Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Clide Thompson on 30 January 2022, following his release from HMP Moorland

A report by the Prisons and Probation Ombudsman

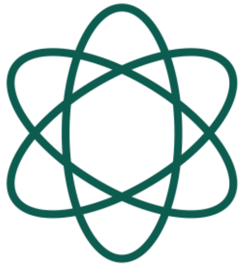
Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T I 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

OGL

© Crown copyright, 2023

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

Summary

1. 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.

2. From 6 September 2021, the PPO is investigating post-release deaths that occur within 14 days of the prisoner's release.

3. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

4. Mr Clide Thompson was found hanged at his home on 30 January 2022 following his release from HMP Moorland on 26 January. He was 42 years old. We offer our condolences to those who knew him.

5. Mr Thompson wrote a complaint to a Senior Probation Officer (SPO) because he was unhappy that his Community Offender Manager (COM) had assessed that his mother's address was an unsuitable release address for him. We found that the SPO did not follow the complaints process correctly.

Recommendations

- The Head of Leeds Probation Delivery Unit should:
  - ensure SPOs follow the correct process to resolve complaints, as per Probation Instruction 51/2014; and
  - arrange for a manager to share this report with the SPO and discuss the Ombudsman's findings with her.

The Investigation Process

6. The PPO investigator obtained copies of relevant extracts from Mr Thompson's prison and probation records.

7. The investigator interviewed Mr Thompson's Prison Offender Manager (POM) at HMP Moorland on 7 March and Mr Thompson's COM at Leeds Probation on 15 March.

8. We informed HM Coroner for Bradford of the investigation. They gave us the results of the post-mortem examination and toxicology reports. We have sent the Coroner a copy of this report.

9. The Ombudsman's family liaison officer contacted Mr Thompson's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Moorland

11. HMP Moorland is a category C prison which holds approximately 1000 adult male prisoners who have either been convicted or are on remand. It is managed by Her Majesty's Prison Service.

Probation Service

12. Probation services supervise individuals serving community orders, provide offenders with resettlement services while they are in prison (in anticipation of their release) and supervise all individuals sentenced for offences committed after the Offender Rehabilitation Act 2014, for a minimum of 12 months after they are released from prison.

Key Events

13. On 24 August 2021, Mr Clide Thompson was remanded in prison custody after breaching a restraining order. He was sent to HMP Hull. In October, Mr Thompson was convicted and sentenced to 16 months imprisonment.

14. Mr Thompson was already under the care of Leeds Probation for a previous violent offence and therefore had a Community Offender Manager (COM). While Mr Thompson was in prison, the COM's role was to assess the suitability of addresses given by him, for his release.

15. On 1 November, Mr Thompson was moved to HMP Moorland. He reported no current thoughts of suicide or self-harm during his induction.

16. On 2 November, Mr Thompson was allocated a Prison Offender Manager (POM). Her role was to provide practical and emotional support while in prison, and support with release planning activities such as accommodation referrals.

17. On 8 November, Mr Thompson rang his COM. He asked her if she would be completing address checks for his release. She confirmed this and agreed to start completing checks on his mother's address.

18. On 11 November, Mr Thompson's COM spoke with his mother to assess the suitability of her address. The COM assessed the address was unsuitable due to victim safety issues.

19. The same day, Mr Thompson rang his COM to discuss the conversation she had with his mother. His COM explained why she assessed the address was unsuitable and Mr Thompson was frustrated by this. His COM said they would need to explore alternative addresses for his release.

20. On 19 November, Mr Thompson rang his COM as he remained unhappy with her decision. She once again explained the reasons and said if he provided an alternative address, she would complete the necessary checks. He said he wanted a new COM and wanted to make a complaint. A case administrator sent him a leaflet explaining the complaint process.

21. On 24 November, Mr Thompson sent a complaint to his COM's line manager, a Senior Probation Officer (SPO), in which he requested a new COM. The SPO told the investigator she did not discuss the complaint with Mr Thompson or escalate it to the complaints team. She said this was due to a high workload at the time and she did not prioritise completing this task.

22. On 3 December, Mr Thompson's COM started checks on his sister's address after he provided this as a potential release address.

23. On 13 December, Mr Thompson's COM submitted paperwork to Moorland saying that Mr Thompson's sister's address was unsuitable, again due to victim safety concerns. The following day, Mr Thompson's COM told Moorland that if Nacro Bail Accommodation and Support Service (BASS - temporary housing service for prisoners who are eligible for release but do not have a suitable address) accommodation became available, she would approve this for his release.

24. On 4 January 2022, Mr Thompson's POM made a referral to Nacro for BASS accommodation.

25. On 21 January, Nacro offered Mr Thompson a temporary accommodation placement.

26. On 26 January, Mr Thompson was released from prison. He attended an induction appointment with his COM which did not raise any concerns.

27. On 30 January, Mr Thompson's sister contacted the police after he sent texts to his mother saying he was going to hang himself. Police went to Mr Thompson's accommodation and found him hanged. Mr Thompson was pronounced dead at 10.57pm.

Post-mortem report

28. The post-mortem report concluded that Mr Thompson died from hanging.

Support for staff

29. During interview, Mr Thompson's POM told the investigator that she found out about Mr Thompson's death the following day from an SPO, who offered her support.

30. Mr Thompson's COM said she found out on 1 February, after a Nacro BASS worker left her a voicemail while she was on annual leave. She spoke with an SPO shortly after, who offered her support and information on services such as counselling.

Contact with Mr Thompson's family

31. Mr Thompson's family were already in contact with police on the night of his death. The police informed the family of Mr Thompson's death in person, after it had been verified.

Findings

Assessment of Mr Thompson's risk of suicide and self-harm

32. Mr Thompson gave no indication to either prison or probation staff that he was at risk of suicide or self-harm. On the day of his release from prison, he met with his COM and gave no cause for concern. We are satisfied that neither prison nor probation staff could have foreseen his death.

Complaints process not followed

33. In November 2021, Mr Thompson's COM assessed that the address he had put forward for his release, his mother's address, was not suitable. She explained the reasons for this to Mr Thompson, but he remained unhappy and wrote a complaint to the SPO asking for a new COM. The SPO did not respond to Mr Thompson or escalate his complaint.

34. Probation Instruction (PI) 51/2014 says line managers should, in the first instance, attempt to resolve any issues informally with the complainant. If the complaint remains unresolved, line managers should escalate them to the Divisional Director. The SPO did not follow either part of the process. We recommend:

The Head of Leeds Probation Delivery Unit should:

- ensure SPOs follow the correct process to resolve complaints, as per Probation Instruction 51/2014; and
- arrange for a manager to share this report with the SPO and discuss the Ombudsman's findings with her.

Inquest conclusion

35. The inquest into Mr Thompson's death, held on 12 May 2023, gave a narrative conclusion. It set out the circumstances in which Mr Thompson was found and noted that there were no suspicious circumstances or third party involvement.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **August 2022**

Prisons & Probation Ombudsman
Independent Investigations

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

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

T I 020 7633 4100