Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terry Pryor, a prisoner at Ashley House Approved Premises, on 3 March 2021

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

Our vision

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

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

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 Terry Pryor was found hanging in his room at Ashley House Approved Premises (AP) on 1 March 2021. He died in hospital of hypoxic brain injury (lack of oxygen to the brain) on 3 March. He was 55 years old. I offer my condolences to Mr Pryor's family and friends.

I have some concerns about the risk assessment process carried out when Mr Pryor arrived at Ashley House five days before he hanged himself. However, I do not consider that Mr Pryor's risk to himself would have justified checks frequent enough to have prevented his actions.

Mr Pryor was discovered hanging by a workman who was not employed by the AP and who had gone to his room to carry out maintenance work. This meant there was a delay of a couple of minutes before AP staff arrived and cut Mr Pryor down and began resuscitation. We cannot say if this delay affected the outcome for Mr Pryor, but we consider that anyone working in an AP should be able to summon help immediately in an emergency.

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 **January 2022**

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Summary

Events

1. Mr Terry Pryor was serving an Imprisonment for Public Protection (IPP) sentence. He was released from prison on 13 November 2019 and was on licence in the community.

2. In February 2021, Mr Pryor's Offender Manager (probation officer) became concerned that Mr Pryor had begun to disengage with probation services, regular contact with probation being a requirement of his licence. He had also lost his accommodation through arrears and substance misuse and was finding it difficult to cope with the restrictions imposed in response to the COVID-19 pandemic. Due to his increased risk, she found him accommodation in an Approved Premises (AP) as an alternative to recalling him to prison.

3. On 17 February, Mr Pryor arrived at Bridge House AP. A 'Risk to Self Assessment and Management Plan' was completed because he was low in mood. This recorded that Mr Pryor had had depression and suicidal thoughts for much of his life. He was currently feeling depressed and thinking of hanging himself and he said he had been using cocaine. His risk to himself was assessed as 'raised' and additional monitoring checks were put in place.

4. Bridge House was only able to provide short-term accommodation, so on 25 February, Mr Pryor moved to Ashley House AP. When he arrived, staff reviewed his risk. Based on his history, his presentation and what he had told them, they assessed his risk as 'low' and considered he did not need additional monitoring other than the routine checks.

5. Mr Pryor engaged with staff and raised no concerns over the next few days. He spent the majority of his time in the AP due to restrictions imposed in response to the pandemic.

6. On the morning of 1 March, Mr Pryor was seen leaving his room at 8.21am. He went outside for a cigarette and returned to his room at 8.28am. He raised no concerns.

7. At 9.15am, a workman entered Mr Pryor's room to repair a window. He found Mr Pryor suspended by a ligature in his wardrobe. He went to the office to alert AP staff. AP staff went to Mr Pryor's room, cut the ligature and telephoned 999. They began cardiopulmonary resuscitation (CPR).

8. Ambulance paramedics arrived and continued CPR. They recovered a pulse. Mr Pryor was taken to hospital but died three days later at 6.30pm on 3 March, without regaining consciousness.

Findings

9. We are concerned that the risk assessment conducted at Ashley House placed too much weight on what Mr Pryor said and how he was known to have behaved in the past and did not give sufficient weight to his current risk factors.

10. However, we do not consider that Mr Pryor's risk to himself would have merited sufficiently frequent checks to have prevented him hanging himself on 1 March.

11. Mr Pryor was found hanging by a workman who was not an employee of the AP. There was a delay of a couple of minutes while he went to the office to get help from AP staff. We do not consider that it would have been reasonable to expect him to have administered first aid to Mr Pryor, but we think he should have been able to summon help quickly in an emergency.

Recommendations

- The Ashley House Management Committee should:
  - remind staff that they need to consider a resident's current risk factors when assessing his risk to himself and should not rely solely on what he says, how he presents or on his behaviour in the past; and
  - ensure that staff receive refresher training in risk assessment and management.
- The National Approved Premises Team should ensure that anyone who is not a direct employee but who regularly works in an AP and has contact with residents, should be made aware of what they should do if they discover a resident has self-harmed, or in other circumstances where risk is raised.

The Investigation Process

12. The investigator issued notices to staff and residents at Ashley House AP informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Pryor's prison and medical records. She interviewed three members of staff in April 2021. All the interviews were conducted by telephone due to revised working practices during the COVID-19 pandemic.

