

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Michael Gibney
a resident at St Joseph's Approved Premises
on 11 September 2015**

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 Michael Gibney was found drowned on 11 September 2015, while a resident of St Joseph's Approved Premises, Eccles, Greater Manchester. He was 34 years old. I offer my condolences to Mr Gibney's family and friends.

Mr Gibney had been released from prison on 1 September and was required to live at St Joseph's. His licence was revoked on 9 September because he had breached his conditions but he went missing that evening. I am satisfied that, during Mr Gibney's short time at St Joseph's, the staff supported him appropriately. Tests showed that Mr Gibney had taken a number of drugs before he died, but staff had warned Mr Gibney appropriately of the dangers and his likely greater susceptibility to the effects of drugs after a period in prison.

While I consider that staff at St Joseph's should have alerted the police to Mr Gibney's whereabouts earlier, after his licence had been revoked, I recognise that it is unlikely that this would have led to his arrest before he went missing and I do not consider that staff could have prevented his death. The police informed Mr Gibney's father of his death, but it took too long for anyone from the approved premises to contact him and offer support.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

May 2016

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Summary

Events

1. On 1 September 2015, Mr Michael Gibney was released on licence from HMP Risley. He was required to live at St Joseph's Approved Premises, Eccles, Manchester, to be of good behaviour, to address his alcohol and drug use, and to attend all mental health appointments.
2. Two days after he arrived at St Joseph's Mr Gibney had a positive breathalyser reading for alcohol and admitted taking non-prescribed medication. On 7 September, Mr Gibney did not attend an arranged meeting with the mental health team. That evening a member of staff considered he appeared to be under the influence of drugs.
3. Late on 7 September and in the early hours of 8 September, Mr Gibney's behaviour was very odd, erratic and out of control. Staff called emergency services and he told ambulance paramedics that he had taken ecstasy. He settled down after that, but, the next day, his offender manager began procedures to recall him to prison for breach of his licence conditions. On the night of 8 and 9 September, he behaved bizarrely again, apparently under the influence of drugs.
4. Mr Gibney did not turn up for a pre-arranged appointment with a psychiatrist at 11.00am on 9 September. At 3.30pm, the National Offender Management Service informed the Police National Computer Bureau of Greater Manchester Police that his licence had been revoked and asked them to arrest Mr Gibney and return him to prison.
5. Mr Gibney returned to St Joseph's shortly after 9.00pm that night and left at about 9.45pm, without informing staff. No one had contacted the police about his recall in the interim. At 11.00pm, a member of staff discovered that Mr Gibney was not in the building and telephoned Mr Gibney, who would not say where he was. The local police said they had not yet been informed about his recall. Mr Gibney did not come back that night. The next afternoon, 10 September, his father saw him and said Mr Gibney had been worried about going back to prison. On 11 September, police found him drowned in the Manchester Ship Canal. A post-mortem report found that Mr Gibney had died by drowning, but it was possible that drugs had contributed to the circumstances.

Findings

6. We are satisfied that staff at St Joseph's gave Mr Gibney appropriate support. They arranged appointments with the mental health team and a psychiatrist and ensured he got appropriate medication. They warned him of the dangers of taking drugs and his likely reduced tolerance after leaving prison.
7. The Probation Service and the National Offender Management Service acted promptly to revoke Mr Gibney's licence and recall him to prison, when it became clear that he had breached his licence conditions. As his recall to prison had been agreed earlier that day, we would have expected someone from St Joseph's to have contacted the police immediately he returned to the approved

premises on the evening of 9 September. However, we recognise that this would have been unlikely to have led to Mr Gibney's detention, as the local police were not aware of the recall decision and he absconded from the premises very shortly afterwards. This was not an urgent recall but it is unfortunate in these circumstances that the police were unable to arrest Mr Gibney and return him to prison before he died.

8. The police informed Mr Gibney's father of his death and we are concerned that it took nearly a week after that, before anyone from the Probation Service contacted his father to offer condolences and support.

Recommendations

- The Deputy Director, North West Division of the National Probation Service should ensure that approved premises staff inform the police immediately when they become aware of the whereabouts of a recalled offender.
- The Deputy Director, North West Division of the National Probation Service should ensure that, when a resident of an approved premises dies, a family liaison officer contacts the resident's next of kin promptly to offer condolences, information, and support.

