Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martyn Hoult, a resident of Ashley House Approved Premises, on 7 May 2021

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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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 Martyn Hoult died on 7 May 2021 after jumping from the Clifton Suspension Bridge whilst a resident at Ashley House Approved Premises (AP) in Bristol. He was 51 years old. I offer my condolences to Mr Hoult's family and friends.

We are not able to say what led Mr Hoult to kill himself. He was due to leave the AP three weeks after his death and there is evidence that he was worried about having somewhere to live after that. It is also possible that he had relationship problems that he had not disclosed.

However, based on the way Mr Hoult presented and the risk information available to them, we do not consider that AP staff or Mr Hoult's offender managers could have foreseen or prevented his death.

Despite good evidence of collaborative working with Mr Hoult's offender managers, AP staff did not know that Mr Hoult had had thoughts of self-harm in December 2018/January 2019. I cannot say whether this knowledge would have made any difference, but I have recommended that, in future, offender managers should obtain all relevant risk information and share it with AP staff to inform 'risk to self' assessments for new residents.

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 McAllister CB
Prisons and Probation Ombudsman **February 2022**

Contents

Summary

Events

1. In 2006, Mr Martyn Hoult was sentenced to life with a minimum term to serve of four and a half years.

2. Mr Hoult was subject to suicide and self-harm monitoring measures, known as ACCT, at HMP Wymott for five days in December 2018/January 2019, after staff found three nooses in his cell.

3. In July 2019, Mr Hoult was transferred from Wymott to HMP Leyhill (an open prison).

4. On 22 February 2021, he was released from Leyhill on licence to live at Ashley House Approved Premises (AP). On arrival, AP staff assessed Mr Hoult's risk to himself as 'low'. Mr Hoult settled well at the AP. Staff described him as "very chatty" and "very upbeat" and did not have any concerns about him.

5. Mr Hoult was due to leave Ashley House on 28 May but had not secured somewhere to live afterwards. At around 9.30am on 7 May, Mr Hoult met his offender managers to discuss his housing situation. They advised Mr Hoult that he needed to start looking at places in hostels for the homeless. Although Mr Hoult was not happy about this, by the end of the meeting he seemed to understand the situation.

6. At around 12.30pm, Mr Hoult signed out of the AP to go for a walk. AP staff said that he seemed his usual self.

7. At around 4.00pm, Mr Hoult killed himself by jumping from the Clifton Suspension Bridge. Ambulance staff confirmed Mr Hoult's death at 5.28pm.

8. A post-mortem examination identified Mr Hoult's cause of death as multiple injuries.

Findings

Management of Mr Hoult's risk of suicide

9. We do not know what led Mr Hoult to take his life.

10. In order to find accommodation after he left the AP, Mr Hoult needed to find employment. He had found neither when he died three weeks before he was due to leave the AP. Although we cannot say if this was a factor in his decision to end his life, we are disappointed that more was not done at HMP Leyhill to help prisoners into employment after release.

11. Based on the way Mr Hoult presented and the risk information available to them, we do not consider that AP staff could have foreseen or prevented Mr Hoult's death.

12. We are concerned that the details of the most recent ACCT opened for Mr Hoult (in December 2018) were not provided to AP staff and were not therefore taken

into account when they completed his ‘risk to self’ assessment on 22 February. However, we cannot say that this would have affected the outcome for Mr Hoult given that he gave no sign of serious distress or suicidal thoughts.

Recommendations

- The Governor of HMP Leyhill should ensure that there is a broad range of community work placements which allow prisoners to progress, develop skills and demonstrate a reduction in their risk, and to help them find employment on release.
- The Probation Service should remind offender managers to ensure that:
    - they obtain details of any time an offender has spent under ACCT procedures prior to release; and
    - share this with AP staff to inform ‘risk to self’ assessments.

The Investigation Process

13. The investigator issued notices to staff and residents at Ashley House informing them of the investigation and asking anyone with relevant information to contact him.

14. The investigator obtained copies of relevant extracts from Mr Hoult's prison, probation and medical records.

15. The investigator interviewed two members of staff at Ashley House AP, and Mr Hoult's offender managers in Bristol and Greater Manchester. All the interviews were completed by video link due to the restrictions imposed as a result of the COVID-19 pandemic.