14. We informed HM Coroner for Avon of the investigation. The Coroner gave us the cause of death. We have sent the Coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Pryor's next of kin, his niece, to explain the investigation and to ask if she had any matters, she wanted the investigation to consider. Mr Pryor's niece did not raise any concerns within the PPO's remit, although she asked why Mr Pryor was still subject to the IPP sentence.

16. Mr Pryor's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

17. The initial report was shared with the Probation Service. They did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

Ashley House Approved Premises (AP)

18. 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 a supportive, structured environment and an enhanced level of supervision in the community for high risk and difficult to manage offenders. Residents are responsible for their own healthcare and are expected to register with a GP.

19. 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, although there are plans for its management to be transferred to the Probation Service in the future. It provides accommodation for up to 22 male residents.

20. 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.

21. Each resident is allocated an assistant manager as a key worker (also known as a support officer). 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

22. Before Mr Pryor's death, there had only been one previous death at Ashley House, a self-inflicted death in 2005. There was subsequently another self-inflicted in May 2021. There are no obvious similarities between that death and Mr Pryor's apart from the fact that both deaths took AP staff by surprise.

Imprisonment for Public Protection (IPP) sentences

23. The IPP sentence was designed for offenders who were considered to pose a serious threat to the public, but whose offences did not warrant a life sentence.

24. An IPP sentence has a tariff (minimum time to serve in prison) but no defined release date. Someone with an IPP sentence can apply to the Parole Board for release once they have completed their tariff. The Parole Board will release an offender only if it is satisfied that it is no longer necessary for the protection of the public for the offender to be in prison.

25. On release IPP prisoners, are subject to a supervised licence, meaning that they may be recalled to prison if they commit any further offences or their risk to the public is considered to have increased.

26. The use of IPP sentences was abolished in 2012, although those who received an IPP sentence before this date continue to be subject to the terms of the original sentence.

Assessment, Care in Custody and Teamwork (ACCT)

27. 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.

28. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. 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.

29. A similar system for assessing and monitoring residents in used by the National Probation Service in Approved Premises. This is known as a 'risk to self' assessment.

Key Events

30. On 20 March 2003, Mr Terry Pryor received an Imprisonment for Public Protection (IPP) sentence for grievous bodily harm, with a tariff of just over five years. He was released on licence and recalled to prison on three occasions for failing to adhere to his licence conditions. The third recall was on 26 December 2018 and Mr Pryor was subsequently released on licence from HMP Bristol on 13 November 2019.

31. Mr Pryor had been subject to suicide and self-harm procedures, known as ACCT, on two occasions in 2005 and 2008, but had no recent history of self-harm in prison. He had a long history of illicit drug and alcohol use and, while in prison, he had demonstrated a desire to address this and remain abstinent and had completed various courses and gained employment.

Bridge House Approved Premises

32. Following his release on 13 November, Mr Pryor initially lived at Bridge House Approved Premises (AP) in Bristol before moving to live independently in the community.

33. In February 2021, Mr Pryor's Offender Manager (probation officer), became concerned that he had begun to disengage with probation services, regular contact with probation being a requirement of his licence. He had also lost his accommodation through arrears and substance misuse and was finding it difficult to cope with the restrictions imposed in response to the COVID-19 pandemic. Due to his increased risk, she looked for accommodation for Mr Pryor in an AP as an alternative to recalling him to prison.

34. On 17 February, Mr Pryor went to Bridge House AP. He had stayed there twice before, so was known to staff.

35. When Mr Pryor arrived at Bridge House, staff opened a 'Risk to Self – Assessment and Management Plan' because Mr Pryor was low in mood. The Plan recorded that he had had depression and periods of suicidal thoughts for much of his life and was currently feeling depressed and having thoughts of hanging himself. He had also been very anxious about the possibility of being recalled to prison. This had resulted in him disengaging with probation. Mr Pryor also said that he was using cocaine, and it was noted that this might be contributing to his depression, and that he was looking underweight. His GP had prescribed citalopram (an anti-depressant) but he had mislaid his medication.

36. Mr Pryor told staff that he had been keeping busy by doing voluntary work in the community, but this had stopped due to the pandemic. He said that he was feeling safer now that he was at the AP and with staff around him. The Plan recorded that Mr Pryor's anxiety had subsided, knowing that he was not going to be recalled but that, although he had no previous history of suicide attempts, the possibility could not be ruled out and the document would remain open.

37. Mr Pryor's key risk factors were identified as continued cocaine use, disengaging from staff or absconding. Plans were made for him to see a GP and have his medication re-prescribed, and for staff to support him in finding new voluntary employment.

