of suicide and self-harm.
4. Mr Hutchinson registered with another GP who referred him to the community mental health team and to a local support service (which helps offenders with mental health needs to access community mental health and social services). Healthcare professionals and staff at approved premises tried repeatedly but unsuccessfully to obtain his mental health records from Wymott.
5. Staff at Withington Road tried to move Mr Hutchinson to an approved premises for residents with mental health issues, but he did not meet their criteria. There was no change in Mr Hutchinson's behaviour at Withington Road. While he told staff he struggled to cope and was worried other residents would find out about his offence, he denied thoughts of suicide or self-harm.
6. At 7.30am on 23 March, staff carried out a routine welfare check of the residents, but did not see Mr Hutchinson in his room. They did not look for him until around 10.45am, when Mr Hutchinson's mother telephoned staff to say she had been unable to contact her son. Staff then found Mr Hutchinson in his room. He had taken his life by tying a ligature made from a shoelace around his neck and attaching it to a window vent. The ligature appears to have snapped from the weight of his body, and staff found him collapsed behind his bed. It was clear Mr Hutchinson had been dead for some time and staff did not try to resuscitate him. Paramedics confirmed Mr Hutchinson's death at 11.07am.

Findings

7. Staff at Withington Road could not have predicted Mr Hutchinson's actions. When they did not see Mr Hutchinson during a welfare check on the morning of 23 March, they should have looked for him. This may have meant that Mr Hutchinson was found sooner; we do not know if it might have prevented his death.
8. Healthcare staff at Wymott should have given Mr Hutchinson a discharge letter for his GP, outlining his recent contact with mental health services at the prison and current prescriptions. The mental health team at Wymott took too long to respond to community requests for his medical records and a summary of Mr Hutchinson's contact with prison mental health services.

Recommendations

- The manager of Withington Road Approved Premises should ensure that staff conducting welfare checks assure themselves of the safety of residents.
- The Head of Healthcare at Wymott should ensure that all healthcare staff comply with Prison Service Order 3050 to enable good continuity of care for prisoners on release.

The Investigation Process

9. The investigator issued notices to staff and residents at Withington Road Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Hutchinson's prison medical records and from his records at the approved premises.
11. The investigator interviewed 13 members of staff and one resident at Withington Road in May and June 2016.
12. NHS England commissioned a clinical reviewer to review Mr Hutchinson's clinical care at HMP Wymott before he was released to approved premises. She interviewed two members of healthcare staff separately.
13. We informed HM Coroner for City of Manchester District of the investigation. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Hutchinson's family, to explain the investigation. They had no specific matters they wanted the investigation to consider.
15. Mr Hutchinson's family received a copy of the initial report. They raised no factual inaccuracies.

Background Information

Withington Road Approved Premises

16. Approved premises (formerly known as probation and bail hostels) house and supervise offenders released into the community as a condition of a court order or prison licence. The National Probation Service, North West Area, manages Bowling Green Approved Premises in Carlisle and Withington Road Approved Premises in Manchester.
17. Withington Road accommodates up to 32 men in a mixture of single and double rooms. Residents must sign when entering or leaving the building and must follow agreed curfews, which staff monitor. During induction, staff tell residents the rules of the premises and assign them a key worker, who is their primary contact for any issues they may have. Residents are responsible for their own health and must register with a GP.

HMP Wymott – Mental Health Services

18. The Lancashire Care NHS Trust delivers mental health services at HMP Wymott. A registered mental health nurse assesses and sees prisoners who are urgently referred to the team. There are six registered mental health nurses in the mental health team, including the team leader. There are two psychological therapists (one of whom works part-time) and one psychological wellbeing practitioner trained to offer guided self-help.

Previous deaths at Withington Road Approved Premises

19. Mr Hutchinson is the second resident at Withington Road to die since June 2005, and the first to take his life.

Assessment, Care and Teamwork

20. Assessment, care and teamwork (ACT) is the care-planning system used in approved premises for residents identified at risk of suicide or self-harm. The purpose of ACT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the resident.