16. We informed HM Coroner for Avon of the investigation and have sent the coroner a copy of this report.

17. We contacted Mr Hoult's family to explain the investigation and to ask if they had any issues that they wanted the investigation to consider. They wanted to understand what might have led Mr Hoult to kill himself and they raised several concerns about Mr Hoult's treatment by the criminal justice system, his physical health and his association with a woman before his death. Some of these matters fall outside the remit of the PPO's investigation (which is concerned with Mr Hoult's contact with the prison and probation services before his death), but we have addressed them where we can.

18. Mr Hoult's family received a copy of the draft report. They raised several issues and questions that do not impact on the factual accuracy or findings of this report. We have provided clarification by way of separate correspondence to them.

19. The initial report was shared with HMP Prison and Probation Service (HMPPS). HMPPS identified one factual inaccuracy, which we have addressed in this report.

Background Information

HMP Leyhill

20. HMP Leyhill is a category D open prison in Gloucestershire, holding almost 500 adult male prisoners in preparation for their release back into the community. Two-thirds of the population have been convicted of sexual offences and the majority are serving long sentences.

HM Inspectorate of Prisons (HMIP)

21. The most recent inspection of Leyhill was a Scrutiny Visit (a shortened inspection during the COVID-19 pandemic) in February/March 2021. HMIP reported that there were not enough probation or prison offender supervisors in post. It was unlikely that the prison would be ready to move to the new Offender Management in Custody model at the end of March 2021, as planned, as there was a shortage of probation staff in the region. Probation offender supervisors had mostly worked off site for the previous 12 months because of the pandemic, attending on a rota basis. Caseloads were high and recorded contact with prisoners was inconsistent.

22. Inspectors identified as a 'key concern' that employer links in the local community were far too limited and, even before the start of the pandemic, were too few for an open prison. Even if the pandemic eased and restrictions on release on temporary licence (ROTL) were lifted, at the time of HMIP's visit the prison had confirmed plans for only 26 prisoners, about 5% of the population, to work in the community. HMIP recommended that there should be a broad range of community work placements which allow prisoners to progress, develop skills and demonstrate a reduction in their risk.

Ashley House Approved Premises (AP)

23. Approved Premises (formerly known as probation or 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 healthcare and are expected to register with a GP.

24. Ashley House is one of four Approved Premises in the Avon & Somerset Probation Area. It is an independent, voluntary AP, run as a registered charity. It provides accommodation for up to 22 male residents.

25. Residents at Ashley House are subject to curfew restrictions, usually from 11:00pm to 6:00am for those not working. CCTV cameras provide oversight of communal rooms and corridor areas throughout the day and night. The AP is staffed by an operational manager, six assistant managers and two permanent waking night supervisors, all of whom are directly employed by Ashley House. In addition, two waking night assistants are provided by an agency providing 24 hour waking cover.

26. Each resident is allocated an assistant manager as a key worker. Key workers are responsible for monitoring the behaviour of their residents and for providing advice and encouragement. Residents are expected to meet weekly with their key workers. The meetings are recorded, and any areas of concern are noted.

Previous deaths at Ashley House

27. Mr Hoult was the third resident at Ashley House to die since 2005. Both the previous deaths were self-inflicted: one was in 2005, but the other was in March 2021, two months before Mr Hoult's death. The Ombudsman's investigation into that death has now been completed and there are no significant similarities.

Assessment, Care in Custody and Teamwork

28. 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.

29. 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 made at irregular intervals to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

30. A similar system for assessing and monitoring residents in used by the Probation Service in Approved Premises but referred to as a 'risk to self' assessment, although the principles remain the same.

Key Events

Background

31. In October 2006, Mr Martyn Hoult was convicted of attempted rape and was subsequently sentenced to life imprisonment, with a minimum term to serve of four and a half years. (Mr Hoult continued to maintain his innocence of both his index offence and a previous rape conviction.)

32. Mr Hoult's OASys report (the Probation Service assessment of an offender's risk to themself and others) records that he said he had made two serious suicide attempts in the community by overdosing on tablets in 1989/1990 in response to his relationship failing, and in 1998/1999 after breaking up with his partner.