38. The Plan noted that the biggest concern was Mr Pryor's cocaine use. AP staff could not complete drug tests at that time due to COVID-19 safeguards, but the Plan recorded that Mr Pryor would be subject to searches if illicit drug use was suspected. His risk was recorded as raised and it was decided that hourly welfare checks would be completed during the day and additional checks during his first night at Bridge House. The Plan also recorded that staff should "check in" with Mr Pryor regularly to see how he was feeling and to check for any signs of substance misuse.

39. Because Bridge House could only offer Mr Pryor a short-term placement, Mr Pryor's Offender Manager contacted the manager at Ashley House AP, to ask whether he could move there. The manager said he knew Mr Pryor from previous periods he had spent at Ashley House and was aware of the issues he had. He offered Mr Pryor a bed from 25 February until 1 April, with a possibility of extending this if space was available. The plan was for Mr Pryor to be able to move back into the community from around 8 April after a period of re-engagement with probation.

Ashley House Approved Premises

40. Mr Pryor moved into Ashley House AP on Thursday 25 February. When he arrived, he completed an induction with a support worker and was provided with information about the AP, rules and housekeeping. The support worker also completed a 'risk to self' assessment and assessed Mr Pryor's risk as 'low'.

41. In the evening he had a meeting with an assistant manager, who was to be his keyworker at Ashley House. The assistant manager told the investigator that she had not met Mr Pryor before. She said he was a very calm person and she was able to tell that he had had some kind of counselling or had engaged with mental health services before because of the way he talked. She said that he was reflective, which was unusual for residents as they are often quite closed and do not want to talk about how they are feeling.

42. The assistant manager said that she was aware that a risk assessment had been completed at Bridge House. She was initially surprised that his risk had been assessed as 'low' at Ashley House, so she conducted her own risk assessment during her meeting with Mr Pryor. She said that she was convinced that there was no risk based on his presentation. She said that Mr Pryor said at least twice that he did not have suicidal thoughts and that he was not planning to do anything to himself. She said that she asked him directly about his recent relapse with drugs as his low moods were linked to this. She said that Mr Pryor said that he felt he had let himself down by using cocaine again but that he felt better after having a phone call earlier that day with a community drug support worker. He assured her that he was not "giving up on himself" or his fight against addiction

43. The assistant manager told the investigator that following her session with Mr Pryor, she concluded that Mr Pryor presented a low risk of harm to himself and that she had no reason to increase observations from the routine checks completed on all residents at the AP.

44. On Friday 26 February, an assistant manager who had known Mr Pryor for some years, went through Mr Pryor's file. She also contacted Bridge House and asked for a copy of Mr Pryor's risk assessment. When she received a copy of the risk

assessment, she noticed that the 'raised' risk box was ticked so she decided to speak to Mr Pryor. She said that they discussed the fact that his risk had initially been assessed as raised, and whether he felt that the support he was receiving at Ashley House was adequate or whether he needed more frequent welfare checks.

45. The assistant manager said that Mr Pryor spoke about his recent relapse with cocaine and how he wanted to move on and put things behind him. He said that he did not want to return to prison and was grateful to her for giving him another chance in the community. She said that Mr Pryor was adamant that he did not want or need more than the regular AP checks and he said that they did not really help him. He said that if he had any problems then he would speak to staff. She said that she gave Mr Pryor some additional support telephone numbers should he need them and spent some time talking to him about previous occasions when he had been in another AP in Bristol.

46. She said she then completed a case review record on the Risk to Self Assessment and Management Plan and recorded that Mr Pryor's risk to himself was 'low' and left it for the manager's attention for Monday morning. She noted that staff were to speak to Mr Pryor daily and that his key worker should follow up if more support was required.

47. On the morning of 27 February, an assistant manager completed a routine check of each room. Mr Pryor was in his room and told her that he was going to see his partner. She said that she was not sure of the exact terms of his licence conditions so went to the office to check. A condition of his original licence was to have no contact with his estranged partner or to visit her address without the prior approval of his Offender Manager.

48. While she was in the office, Mr Pryor came in and asked if he could use the office phone to contact his partner as he had no credit on his mobile phone. The assistant manager challenged Mr Pryor about the fact he was not allowed contact with his partner. Mr Pryor told her that this was a new partner and not his estranged partner to whom the restrictions applied. She allowed him to use the office telephone and remained in the office while he did so. Mr Pryor telephoned his partner and when he came off the phone, he told her that his partner said that she was going shopping with her daughter. Mr Pryor then went back to his room.

49. As part of his licence conditions, Mr Pryor was required to sign in at the office at Ashley House at 1.00pm each day. He did this on 26, 27 and 28 February as required, and raised no concerns.