Key Events

HMP Wymott

21. On 8 February 2011, Mr Gareth Hutchinson was remanded to HMP Liverpool for a serious sexual offence and later sentenced to 15 years in prison. The prison GP diagnosed Mr Hutchinson with mild depression and prescribed antidepressants. A mental health nurse noted he had a history of self-harm and contact with community mental health services. From November 2011 to October 2012, he had no significant contact with mental health services.
22. On 6 November 2012, Mr Hutchinson was transferred to HMP Wymott. He told the nurse he had a history of depression, but had not been prescribed antidepressants for a year. He self-harmed three times between June 2013 and May 2014. Staff monitored his risk of suicide and self-harm on each occasion. The prison GP prescribed antidepressants from June 2013 but noted no evidence of mental illness. Mr Hutchinson had no contact with the prison's mental health team from April 2015 until January 2016, when he asked for their support.
23. On 20 January 2016, Mr Hutchinson saw a mental health nurse. He said that he was anxious about his release, integrating into the community and possible retribution from his victim's family. He felt his antidepressants were not working. Mr Hutchinson expressed no thoughts of suicide or self-harm.
24. On 26 January, Mr Hutchinson saw a psychotherapist. Mr Hutchinson told him he was anxious about how he would cope on release and said he had "not been right" since he was assaulted a year earlier. He diagnosed Mr Hutchinson with severe anxiety and depression.
25. On 26 January, an officer told Mr Hutchinson he would be released to Bowling Green Approved Premises in Carlisle because there were no approved premises beds available in Manchester, his probation area.
26. On 2 February, the psychotherapist saw Mr Hutchinson and noted he was still worried about his release and the practicalities of getting to Carlisle. He denied any thoughts of suicide or self-harm. At a final session on 4 February, he noted that Mr Hutchinson was still anxious. He gave Mr Hutchinson information about getting to Carlisle and discussed ways to solve problems. He discharged Mr Hutchinson from his care.
27. On 7 February, a nurse assessed Mr Hutchinson before his release. The nurse noted that he was "fit and well" and had collected his antidepressants. Healthcare staff did not give Mr Hutchinson a discharge letter or any other information outlining his mental health needs for his community GP.
28. On 8 February, Wymott released Mr Hutchinson on licence. His father took him to the train station so he could get a train to Carlisle. In a police statement after Mr Hutchinson's death, his father said Mr Hutchinson had appeared extremely anxious and paranoid that day. Mr Hutchinson's approved premises referral form dated 26 October 2015, noted his history of self-harm, depression and that he had tried to take his life when he was previously released from prison.

Bowling Green Approved Premises

29. A residential services officer gave Mr Hutchinson an induction to Bowling Green Approved Premises when he arrived. Mr Hutchinson told him that he had difficulty in dealing with everyday situations. He noted that Mr Hutchinson was subdued and that it was difficult to gauge what he understood.
30. On 10 February, Mr Hutchinson spoke to his probation officer. She noted that Mr Hutchinson appeared to be struggling, felt anxious and lost. She told Mr Hutchinson that that he might be moved at short notice to approved premises in Manchester.
31. Mr Hutchinson's father told the probation officer and the residential services officer that he was worried about his son's behaviour and mental state, and described him as scared, lost and withdrawn. He was concerned his son might harm himself. The probation officer told Mr Hutchinson's father that staff were aware of his son's mental state.
32. On 12 February, Mr Hutchinson registered with a GP who noted that he was slow to respond, appeared socially isolated, struggled with his memory and failed to answer questions fully. The GP questioned Mr Hutchinson's cognitive thinking and said that the community learning disability team might need to assess him.
33. A senior probation officer noted in Mr Hutchinson's probation records that the GP had said that Mr Hutchinson did not need to be urgently referred to mental health services or for a neurological assessment. The probation officer and the senior probation officer agreed to refer Mr Hutchinson to St Joseph's Approved Premises, which catered for residents with enduring mental health needs. St Joseph's said that Mr Hutchinson did not meet their admission criteria.
34. On 15 February, the senior probation officer referred Mr Hutchinson to a specialist community learning disability nurse to assess his cognitive functioning. The nurse said there was not enough evidence to suggest that Mr Hutchinson had a learning disorder and as such the team were unable to assess or support him. He noted that Mr Hutchinson might have had a head trauma, resulting in neurological damage. He suggested it be discussed with Mr Hutchinson's GP, with a view to Mr Hutchinson having a neurological assessment or being referred to mental health services.
35. On 18 February, Mr Hutchinson told another residential services officer that he had seen the mental health team at Wymott. He said he was afraid for his safety and worried that other residents knew about his offence. He told Mr Hutchinson that he was not in danger and Mr Hutchinson denied thoughts of suicide or self-harm. He did not consider suicide and self-harm prevention monitoring, as Mr Hutchinson's behaviour was not unusual. He described many offenders as anxious on release.
36. On 19 February, the residential services officer contacted Wymott to obtain information about Mr Hutchinson's contact with the prison's mental health services. An administrator confirmed Mr Hutchinson had contact, but said she could not give any further details without written consent. She suggested that he contact the community mental health team to access his medical records.