33. Mr Hoult's prison records show that he was monitored under Prison Service suicide prevention measures, known as ACCT, in October 2006 after being convicted, and in June 2011 after he threatened to take his own life during a telephone call. Staff closed the ACCT the following day after Mr Hoult assured them that he made the comment in the heat of the moment and had no thoughts or suicide or self-harm.

34. On 28 December 2018, while at HMP Wymott, ACCT procedures were opened again after staff found three nooses in Mr Hoult's cell and he threatened to cut his throat after he was told he was being moved to another wing in the prison where he believed he would be under threat from another prisoner. Five days later, on 2 January 2019, staff closed the ACCT after Mr Hoult's presentation and mood improved and the wing transfer issue was resolved. Although the details of this ACCT are recorded in Mr Hoult's prison record (NOMIS), his OASys report records that the circumstances of this ACCT "are unknown and are yet to be explored".

HMP Leyhill

35. On 18 July 2019, Mr Hoult was transferred from Wymott to HMP Leyhill (an open prison).

36. In November 2019, Mr Hoult was assigned an offender supervisor at Leyhill. (The role of offender supervisors in prison is to build supportive relationships with prisoners with the aim of reducing re-offending.) Although it had been intended that Mr Hoult would be released to an AP in his home area of Greater Manchester, from November 2019 onwards, Mr Hoult said that he wanted to make a fresh start in the Bristol/Gloucester area where he said he thought there would be more employment opportunities. His offender supervisor therefore explored the possibility of release to Ashley House AP. She maintained regular contact with Mr Hoult until his release from prison.

37. In September 2020, in advance of Mr Hoult's upcoming parole hearing (where his eligibility for release was to be considered), he was assigned a community offender manager (probation officer). In interview, she explained that she was Mr Hoult's offender manager in the Greater Manchester area where he was initially registered. She also told the investigator that Mr Hoult had remained in prison for such a long time, despite having only a four-and-a-half-year tariff, because he

had refused to take part in any offending behaviour programmes because he maintained his innocence. As a result, it had been difficult for him to demonstrate that his risk of reoffending had reduced.

38. As Mr Hoult wanted to resettle in Bristol after his release, an offender manager in Bristol was assigned to work alongside his community offender manager to help facilitate this in advance of his release.

39. On 2 December 2020, Mr Hoult was told by the Parole Board that he would be released from prison on licence on 22 February 2021.

40. On 30 December, Mr Hoult complained of stomach pains and passing blood in his stools. He was seen by a prison GP and was taken to hospital, where they suspected he was suffering from diverticulitis (a digestive condition that affects the large intestine) and discharged him after a few hours with painkillers. Mr Hoult continued to complain of pain and bleeding and a prison GP referred him to hospital again. He was admitted to hospital on 9 January 2021 and had scans and blood tests before being discharged on 13 January with a diagnosis of uncomplicated diverticulosis. He was prescribed painkillers.

41. Following his return to Leyhill, Mr Hoult continued to complain of pain and asked to be prescribed morphine. Over the next few weeks, Mr Hoult continued to ask for painkillers and prison GPs recorded concerns that he may be drug- seeking. There were also suspicions that he may be bullying other prisoners for their medication. On 3 February, Mr Hoult had a telephone consultation with a hospital doctor as he was still reporting pain and bleeding. As he was due to be released from prison shortly, healthcare staff gave Mr Hoult's release address details to the hospital so he could be followed up if required.

42. On 18 February 2021, Mr Hoult met his prison offender supervisor for the final time. She discussed the practicalities of Mr Hoult's release with him, including benefit payments and potential employment opportunities. She recorded on NDelius, the probation service case management system, that Mr Hoult seemed motivated by his release.

43. On 22 February, Mr Hoult was given a copy of his licence and conditions and was released from Leyhill to Ashley House AP. The licence conditions were typical of those for people convicted of sexual offences.

