Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher MacGillivray on 14 October 2021, following his release from HMP Durham

A report by the Prisons and Probation Ombudsman

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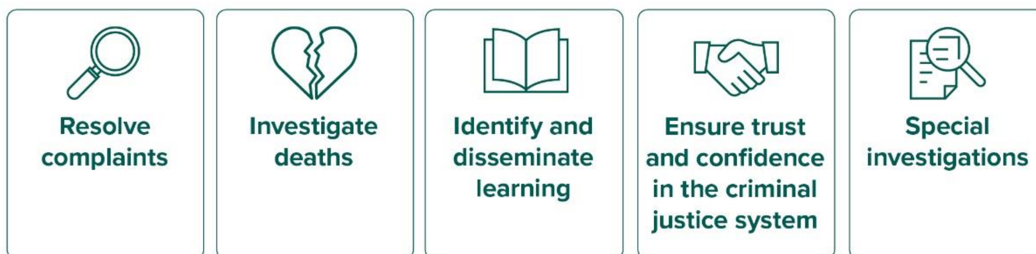
OUR VISION

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

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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 Christopher MacGillivray was found hanged at his home on 14 October 2021, following his release from HMP Durham on 12 October. He was 34 years old. We offer our condolences to those who knew him.

5. Mr MacGillivray was managed under Prison Service suicide and self-harm procedures (known as ACCT) from 10 October up to his release from prison. We are very concerned that the prison did not tell probation staff about this or provide any details about why he had been assessed as at risk of suicide and self-harm.

6. In April 2021, while under probation supervision, Mr MacGillivray was found standing on a bridge. He told police he was not suicidal but was having substance misuse and relationship issues. We found that the Community Offender Manager (COM) missed an opportunity to explore this incident with Mr MacGillivray. We also found that the case handover between that COM and the subsequent COM was not thorough. Also, we found that the COMs were not offered support following Mr MacGillivray's death.

Recommendations

- The Governor should ensure, in line with the Annex to PSI 64/2011, that where a prisoner has been subject to ACCT monitoring within 12 months of release, staff share relevant risk information with probation colleagues, including the community offender manager, prior to release.
- The Regional Probation Director North East should ensure that COMs explore incidents of concern with the service user and relevant intervention work is completed if required.
- The Regional Probation Director North East should ensure that officers:
- Complete detailed handovers when a case is transferred and record details in the probation record;
- Undertake a thorough review of records when given a new case.
- The Regional Probation Director North East should ensure COMs are offered support following the death of a service user on their caseload.

The Investigation Process

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

8. The investigator interviewed Mr MacGillivray's two most recent COMs on 8 December.

9. We informed HM Coroner for North Tyneside 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.

10. The Ombudsman's family liaison officer contacted Mr MacGillivray's next of kin, his ex-partner, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not ask any questions but shared her concerns about the support probation provided Mr MacGillivray and his mental health issues.

11. We shared our initial report with HM Prison and Probation Service (HMPPS). They pointed out that there was existing policy on sharing ACCT information with probation colleagues prior to release from prison and we amended our first recommendation as a result. They provided an action plan which is annexed to this report.

12. We sent a copy of our initial report to Mr MacGillivray's next of kin. She commented on the report but did not identify any specific factual inaccuracies.

Background Information

HMP Durham

13. HMP Durham is a category B prison which holds up to approximately 1000 male prisoners who have either been convicted or are on remand. It is managed by Her Majesty's Prison Service.

Probation Service

14. 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

15. In January 2021, Mr Christopher MacGillivray was convicted of motoring offences and sentenced to an 18-month suspended sentence order. He was allocated a Community Offender Manager (COM) at North Tyneside Probation to manage his sentence.

16. In March, Mr MacGillivray was further convicted of violent offences and received an additional 16 and a half month suspended sentence order, which ran alongside the order he was already serving.

17. On 7 April, Mr MacGillivray's COM reviewed his risk assessment report. The assessment noted a previous suicide attempt but did not assess Mr MacGillivray posed a risk to himself.

18. On 16 April, CCTV operators alerted police after they saw Mr MacGillivray standing on a bridge. Mr MacGillivray told the police he was having difficulties with alcohol, drugs and his relationship but he was not suicidal. Police passed this information to probation and on 19 April, Mr MacGillivray's COM logged it on Mr MacGillivray's probation record. There is no record that Mr MacGillivray's COM discussed the incident with him or that he updated his risk assessment.

19. On 19 May, a new COM took over Mr MacGillivray's case. The two COMs told the investigator that there was a handover, which consisted of an informal conversation about Mr MacGillivray's risk factors and current concerns, but this was not recorded on probation records. The new COM said she read through Mr MacGillivray's record but despite this, she said she was not aware of the events of 16 April.

20. On 17 September, police arrested Mr MacGillivray for theft from a motor vehicle. He was given bail and a condition of this was a curfew which was monitored electronically.

21. On 9 October, a member of the public reported to police that they were concerned about someone they saw on a bridge. Police attended and found Mr MacGillivray. He was found to have breached his curfew, so was arrested for breach of bail conditions. He was remanded in custody and transferred to HMP Durham the following day.

22. There is conflicting information around this incident. Police records state that officers had no concerns about Mr MacGillivray, however, when Mr MacGillivray arrived at Durham, he had documentation with him stating he had been under constant watch in police custody as he planned to jump from the bridge and had overdosed on drugs.