37. On 20 February, staff noted that Mr Hutchinson appeared in a better frame of mind. On 24 February, his probation officer told Mr Hutchinson that he would move to Withington Road Approved Premises in Manchester, and that the senior probation officer would drive him there.

Withington Road Approved Premises

38. On 26 February, Mr Hutchinson arrived at Withington Road. A residential services officer explained to him his licence conditions, the approved premises' rules and plans for his first few days, including registering with a GP. She told the investigator that she could not recall discussing Mr Hutchinson's risk of suicide and self-harm with him or colleagues.
39. The probation officer met Mr Hutchinson. She noted that he was subdued, anxious and worried that people would find out about his offence. She told him that staff at Withington Road would take things slowly with him and that he should ask if he was unsure about anything. She told the investigator that residents with offences similar to Mr Hutchinson's would often worry that other residents might find out about them. On 29 February, a probation officer noted that Mr Hutchinson continued to struggle with anxiety and paranoia, and needed significant support.
40. On 1 March, a clinical psychologist at the Salford and Stretford Insight Personality Disorder Team assessed Mr Hutchinson because of concerns about his behaviour. She said that she had been told that Mr Hutchinson may have had a brain injury in prison. She noted no symptoms of mental illness but that Mr Hutchinson made little eye contact, talked slowly, did not express himself well and was anxious and paranoid. Mr Hutchinson denied thoughts of suicide and self-harm.
41. She shared her findings with staff, and suggested that Mr Hutchinson see Manchester Offenders Diversion Engagement and Liaison Team (MODEL) who help offenders with mental health needs to access community mental health and social services. She told the investigator that she did not believe Mr Hutchinson had a personality disorder or psychosis.
42. On 2 March, a mental health nurse from MODEL met Mr Hutchinson and agreed to see him weekly. The nurse noted that Mr Hutchinson had no thoughts of suicide or self-harm.
43. Later that afternoon, Mr Hutchinson registered with a GP. She noted that he was withdrawn, difficult to engage and although he had harmed himself previously, he had no current thoughts of doing so. She agreed to see him again, and suggested that he see MODEL and the community mental health team. She changed his antidepressants to mirtazepine.
44. On 3 March, Mr Hutchinson missed a morning appointment with a residential services officer. Later in the day, the psychologist took him to the local job centre as he did not know the way. She told his probation officer that he was overwhelmed and incapacitated with anxiety at the job centre, and that this behaviour impacted significantly on his daily functioning. She said she believed Mr Hutchinson needed a higher level of support.

