Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Reginald Roach, a prisoner at Ty Newydd Approved Premises, on 5 November 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Reginald Roach was a resident at Ty Newydd Approved Premises (AP). He died in hospital from shock and haemorrhage caused by incised wounds after he removed his genitalia on 6 November 2022. He was 63 years old. I offer my condolences to Mr Roach's family and friends.

Mr Roach had been released from prison six days before he died, and had a history of mental health issues, substance misuse and self-harm. Although Mr Roach died in violent circumstances, AP staff provided good and effective care and did their best to meet his needs and manage his risk appropriately during his short time at the AP.

There was clear evidence of good joined-up working on Mr Roach's release from prison. It was positive to see that HMP Berwyn also did their best to ensure Mr Roach's safety on release by escorting him 80 miles to meet his probation officer. The probation service and the Community Resettlement Team referred him promptly to the community mental health team and his GP. AP staff also promptly arranged for him to receive his prescribed medication.

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

Adrian Usher
Prisons and Probation Ombudsman **June 2023**

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Summary

Events

1. Mr Reginald Roach was remanded into custody in September 2022 for a sexual offence. On 31 October, he was sentenced to eight weeks in prison.

2. Due to the time he had served on remand, he was released on licence to Ty Newydd Approved Premises (AP) on 1 November 2022.

3. Mr Roach had a history of self-harm, substance misuse and mental health issues. As part of his induction, AP staff explained to Mr Roach his licence conditions and the AP rules.

4. Staff said that he was sometimes confused and his poor mental health appeared to hinder his understanding of his situation. He also displayed some remorse for his offence and expressed some fleeting thoughts of self-harm.

4. At 10.00am on 5 November, Mr Roach left the AP. He failed to return before his curfew time at 11.00pm and staff reported him as 'unlawfully at large'. The next day, a member of the public found him unconscious in a park, having removed his genitals. Paramedics attended and he was taken to hospital, where he died at 1.08pm.

5. The post-mortem examination confirmed that Mr Roach died from shock and haemorrhage caused by incised wounds having removed his genitalia.

Findings

Good practice: Management of Mr Roach's risk

6. AP staff appropriately assessed Mr Roach's risk of self-harm during his induction and offered a supportive environment in which he could address his offending behaviour.

Other learning

7. Although the police broke the news of Mr Roach's death to his family, the AP should have contacted his family within 48 hours, in line with national instructions.

The Investigation Process

8. The PPO was notified of Mr Roach's death on 7 November 2022. The investigator issued notices to staff and prisoners at Ty Newydd Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

9. The investigator obtained copies of relevant extracts from Mr Roach's probation records. He interviewed five members of staff in December 2022. He liaised with the police who shared relevant information about Mr Roach's death.

10. We informed HM Senior Coroner for North Wales (West) of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

11. We wrote to Mr Roach's next of kin to explain the investigation. They had no specific questions.

12. The initial report was shared with the Regional Probation Director for Wales, who identified no factual inaccuracies.

Background Information

Ty Newydd AP

13. APs (formerly known as probation or bail hostels) accommodate those 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.

14. Ty Newydd AP in Wales is managed by the National Probation Service. It holds up to 17 men in single rooms. Each resident is allocated a key worker/offender supervisor to oversee their progress and wellbeing and to ensure that residents adhere to their licence conditions and the premises rules.

15. Residents are subject to AP rules in addition to any licence conditions they have been given. They are not allowed to leave the building between 11.00pm and 6.00am. Ty Newydd is staffed 24-hours a day.

Previous deaths at Ty Newydd AP

16. Mr Roach was first resident to die at Ty Newydd AP since January 2011.

Key Events

17. On 13 September 2022, Mr Reginald Roach was remanded in custody for failing to comply with a sex offender notification order. He was sent to HMP Berwyn. He had a history of violent offending, self-harm, substance misuse and had a personality disorder, bipolar disorder, schizophrenia and frontal lobe damage. He was known to the community mental healthcare team and was under the care of the prison's mental health team.

18. Prison staff described Mr Roach as frail. From 25 September, they monitored him under suicide and self-harm prevention procedures, known as ACCT, after he made serious cuts to his arm. Mr Roach said he harmed himself because he felt guilty about the sexual offence he had committed.

19. Following a psychiatric assessment on 12 October, it was noted that Mr Roach had significant cognitive deficits, struggled with his memory, was at times unable to recall his name or that he had harmed himself. He also claimed that he was Hitler and wanted to be spoken to in German. It was noted he had exposed his genitals to a prison officer and often made inappropriate sexual remarks.