Events of 1 March

50. On 1 March, a night worker at the AP completed a check of all residents at around 7.00am. She said she could not remember whether she had actually seen Mr Pryor but that she received a verbal response from all the residents.

51. A resident later told AP staff that he had seen Mr Pryor at around 7.30am and that he had appeared fine. CCTV shows Mr Pryor leaving his room at 8.21am and going outside to have a cigarette. He re-entered the building at 8.26am. He stopped briefly to make himself a hot drink then returned to his room at 8.28am.

52. A previous assistant manager at Ashley House and now looks after the maintenance on a self-employed basis. He was upgrading the windows and doors and told the investigator that he had previously taken measurements of the window in Mr Pryor's room (Room 6) but needed to do some final checks. CCTV shows him entering Mr Pryor's room at 9.15am.

53. The previous assistant manager told the investigator that when he reached Room 6, he knocked on the door and received no response. He then entered the room and saw the doors to the cupboard in the room open. He could see Mr Pryor's legs sticking out from behind the door as if he was sitting in the cupboard. he said that he moved forward saying, 'Oh I am sorry, I did knock,' and that as he rounded the door, he saw Mr Pryor suspended by a ligature around his neck.

54. The previous assistant manager said that it was a shock and it took him a few seconds to understand what he was seeing, and then his immediate thought was that he needed to inform the staff downstairs. CCTV shows him momentarily leaving the room, before going back in. He said that on leaving the room, he realised that he did not know what Mr Pryor's condition was. He went back in the room and checked for a pulse but could not find one, although Mr Pryor felt warm to the touch. He did not remove the ligature. He left the room at 9.16am and went downstairs to the office to inform AP staff.

55. The AP manager was in the office with an assistant manager, when the previous assistant manager came into the office at 9.17am and told them that he had found the occupant of Room 6 hanging. All three immediately made their way up to Room 6 and took a first aid 'grab bag'.

56. The previous assistant manager they found Mr Pryor sitting in his wardrobe with a belt around his neck. He looked 'lifeless.' (He said he had not seen Mr Pryor since he arrived at Ashley House and did not immediately recognise him as he had lost so much weight.) He dialled 999 using his mobile telephone while the assistant manager used a cut down tool to release the ligature from Mr Pryor's neck and laid him on the floor. He confirmed that there was no pulse and started cardiopulmonary resuscitation (CPR) on the advice of the emergency call handler. He asked the assistant manager to collect the defibrillator and they continued with CPR.

57. The assistant manager returned with the defibrillator and attached it to Mr Pryor's chest. It advised to continue with CPR. The assistant manager and the AP manager alternated compressions between them. The assistant manager is first aid trained and had completed an advanced first aid course, the AP manager had completed a first aid course although his certificate was out of date and the previous assistant manager was not first aid trained.

58. Paramedics arrived at the AP at 9.30am and advised the staff to continue chest compressions while they put on personal protective equipment (PPE). They then asked the staff to leave the room. Over the next 10 -15 minutes further paramedics arrived, together with a critical care doctor, and attempts to resuscitate Mr Pryor continued. Eventually, a pulse was detected, and at 10.15am, Mr Pryor was transferred to Southmead Hospital by emergency ambulance.

59. Mr Pryor did not respond to treatment in hospital. He had no brain function and was kept on life support so that his organs could be donated in line with his wishes. At 6.30pm on 3 March, it was confirmed that Mr Pryor had died.

Contact with Mr Pryor's family

60. On 1 March, Mr Pryor's Offender Manager contacted Mr Pryor's next of kin, his niece, to inform her that Mr Pryor had been taken to hospital.

61. The AP manager said that Mr Pryor's niece later contacted the AP and asked whether he had left a suicide note, which he had not. She visited the AP to collect Mr Pryor's belongings.

62. The National Probation Service contributed towards the costs of Mr Pryor's funeral in line with national guidance.

Support for residents and staff

63. Residents and staff received support following Mr Pryor's death. Mr Pitman ensured that staff and residents had the opportunity to talk about what had happened individually or as a group, and contact details for the Samaritans were provided to those residents who attended the meeting.

64. The AP manager told the investigator that following the incident, a discussion took place between the staff and as a result, the rails in the wardrobes in residents' rooms have been changed to ones that would not support the weight of a person, in an attempt to make the rooms safer.

Cause of death

65. No post-mortem was conducted, and the coroner accepted the cause of death provided by a hospital doctor as hypoxic brain injury caused by a lack of oxygen to the brain. No post-mortem toxicology tests were carried out.