45. A residential services officer told the investigator that while Mr Hutchinson was quiet, seemed to struggle with what was asked of him and did not appear to retain information, he seemed lucid when talking to friends by telephone. She said his change of behaviour was spontaneous. She said that when he played pool, he would laugh and joke with the other residents.
46. On 4 March, the probation officer met Mr Hutchinson and noted no change in his presentation. He told her that he was struggling and had not seen his parents since coming back to Manchester. He said he had had some contact with his brother.
47. On 7 March, Mr Hutchinson started taking his antidepressants again, having not taken them for a couple of days. The probation officer told colleagues that they should see Mr Hutchinson informally as he had difficulty remembering appointment times and had to be encouraged to shower and wash his clothes. Mr Hutchinson continued taking his antidepressants until his death.
48. On 8 March, the mental health nurse met Mr Hutchinson. He noted that Mr Hutchinson was anxious and had a low mood. He asked the mental health team at Wymott for information about Mr Hutchinson's contact with them, including his diagnosis, treatment plan and whether a neurological assessment had been completed. He attached a completed consent form from Mr Hutchinson. The request for information was rejected because he had submitted the wrong consent form. On 10 March, he wrote to the GP to ask her about arranging a neurological assessment for Mr Hutchinson.
49. On 9 March, the mental health nurse sent a further request to Wymott. This too was rejected because it was not the correct consent form. The next day, a residential services officer sent a third signed consent form to Wymott, but this too was rejected because it was not the correct form. She told the mental health nurse that Wymott would do nothing further without the correct consent.
50. On 11 March, a senior probation officer spoke to Mr Hutchinson as staff were anxious about his behaviour. She noted Mr Hutchinson had said he could not cope and that he found it difficult to articulate his feelings. She tried to reassure Mr Hutchinson that other residents did not know about his offences. She said that Mr Hutchinson denied thoughts of suicide or self-harm.
51. On 13 March, Mr Hutchinson told a trainee probation officer that he found it difficult to manage his life and his offence did not help the situation. She noted that he looked confused and lost. She said that he was stroking his arm with a plastic key fob when he spoke to her. She reported her concerns to a residential services officer, who tried to reassure Mr Hutchinson. She said she and the residential services officer did not discuss whether to start monitoring Mr Hutchinson's risk of suicide or self-harm. She said Mr Hutchinson denied thoughts of self-harm or that other residents were threatening him.
52. On the evening of 14 March, Mr Hutchinson was noted as being in good spirits. The next day, played pool and interacted well with other residents.
53. On 15 March, the adult community learning disabilities team in Manchester rejected Mr Hutchinson's referral as he did not meet their criteria. The next day

the mental health nurse saw Mr Hutchinson. He noted that his mood was still low and he was still anxious that other residents knew about his offence. He said that in each of his meetings Mr Hutchinson did not express thoughts of suicide or self-harm.

54. On 18 March, the mental health nurse sent Wymott another request for Mr Hutchinson's mental health records, together with another consent form. The clinical mental health lead at Wymott agreed to send a summary of Mr Hutchinson's care to him. (Although Wymott produced a summary, they did not send it to him before Mr Hutchinson's death six days later.)
55. On 19 March, Mr Hutchinson told a residential services officer he could not cope and that his parents had offered to visit. She talked to him for over an hour and suggested his parents visit him. (At 8.53am on 23 March, the morning of Mr Hutchinson's death, she emailed colleagues, noting her concerns about the way Mr Hutchinson retained information.) She said he had never talked of suicide or self-harm and that she reassured him that no one would know about his offence unless he told them.
56. In his police statement, Mr Hutchinson's father said that, on 20 March, his son had gone for a drink with his cousin. Mr Hutchinson's father said Mr Hutchinson asked his cousin lots of questions about his uncle who had hanged himself. Mr Hutchinson's father did not share this information with staff.
57. On 21 March, Mr Hutchinson forgot to meet his probation officer. She later saw him looking in the office and invited him in for a chat. She said Mr Hutchinson did not talk, but that this was not unusual for him. She asked if he was okay or needed anything. Mr Hutchinson said he did not know, but later said he was struggling and asked she if she knew why he was at Withington Road. She told him that as a member of staff, she was aware and was there to help him if needed. She told him he could speak with any member of staff at any time.
58. A probation officer told the investigator that at times she would see Mr Hutchinson laughing and smiling with other residents but he behaved differently in one-to-one meetings with staff. She said the mental health nurse had told her that Mr Hutchinson was more capable than staff gave him credit for.
59. On 22 March, the mental health nurse noted that the GP was unsure why Mr Hutchinson needed a neurological assessment, and suggested that he might benefit from access to psychological therapy and ongoing social care. (The GP had already referred Mr Hutchinson to the community mental health team.)
60. On 22 March, a probation officer spoke to Mr Hutchinson. He told her that everyone knew about his offence. She told him that this was not the case. During their conversation, Mr Hutchinson took a phone call. She thought it might have been from a family member. She said Mr Hutchinson's demeanour changed beyond recognition immediately. She said he went from holding his head in his hands and giving monosyllabic answers to being upbeat and laughing during the phone call.