20. At his ACCT review on 27 October, Mr Roach denied having thoughts of suicide or self-harm and prison staff reduced the level of ACCT monitoring. That day, the prison psychiatrist reviewed Mr Roach and prescribed risperidone (an antipsychotic).

21. On 31 October, Mr Roach attended court and was sentenced to eight weeks in prison. As his eligibility date for his conditional release from prison had passed, immediate arrangements were made for Mr Roach to be released from prison. It was agreed that Mr Roach would be released the next day as it was late in the day, his mental health was poor and he had nowhere to live in the community. It was hoped that this would give the probation service extra time to find him urgent accommodation.

1 November 2022

22. On 1 November, the probation service initially made an urgent accommodation referral for Mr Roach to the local authority in Wales. The local authority said that they were unable to house Mr Roach for a couple of days and suggested that Mr Roach could perhaps be housed in an AP in Wales until then. A probation officer, subsequently applied for Mr Roach to have for a short-term place in an AP.

23. The probation officer told us that the prison had confirmed that Mr Roach was not being released with any prescribed medication. The referral noted that Mr Roach was unexpectedly being released that day, and had no accommodation arranged. It noted that he was chaotic, unpredictable and had previously been sectioned under the Mental Health Act. It also noted that he had been diagnosed with schizophrenia and brain damage following a road traffic accident decades earlier. His engagement with the community mental health team was described as sporadic. The probation officer told us he had tried many times to contact Mr Roach's community GP but was unable to obtain any additional information. The mental health team at Berwyn also referred Mr Roach to the community mental health team and his GP for

support. They explained that he had been released from prison that day, described his presentation and asked for him to be reviewed.

24. Mr Roach secured a place in Ty Newydd AP until 3 November, after which the plan was for the local authority to find him accommodation.

25. Later that day, Mr Roach was released from HMP Berwyn on licence. A prison duty driver drove Mr Roach to North Wales to meet his probation officer due to concerns about his mental capacity to make the 80-mile journey himself.

26. The probation officer met Mr Roach at Llangefni police station at 5.30pm. Mr Murphy explained Mr Roach's licence conditions to him and that he had arranged emergency accommodation for him at Ty Newydd AP.

27. At interview, the probation officer told us that while he had no specific concerns about Mr Roach during their conversation, he noted his mental capacity appeared low and that he was not able to hold a conversation. He said that Mr Roach kept repeating himself and at times appeared easily confused about staying at the AP. He said that Mr Roach was worried that he was considered a paedophile. He said that Mr Roach smirked and pointed towards his crotch and said, "I am cold now and have no use for these anymore. You can take them if you want." He said he thought that Mr Roach was trying to joke and he did not give his statement much more thought. He said that Mr Roach said that he was happy to have been allocated accommodation at the AP.

Ty Newydd AP

28. After the probation officer spoke to Mr Roach, the police drove Mr Roach to Ty Newydd AP. They arrived shortly before 8.00pm.

29. A residential worker started her night shift at 8.00pm. Because Mr Roach arrived late in the day, she and a relief worker at the AP, completed a short induction with him, including completing a support and safety plan (a guided welfare assessment to identify and manage residents who needed additional support).

30. The residential worker noted that Mr Roach had recently been monitored under ACCT procedures in prison after he harmed himself in September 2022 and asked him about this. Mr Roach described the incident as a cry for help and said that he had had no intention to take his life. He denied thoughts of suicide or self-harm and said he felt safe at the AP. He talked about his offence of exposure and said that he had not meant to hurt anyone. He said the best thing for him would be to cut off his penis and testicles which, in the context of their conversation, she considered he said in jest. He said he was not taking any medication but asked for an appointment with the local GP as he had previously been prescribed medication, including risperidone, codeine (for pain relief) and sertraline (an antidepressant).

31. The residential worker told us that Mr Roach appeared to understand parts of their discussion. However, the induction process took longer than usual, and it was noted that Mr Roach would likely have to be reminded regularly about the AP rules because of his low mental capacity. Mr Roach said he was tired and wanted to settle for the night.

32. AP staff showed him to his room. The residential worker thought that Mr Roach was "clearly unwell, both mentally and physically…" and looked "very thin and frail" but did not present as being at immediate risk of self-harm. She told the AP area manager, about Mr Roach. It was agreed that staff would monitor him hourly during his first night at the AP. Staff also ensured that Mr Roach had no sharp-edged items (such as razor blades) with him. Staff raised no concerns about Mr Roach that night.