Findings

Consideration of Mr Pryor's risk to himself

66. We have considered whether Mr Pryor's risk to himself was appropriately assessed and managed by AP staff.

67. When Mr Pryor arrived at Bridge House on 17 February, a 'risk to self' document was opened in response to his low mood. His risk was assessed as 'raised' and staff were asked to 'check in' with him regularly and to watch for signs of substance misuse (which was considered to be his most significant risk factor).

68. When Mr Pryor moved to Ashley House on 25 February, his risk was assessed as 'low'. This was on the basis that he said he was feeling better, denied suicidal thoughts, and said that he did not want the extra checks and that he would speak to staff if he needed support. Staff were to speak to him daily, but there is no evidence to show whether they did or not.

69. The risk assessment at Ashley House was less detailed than the one completed at Bridge House. It did not highlight the risks of Mr Pryor using cocaine to the same extent and did not specify the support he was to be given by his key worker. In assessing Mr Pryor's risk, an assistant manager (who did not know Mr Pryor) and another assistant manager (who knew him well) both relied very much on what Mr Pryor told them and how he presented. An assistant manager also took into account the fact that, although Mr Pryor was known to have a history of suicidal thoughts, he had never previously acted on them.

70. We are conscious that we have the benefit of hindsight. Nevertheless, we consider that they relied too heavily on what Mr Pryor said and how he presented and did not give sufficient consideration to his risk factors, particularly the risk of using cocaine again. No post-mortem toxicology tests were conducted and so we do not know if Mr Pryor had used cocaine or other drugs on 1 March or if this played any part in his decision to hang himself. However, we think that the risk assessment should have paid more attention to this, particularly as staff were not able to conduct drug tests during the pandemic and therefore had to rely on their observations of Mr Pryor.

71. The AP manager described Mr Pryor's relationship with his partner as 'toxic' and said that she was a known drug user. We do not know if Mr Pryor told an assistant manager the truth when he said the phone call, he made on 27 February was to a new partner. Although she acted appropriately in challenging Mr Pryor about his contact with his partner, we consider that she could have asked more questions about the new partner.

72. We note that the AP manager told the investigator that staff at Ashley House had had very little training in suicide and self-harm assessment and management. He thought that some of the assistant managers had done a one-hour session on the subject.

73. We do not know what, if anything, happened on the morning of 1 March that caused Mr Pryor to hang himself. However, despite our concerns about the robustness of the risk assessment, we consider that, even if his risk had been assessed as

'raised' and additional checks had been in place, it is unlikely that they would have been sufficiently frequent to have prevented his actions that morning.

74. We make the following recommendation:

The Ashley House Management Committee should:

- **remind staff that they need to consider a resident's current risk factors when assessing his risk to himself and should not rely solely on what he says, how he presents or on his behaviour in the past; and**
- **ensure that staff receive refresher training in risk assessment and management.**

Emergency response

75. When the previous assistant manager discovered Mr Pryor, he was initially shocked. He then left the room before returning to check Mr Pryor for signs of life. Although he checked Mr Pryor for a pulse, he did not remove the ligature from Mr Pryor's neck. There was, therefore, a delay of a couple of minutes between him finding Mr Pryor and the AP staff arriving and removing the ligature. We cannot say whether this delay affected the outcome for Mr Pryor.

76. Although the previous assistant manager is not employed by Ashley House, he does work there regularly and has contact with residents and sometimes needs to enter residents' rooms. In the nature of things, residents in APs present a higher risk to themselves and others than will be the case in many other settings where people may work.

77. In these circumstances, we think that anyone who regularly works in an AP and has contact with residents should be briefed about what to do in circumstances that may pose a risk (such as a resident disclosing suicidal thoughts; finding a resident seriously ill or unresponsive; or observing drug taking or violent or threatening behaviour). We consider that it would also be reasonable for them to carry a personal alarm so they can summon help in an emergency for themselves or residents.

78. We make the following recommendations:

The National Approved Premises Team should ensure that anyone who is not a direct employee but who regularly works in an AP and has contact with residents should be made aware what they should do in if they discover a resident has self-harmed, or in other circumstances where risk is raised.

79. Approved premises staff are trained to deliver first aid and training should be updated every three years to ensure that these skills are kept up to date. The AP manager told the investigator that all staff at the AP had up to date first aid and advanced first aid training, although his had recently expired. We are satisfied that staff responded promptly and effectively when Mr Pryor was found hanging.

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Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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T l 020 7633 4100