23. On 10 October, prison staff started suicide and self-harm prevention procedures (known as ACCT) because Mr MacGillivray had told a member of the drug and alcohol recovery team (DART) that he might harm himself. Staff put him on hourly observations.

24. The same day, a prison nurse completed a mental health assessment with Mr MacGillivray. She assessed that he did not need to be under the care of the mental

health team but that he should continue to work with DART. She noted that he appeared under the influence and did not engage fully with the assessment.

25. At an ACCT review the next day, Mr MacGillivray said that he did not expect to be in prison for long as he was expecting to get bail.

26. On 12 October, the court granted Mr MacGillivray bail. Prison staff held an ACCT review with Mr MacGillivray who said he was pleased to be getting out. They closed the ACCT. They did not pass any information about the ACCT to the probation service.

27. On 14 October, Mr MacGillivray's ex-partner found him hanged in his flat. Paramedics attended and at 2.30pm, pronounced him dead.

Post-mortem report

28. The post-mortem concluded that Mr MacGillivray died from pressure to his neck from hanging.

Support for Staff

29. During interview, Mr MacGillivray's previous COM said he found out about Mr MacGillivray's death from a police officer that worked with probation. He said he was not offered any support.

30. Mr MacGillivray's most recent COM said she thought a Senior Probation Officer (SPO) had told her of Mr MacGillivray's death. She said she was not offered any support, though she said she felt confident that she knew who to approach if she was struggling.

Contact with Mr MacGillivray's family

31. On 14 October, Mr MacGillivray's ex-partner, who was also his next of kin, reported to police that she had found him hanging in his flat. She was therefore already aware of Mr MacGillivray's death by the time probation staff were told.

Findings

Lack of handover between prison and probation about suicide and self-harm risk

32. Prison staff monitored Mr MacGillivray under ACCT from 10 October up to when he was released on bail on 12 October. This information was not passed to the probation service when Mr MacGillivray was released from prison.

33. The investigator spoke with the Safer Custody Team at HMP Durham to establish what procedures were in place around sharing suicide and self-harm concerns to probation upon release. He was told that if a prisoner was not on the mental health team's caseload, then no information was shared with external agencies upon release.

34. Mr MacGillivray had been assessed by prison staff as being at risk of suicide and self-harm and an ACCT was opened on 10 October. The ACCT was only closed two days later because Mr MacGillivray was released from prison. Had he remained in prison, he would have remained on an ACCT, until such time as staff assessed that he no longer posed a risk to himself. We find it extremely concerning therefore, that no information about Mr MacGillivray's risk of suicide and self-harm was shared with community probation staff upon release. During ACCT meetings, Mr MacGillivray had shared that he expected to be bailed, so there would have been ample time for prison staff to ensure suicide and self-harm concerns got passed to probation staff upon his release.

35. The Annex to Prison Service Instruction (PSI) 64/2011, which sets out the ACCT process, says that if a prisoner who is due to be released has been supported using ACCT in the previous 12 months, relevant risk information from their most recent ACCT must be shared by the Offender Management Unit with probation colleagues prior to release wherever possible. Relevant risk information includes the Risks, Triggers and Protective Factors Form, the Care Plan and the record of the final case review. We recommend:

    The Governor should ensure, in line with the Annex to PSI 64/2011, that where a prisoner has been subject to ACCT monitoring within 12 months of release, staff share relevant risk information with probation colleagues, including the community offender manager, prior to release.

Missed opportunity to review Mr MacGillivray's risk of suicide and self-harm

36. On 16 April, police were alerted after Mr MacGillivray was seen standing on a bridge. Mr MacGillivray told police he was not suicidal but was experiencing personal difficulties. The police passed this information to probation and on 19 April, Mr MacGillivray's COM recorded that he had received it. However, there is no record that Mr MacGillivray's COM discussed this incident with him.

37. We consider that there was a missed opportunity to explore the incident on 16 April, which may have led to completing work around suicide and safety planning, or how

Mr MacGillivray could manage low moods. Mr MacGillivray had made previous suicide attempts and this should have been explored further. We recommend:

The Regional Probation Director North East should ensure that incidents of concern are explored and relevant intervention work is completed if required.

Handover to new COM

38. On 19 May, Mr MacGillivray's case was transferred to a new COM. During their interview, both COMs told the investigator that a handover took place, which was an informal conversation highlighting risk factors and current concerns. However, this was not logged on probation systems.

39. The new COM told the investigator that when given a new case, they were required to review the records. The new COM said that following her review of Mr MacGillivray's records, she had no concerns around suicide or self-harm. She also said she was not aware of the incident on 16 April. This is despite it being recorded in the probation records.

40. The investigator found there was a further missed opportunity for the new COM to explore this incident. We recommend:

The Regional Probation Director North East should ensure that officers:

- **complete detailed handovers when a case is transferred and record details in the probation record;**
- **undertake a thorough review of records when given a new case.**

Staff support

41. Probation Instruction (PI) 01/2014, Reviewing and Reporting Deaths of Offenders under Probation Supervision in the Community, says that COMs should be made aware of support services available to them, such as counselling, after a death. COMs should be told they can use these services at a later date if required. We find that this process was not followed and the COMs who worked closely with Mr MacGillivray were not offered support following his death. We recommend:

The Regional Probation Director North East should ensure COMs are offered support following the death of a service user on their caseload.

Sue McAllister CB
Prisons and Probation Ombudsman **January 2023**

Inquest

The inquest, held on 8 April 2024, concluded that Mr MacGillivray hanged himself by a ligature whilst under the influence of a combination of cocaine and alcohol.

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