2 November

33. AP staff emailed the probation officer and confirmed that there were no concerns about Mr Roach at the AP and he had settled overnight. Mr Roach said that he had previously been prescribed medication so the probation officer contacted, Mr Roach's Community Resettlement Officer, in Anglesey County Council. She said she would contact Mr Roach's GP so that his medication could be restarted. She also confirmed that Mr Roach was already on the community mental health team's caseload and had been referred for support.

34. That day, a Probation Service Officer (PSO) completed Mr Roach's second-stage induction. He noted that Mr Roach appeared confused but had periods when he seemed lucid. The PSO noted that the local authority had arranged new accommodation for Mr Roach to move into the following day so it was not practical for him to be registered with the AP's local GP. Instead, the PSO contacted Mr Roach's previous GP surgery which was closer to his new accommodation. When he called them, he found out that Mr Roach's Community Resettlement Officer had also contacted them. The surgery agreed to review Mr Roach's medical history and he could see the GP when he moved. The probation officer was due to visit him at the AP the following day.

35. The PSO spoke again to Mr Roach later that day and discussed his move to his new accommodation. Mr Roach appeared happy about it.

36. At around 11.00pm, a PSO noted that Mr Roach had wanted to leave the AP after the curfew time. He said Mr Roach presented as "being very vacant, despondent", and expressed "suicidal ideation". He sought advice from the AP area manager who advised that Mr Roach should be monitored every half an hour until he fell asleep. However, Mr Roach stayed awake for most of the night. AP staff spoke to Mr Roach at length throughout the night and tried to encourage and reassure him. The PSO noted that Mr Roach repeated himself, kept losing track of what he said, appeared overcome with remorse and regret and said he could not live with himself and intended to do something drastic when he left the AP. The PSO considered that Mr Roach was displaying dementia-like symptoms. However, he said that by the morning, Mr Roach's mood had improved and he appeared more optimistic about moving to a new flat.

3 November

37. At 7.06am on 3 November, the PSO emailed the probation officer about Mr Roach's presentation the previous night.

38. At around 7.50am, just before his shift finished, the PSO completed a handover to staff, including updating them about Mr Roach. He also checked on Mr Roach but had no concerns at that time.

39. At around 9.00am, Mr Roach walked out of the AP without signing out or telling staff where he was going. This broke the AP rules. Due to the recent concerns about his mental health and that he posed a risk to the public for exposure, staff reported him missing to the police and told his probation officer.

40. At around 10.30am, the police found Mr Roach, and returned him to the AP at around 11.00am. The AP manager told us that the police raised no concerns about him.

41. That afternoon, the probation officer visited Mr Roach at the AP to discuss his recent behaviour. He said that Mr Roach appeared confused and could not explain why he had left the AP or where he had gone. He produced a set of keys which he said belonged to a previous flat where he had lived and he said he was not sure if he was supposed to return to that address. He told Mr Roach that unfortunately, the bed space that had originally been offered to him had been withdrawn but alternative accommodation had been secured and would be ready for him on 7 November. He said that Mr Roach seemed happy about this. He also told him that the community mental health team and GP had agreed to restart his medication which would be delivered to the AP the next day and dispensed by AP staff. He noted that the news about his medication and impending move appeared to have a positive effect on Mr Roach.

42. That afternoon, the AP manager conducted a welfare check on Mr Roach. He said that Mr Roach's mood and emotional state appeared to have improved.

43. Mr Roach's medications were hand-delivered to the AP that afternoon.

44. A PSO conducted another welfare check on Mr Roach later that day and raised no concerns.

4 November

45. On the morning of 4 November, Mr Roach told staff that he wanted to leave the AP because he had herpes which he was concerned he may pass on to other residents. Staff reassured him that this was not possible and reminded him that he was leaving the AP soon.

46. A PSO noted that although Mr Roach was aware that the GP had prescribed him medication, he had refused to take them. It was noted that Mr Roach spent large parts of the day walking in, around and out of the AP. (His AP medication sheet showed that he had not taken any of his antidepressants.)

5 November

47. At 10.00am on 5 November, Mr Roach walked out of the AP without signing out or telling staff where he was going. AP staff tried to phone Mr Roach several times that day but he failed to respond.

48. As Mr Roach had not returned to the AP before the curfew time of 11.00pm, AP staff contacted the on-call manager who started the emergency process for recalling Mr Roach's licence.

Sunday 6 November

49. At around 10.00am on 6 November, the police contacted the AP and told them that Mr Roach had been taken to hospital after a member of the public had found him earlier that morning, unconscious in a field, around a mile from the AP. It was noted that Mr Roach had cut off his penis and testicles.

50. The police later told the AP that Mr Roach had died in hospital at 1.08pm. His AP room was sealed on the instructions of the police as it was considered a crime scene.