Ashley House Approved Premises

44. When Mr Hoult arrived at Ashley House, two probation residential workers completed his induction. They explained the AP's rules and procedures to him. They recorded in his 'risk to self' assessment that suicide and self-harm had not previously been identified as an area of concern for him, but that he had "had thoughts over 30 years ago". They also recorded that Mr Hoult had been subject to ACCT procedures on the first night of his sentence back in 2006. The ACCTs that had been opened in June 2011 and December 2018 were not mentioned on the form. They assessed his overall risk to himself as low.

45. On 5 March, the Bristol offender manager spoke to Mr Hoult on the telephone to find out how he was getting on at the AP. She recorded on NDelius that Mr Hoult

had started looking for private rented accommodation and he was aware that finding somewhere to live in Bristol would be difficult. Mr Hoult told her that he had arranged universal credit for himself and received a payment of £409.

46. On 12 March, the offender manager met Mr Hoult and told him that Bristol City Council might not consider they had a duty to house him as he had no local links to the area. Mr Hoult told her that he did not want to go back to Greater Manchester as he wanted a new start. He said he was applying for jobs, taking part in a mentoring scheme and had started a course to help secure work as a labourer.

47. On 1 April 2021, Mr Hoult did not go to a scheduled key work session with his key worker, as he was intoxicated.

48. On 9 April, a three-way meeting took place between Mr Hoult, his community offender manager and his Bristol offender manager. Mr Hoult said he felt stressed about his housing situation but continued proactively looking for somewhere to live.

49. On 14 April, a senior AP staff member emailed the community offender manager to tell her that Mr Hoult had bought numerous resistance bands for exercise and given his offending history, he was concerned about him using them to harm someone. She responded to say that there was nothing in Mr Hoult's records to suggest he would use the bands in a violent way, and that she had no concerns about the risk of him using them.

50. Over the next few weeks, AP staff did not raise any concerns about Mr Hoult's presentation, demeanour or overall wellbeing. The community offender manager and the Bristol offender manager continued to meet Mr Hoult regularly, and helped him with several issues including accessing benefits and attempting to secure suitable accommodation. He was particularly keen to secure accommodation, as he was due to leave the AP on 28 May.

7 May

51. At 7.55am, Mr Hoult came down for breakfast at the AP. In her statement, a member of security staff said that Mr Hoult told her that he was having trouble finding somewhere to live, and that he said, "I've just done a 15-year stretch, I'm not going back there".

52. At around 9.30am, the community offender manager and the Bristol offender manager met Mr Hoult via video call to discuss his housing situation. They advised Mr Hoult that he needed to start looking at supported accommodation and hostels for those at risk of homelessness, as his due date to leave Ashley House was fast approaching. Mr Hoult became slightly agitated. He said he did not want to live in supported housing and made derogatory comments about the type of people who he would be living with. In interview, his Bristol offender manager told us that they talked through the options available to Mr Hoult and tried to manage his expectations. She said that, from her point of view, the appointment did not end on a negative note and Mr Hoult accepted what they were telling him.

53. Later that afternoon, the Bristol offender manager was informed by email that a space for Mr Hoult was available at Logos House in Bristol, a homeless shelter run by the Salvation Army. However, she did not get chance to tell Mr Hoult before his death.

54. Between 12.00pm and 12.30pm, Mr Hoult asked a residential worker at the AP if he could help him find an email from the council about his housing situation. The worker told him that he was busy doing key work sessions for the next couple of hours but would be free to help after that. The worker suggested that he ask one of the other members of staff instead, and Mr Hoult said that he would. In interview, the worker said there was nothing in Mr Hoult's demeanour that raised any concerns for him. He described Mr Hoult as being chatty, engaging and courteous, and said he was smiling and joking as normal.

55. At around 12.30pm, Mr Hoult signed out of the AP to go for a walk.

56. At around 4.00pm, Mr Hoult killed himself by jumping from the Clifton Suspension Bridge. Ambulance staff confirmed Mr Hoult's death at 5.28pm.

57. At 7.05pm, police officers arrived at the AP and told the assistant AP manager what had happened. In her statement, she said she asked the officer if she had the right person because Mr Hoult had not given any indication that he had intended to take his own life.