61. That evening, the probation officer held a residents' meeting. Mr Hutchinson attended. He told her that he had eaten his meal and was okay. This was her last conversation with Mr Hutchinson.
62. A resident at Withington Road said Mr Hutchinson did not mix much with other residents, would stay in his room and spend hours in the communal areas, staring out the window. He described Mr Hutchinson as scared and confused, and said Mr Hutchinson has said he could not cope and did not want to go back to prison. He assumed Mr Hutchinson was worried about being recalled.
63. Mr Hutchinson's father told police that Mr Hutchinson had telephoned his mother the day before he died, asking her to pick him up from Withington Road, but she could not as she was at work. Mr Hutchinson's father said Mr Hutchinson seemed to be unresponsive and withdrawn.
64. At 8.00pm, residential services workers Mr A and Mr B started their shift. (Mr B had retired from the probation service, but worked a couple of shifts each month.) The men received a handover from the day staff and were told that Mr Hutchinson remained anxious.
65. At 11.00pm, both carried out the evening check of residents. Mr A said that when he checked Mr Hutchinson, he was sitting on his bed and had said he was okay. Mr B said he did not speak to Mr Hutchinson as he did not know him or the other residents. That night they carried out hourly patrols in turn of the approved premises.
66. At 7.30am on 23 March, Mr B conducted the routine morning check of residents. Although he did not go into Mr Hutchinson's room, he looked in but did not see Mr Hutchinson. He did not tick his name on his list of residents. When he returned to the office at about 7.45am, he checked to see if Mr Hutchinson (and two other residents who he had not seen) had signed out of the building. They had not.
67. Mr A gave a handover to the day staff at around 8.05am and left the building ten minutes later. He said that there had been no concerns about Mr Hutchinson that night. Mr B said he told his colleagues that he had not seen Mr Hutchinson or two other residents during the morning check. Day staff said they could not recall him telling them that or that Mr A discussed Mr Hutchinson in his handover.
68. That day staff received a call from Mr Hutchinson's mother at around 10.45am, asking for someone to check on her son as she could not get hold of him. Around five minutes later, he knocked on Mr Hutchinson's room door. There was no response. He went into the room and noticed that Mr Hutchinson's bed had not been slept in. He then noticed Mr Hutchinson slumped between the bed and the window, with most of his body obscured by the bed. He said he did not check Mr Hutchinson more closely, as it was clear he was dead. He left the room to get help from his colleague and a police officer, who were in a nearby room.
69. His colleague went into Mr Hutchinson's room and saw him lying between the bed and the window. She said it was obvious he was dead. (It would appear that Mr Hutchinson had used a shoe lace as a ligature, which he had tied around

his neck and attached to the window. The ligature had snapped, causing Mr Hutchinson to fall between his bed and the window.) She fetched the police officer, who checked Mr Hutchinson for signs of life. There were none. The police officer asked for an ambulance to be called. No one tried to resuscitate Mr Hutchinson as it was clear he was dead.

70. Staff had collected first aid equipment, including a defibrillator, but when they went back to Mr Hutchinson's room they were told Mr Hutchinson was dead. Paramedics pronounced Mr Hutchinson dead at 11.07am.

Contact with Mr Hutchinson family

71. Manchester Police notified Mr Hutchinson's family of his death. The North West Divisional Effective Practice Manager spoke with members of Mr Hutchinson's family, and offered support. In line with national instructions, the National Probation Service offered to contribute to funeral expenses.

Support for prisoners and staff

72. After Mr Hutchinson's death, the manager debriefed the staff involved in the incident and offered support. Staff told other residents of Mr Hutchinson's death and offered support in case they had been adversely affected.