Contact with Mr Roach's family

51. The police notified Mr Roach's family of his death at 4.00pm that day and visited them the next day.

52. The Wales Approved Premises Area Manager was appointed as the single point of contact for Mr Roach's next of kin. She sent a letter of condolence to Mr Roach's next of kin on 18 November, offering support and in line with national instructions, offered to contribute to the costs of the funeral.

Support for residents and staff

53. The AP manager spoke to staff and residents who had had interactions with Mr Roach and gave them information about how to access support if they needed it.

Post-mortem report

54. The post-mortem examination confirmed that Mr Roach died from shock and haemorrhage caused by incised wounds having removed his genitalia. It noted that he was likely to have bled profusely when he removed his genitals. The post-mortem toxicology tests did not find any alcohol or substances in Mr Roach's system.

Inquest

55. An inquest was concluded on 19 January 2024 which concluded that Mr Roach's death was due to suicide. The coroner gave a verdict in which she said:

    "Reginald Alan Roach was found on 6 November 2022 with self inflicted injuries from removing his genitalia. He was taken to Ysbyty Gwynedd where he died shortly after arriving on that day."

Findings

56. Although Mr Roach died in violent circumstances, AP staff provided effective care and did their best to meet his needs during his short time at the AP. We have set out below the good practice we found during our investigation.

Management of Mr Roach's risk

Good practice

57. There was clear evidence of good joined-up working and communication within the criminal justice system when Mr Roach was released from prison. It was noted that he was vulnerable and had a significant history of self-harm, substance misuse and poor mental health. Prison staff from HMP Berwyn escorted him more than 80 miles to meet his probation officer in order to ensure his safety. Probation and the Community Resettlement Team referred him promptly to the community mental health team and his GP due to his ongoing mental health concerns. AP staff appropriately and promptly repeated these actions when Mr Roach arrived at Ty Newydd AP. They also promptly arranged for him to receive his prescribed medication. Although Mr Roach refused to take his medication at the AP, it is unlikely that it would have had an immediate positive impact on his mental health in such a short period of time.

58. During Mr Roach's induction and first night at the AP, staff appropriately completed a support and safety plan for him as they were concerned about his mental capacity and history of self-harm. Mr Roach denied thoughts of self-harm. Although AP staff had no immediate concerns about Mr Roach's risk to himself, it was good practice that they monitored him frequently because of his low mental capacity and because he was a new resident. They recorded their actions well and communicated their observations to other probation staff so that appropriate steps could be taken to help Mr Roach settle at the AP.

59. Mr Roach had made comments to his probation officer and AP staff during his induction about removing his genitals. None of the staff considered these the comments were made with meaningful intent and on balance, it is reasonable, without the benefit of hindsight, that AP staff thought that he made the comments in jest rather than as an expression of his intention to harm himself.

60. Mr Roach twice broke the AP rules. This appeared to be as a direct result of his poor mental health, memory and his low mental capacity. On his second night at the AP, he tried to leave the premises and did not understand that this was not in line with the AP curfew time. While staff managed this situation, AP staff appropriately identified that Mr Roach was at risk of self-harm and monitored him regularly throughout the night. While their efforts appeared to have helped to reduce Mr Roach's immediate thoughts of self-harm at the time, he still presented as confused and went missing from the AP soon afterwards on his third day at the AP. Mr Roach's behaviour appeared irrational and unpredictable and the AP staff appropriately escalated the matter to the police, recognising his risk to the public and himself. Mr Roach was also well supported by his probation officer and the AP manager who regularly checked on him.

Other learning

61. When Mr Roach went missing for a second time, staff were not overly concerned and did not contact the police. Staff had raised no major concerns about him in the previous couple of days and, when he had previously gone missing, the police had raised no concerns about him. While Mr Roach's absence did not break the AP rules, he had once again failed to sign out of the AP and tell staff where he was going, and then did not return. We cannot know whether the police would have found him earlier and before he harmed himself if AP staff had reported him missing earlier in the day.

Contacting Mr Roach's next of kin

62. Probation Service instructions state that following the death of an AP resident, a single point of contact for the AP "should liaise with the police to ensure the next of kin is kept informed of the resident's death. The single point of contact should contact the next of kin to offer support and provide contact details within 24 hours and signpost as appropriate."

63. Although the police broke the news of Mr Roach's death to his next of kin, the AP did not contact them within 48 hours, in line with national instructions. AP staff did not make initial contact with Mr Roach's family until 18 November, 12 days after Mr Roach's death. Given that Mr Roach lived at the AP and was under their care, they should have done so sooner. AP staff have acknowledged this delay.

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