58. In interview, a residential worker who was also on duty that evening, told us that the one of the police officers asked him to accompany her to Mr Hoult's room to conduct a search. He said that he found a diary which indicated that Mr Hoult may have been in a relationship with someone dating back to his time in prison. He described this person as his "one true love".

Contact with Mr Hoult's family

59. Mr Hoult's family were notified of his death by the police on 7 May, once his body had been identified. A senior probation service manager telephoned Mr Hoult's next of kin shortly after 10.00pm on 7 May to offer his condolences and discuss next steps.

60. Ashley House maintained contact with Mr Hoult's family and, in line with national instructions, offered to contribute to the costs of the funeral.

Support for residents and staff

61. The AP manager spoke to staff and residents who had had interactions with Mr Hoult and provided contact details for support organisations if they wanted further support.

Post-mortem report

62. A post-mortem examination identified Mr Hoult's cause of death as multiple injuries.

63. Toxicology tests found a blood alcohol level of 36mg per 100ml, which is significantly below the legal limit for driving. No other drugs were detected on analysis or screening.

Findings

Management of Mr Hoult's risk of suicide

64. There is evidence of good joint working between Mr Hoult's two offender managers and good interaction with AP staff during Mr Hoult's time at Ashley House.

65. In their statements and in interview, AP staff described Mr Hoult as a positive and upbeat person and expressed their complete shock and surprise that he chose to take his own life. Throughout his time at Ashley House, Mr Hoult gave staff no indication that he was at risk of suicide, and we can only speculate as to why he killed himself.

66. Mr Hoult had been in prison for 15 years. After a sentence of that length, it is likely to take time to readjust after release and to get used to the responsibilities that accompany freedom. While at Leyhill, Mr Hoult had used his periods of day release to explore employment and accommodation options and he seemed motivated and positive and talked about opening his own business. However, the reality of finding employment and accommodation, especially during the pandemic, may have felt very different.

67. Finding employment after release is a key factor that reduces the risk of reoffending. We, therefore, share HMIP's disappointment that Mr Hoult was effectively left to find employment himself and that so little was done at Leyhill to help prisoners into employment (for example, forming links with employers in the community).

68. Without a job, Mr Hoult would have been unable to afford the kind of accommodation he seems to have wanted, and would almost certainly have had to move into some kind of hostel for homeless people, which he did not want to do. His three months at Ashley House were almost over by the time he died, and he had still not been able to find accommodation. It is possible that Mr Hoult's worry about a lack of secure accommodation for the future was a factor in his suicide – but we do not know.

69. There is also evidence that Mr Hoult was in a relationship with a woman in the Bristol/Gloucester area which pre-dated his release from prison. Given the nature of his offending, Mr Hoult should have disclosed this to his offender manager, but had not done so. Mr Hoult had made two serious suicide attempts in the past following the ending of a relationship, but we have no way of knowing whether that may have been an issue at the time he died.

70. Mr Hoult's family also wondered if his stomach problems may have been a factor in his suicide, but there is nothing to suggest he raised this with anyone at the time or that his condition was particularly serious.

71. Given the way Mr Hoult presented and the risk information available to them, we do not consider that his offender managers or the AP staff could have foreseen or prevented his death.

72. However, we are concerned that the details of Mr Hoult's most recent ACCT (opened at HMP Wymott in December 2018) were not known to his offender manager when she completed his OASys report, and that AP staff did not know about this ACCT at all when they considered Mr Hoult's 'risk to self' on 22 February. Although Mr Hoult did not self-harm while on the ACCT, and the ACCT was over two years before his release, we consider that all relevant information should have been available to AP and probation staff so that they had a complete picture when assessing his current level of risk.

73. Although we cannot say whether this would have in any way affected the outcome for Mr Hoult, it is possible that AP staff may have assessed his current level of risk differently and provided him with additional support if they had known about the ACCT.

74. We make the following recommendations:

The Governor of HMP Leyhill should ensure that there is a broad range of community work placements which allow prisoners to progress, develop skills and demonstrate a reduction in their risk, and to help them find employment on release.

The Probation Service should remind offender managers to ensure that:

- **they obtain details of any time an offender has spent under ACCT procedures prior to release; and**
- **share this with AP staff to inform 'risk to self' assessments.**

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