Post-mortem report

73. A post-mortem gave the cause of death as ligature strangulation. Toxicology tests detected therapeutic levels of mirtazepine, codeine and paracetamol but found no evidence of illicit substances in Mr Hutchinson's blood.

Findings

Assessment of Mr Hutchinson's risk

74. Staff at Bowling Green and Withington Road were aware of Mr Hutchinson's history of self-harm and that he had tried to take his life when he was last released from prison. Yet, Mr Hutchinson never harmed himself after his release and denied plans to do so or to take his life. Mr Hutchinson's behaviour did not change from the time he was released from prison until his death. Staff at both approved premises noted that he was withdrawn, confused, anxious, poor at coping, and found it difficult to carry out basic tasks. They supported him well and helped him access services such as MODEL, and it is likely that the support he received was greater than he would have received if he lived alone in the community.
75. Staff at Withington Road said that Mr Hutchinson's interaction with them was sometimes at odds with his interaction with others. For example, he appeared to enjoy playing pool and was competent at it, and he interacted well when speaking to friends by telephone. It is reasonable in this context that staff did not consider Mr Hutchinson at risk of suicide and self-harm, and we saw no evidence that staff could reasonably have predicted that Mr Hutchinson would take his life.

Welfare checks

76. The Approved Premises Manual issued by the National Offender Management Service says that staff should monitor residents' presence, behaviour and wellbeing. An internal investigation carried out at Withington Road after Mr Hutchinson's death identified that managers expect night staff (who finish their shift at 8.20am) to locate any residents missing during the morning welfare check before handing over to the day shift staff. If night staff have not found the missing person by 8.00am, they should agree a plan of action to find the person and they should notify the approved premises manager.
77. When Mr B did not see Mr Hutchinson during the morning check on 23 March, this did not happen. He said he told Mr A and other colleagues during the morning handover that he had not seen Mr Hutchinson. (Day staff could not recall this and we were unable to interview Mr A.) No one looked for Mr Hutchinson or went to his room again until Mr Hutchinson's mother telephoned over three hours after he was noted as missing.
78. While we recognise that Withington Road had several staircases, bathrooms and other communal rooms and it is difficult to check that all the residents are in the building, staff should have tried to find Mr Hutchinson when Mr B reported him missing from his room. It appears that Mr Hutchinson had been dead for some time when he was found but we do not know if Mr Hutchinson's death could have been prevented if staff had found him sooner. We make the following recommendation:

The manager of Withington Road Approved Premises should ensure that staff conducting welfare checks assure themselves of the safety of residents.

Discharge from Wymott healthcare and requests for medical information

79. Prison Service Order 3050 on the continuity of healthcare for prisoners says that a prisoner's healthcare needs should be assessed to ensure continuity of care when prisoners are released into the community. It says that written guidelines must be in place setting out the procedures to follow when releasing prisoners, including identifying their mental health problems and their potential for self-harm, and considering whether to refer them to local community mental health services.
80. Wymott had no clear procedures in place to pass on information about the health needs of prisoners being released. They failed to consider Mr Hutchinson's onward mental health care in the community and did not give him a discharge letter for his GP outlining his mental health needs or ensure contact with the mental health team just before his release. There was also an unacceptably bureaucratic delay in the mental health team sending Withington Road his medical records and a summary of his contact with the mental health team. The clinical reviewer said that information necessary for patient safety should not have been delayed because of the risk of data protection issues. Without information from Wymott, healthcare providers in the community appear to have struggled to make sense of Mr Hutchinson's health needs and had inadequate information about his history of attempts to take his life.
81. The clinical reviewer concluded that while the clinical care Mr Hutchinson received from Wymott was satisfactory, his discharge from mental health services without consideration of his onward care was not equivalent to that he would have received in the community. She made findings beyond the remit of our investigation about the onward care Mr Hutchinson received on his release from prison, which NHS England will need to address. We make the following recommendation:

The Head of Healthcare at Wymott should ensure that all healthcare staff comply with Prison Service Order 3050 to enable good continuity of care for prisoners on release.

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