The Investigation Process

9. The investigator issued notices to staff and residents at St Joseph's Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator visited St Joseph's on 9 October. He obtained copies of relevant extracts from Mr Gibney's records and interviewed five members of staff.
11. We informed HM Coroner for Greater Manchester West District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Gibney's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He asked why no one from St Joseph's had contacted him when Mr Gibney went missing on 9 September, particularly as he suffered from mental health issues. He also asked whether Mr Gibney had been in a fit state of mind when he left prison and what medication he had received when he was released.
13. The initial report was shared with the National Probation Service. The Probation Service did not find any factual inaccuracies and their action plan has been annexed to this report.
14. Mr Gibney's family received a copy of the initial report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Gibney's family also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

St Joseph's Approved Premises

15. Approved premises (formerly known as probation and 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 health and are expected to register with a GP.
16. The National Probation Service manages St Joseph's Approved Premises in Eccles, Manchester. It has 29 beds and is one of six approved premises in Greater Manchester. It provides evening meals and there is a communal area for dining and socialising, and areas for group work. Each resident is allocated a key worker or offender supervisor to oversee their progress, wellbeing, and adherence to licence conditions and the premises' rules. Probation Service employees are on duty at St Joseph's 24 hours a day.
17. St. Joseph's has specialist services to treat offenders with severe and enduring mental health disorders. It employs a full-time community psychiatric nurse and other mental health support staff. Three consultant psychiatrists also visit regularly to see individual residents under their care.

Previous deaths at St Joseph's Approved Premises

18. Mr Gibney was the first resident to die at St Joseph's since 2008.

Key Events

19. On 1 September 2015, Mr Michael Gibney (who sometimes used the name Michael McFarland) was released on licence from HMP Risley, after serving a sentence for theft and violence offences. Mr Gibney suffered from paranoid schizophrenia and multiple personality disorder. He also had a history of alcohol and drug abuse.
20. Mr Gibney's licence conditions required him to live at St Joseph's Approved Premises and be on the premises between 9.00pm and 7.00am; be of good behaviour; address his alcohol and drug use; and attend all mental health appointments. Mr Gibney understood that if he breached his licence conditions he could be recalled to prison.
21. When he was released from prison, Mr Gibney was required to arrive at St Joseph's by 2.00pm, but he did not get there until approximately 5.00pm. A residential services worker completed an induction with Mr Gibney. Mr Gibney signed to say he understood that he must not arrive late for his curfew time and he must not be under the influence of drugs or alcohol or he could be recalled to prison. The worker warned Mr Gibney that, after his time in prison, his tolerance to drugs would be reduced and therefore if he took drugs he would be at increased risk of overdose.
22. The residential services worker suspected that Mr Gibney had drunk alcohol before arriving at St Joseph's and Mr Gibney admitted that he had "a couple of pints". He said that at the time he did not know that this was not allowed. Mr Gibney said that the prison had not given him a supply of medication when he left.
23. At 3.05am on 2 September, Mr Gibney told a residential services worker that he needed to see a psychiatrist because his mental health was poor. He said that Risley had stopped his medication because he had taken some medication that was not prescribed to him. The worker did not consider there was an immediate crisis as Mr Gibney was lucid and coherent and arranged for someone to call mental health services in the morning. At 4.30am, Mr Gibney said that he had taken non-prescribed pregabalin (used to treat nerve pain or seizures but is often misused by people with substance misuse problems because of its euphoric effects).
24. At 9.30am, a residential services worker spoke to a community psychiatric nurse based at St Joseph's about Mr Gibney's mental health. The nurse contacted healthcare staff at Risley, who said that Mr Gibney had not engaged with mental health services and had not recently been prescribed pregabalin. He had been prescribed mirtazapine (an antidepressant drug) and quetiapine (an antipsychotic drug). The mental health team organised a prescription for this medication. The nurse arranged appointments for Mr Gibney with the mental health team on 7 September and another with a psychiatrist on 9 September, both to be held at St Joseph's.
25. Mr Gibney spent most of the day out of the premises on 2 September. At 9.40pm, a residential services worker tested Mr Gibney's breath, which was positive for alcohol. She reported this to Mr Gibney's offender manager. That evening, a residential services worker gave Mr Gibney mirtazapine and

quetiapine, which a local pharmacy had delivered. (It is not clear why Risley had not issued Mr Gibney with a supply of medication when he was released but we are satisfied that staff at St Joseph's arranged his medication promptly.)

26. At 2.17am on 3 September, Mr Gibney told a residential services worker that he had taken non-prescribed pregabalin. At 5.55pm on 3 September, two residential services workers searched Mr Gibney's room for further medication, but did not find anything.
27. On 4 September, Mr Gibney told his offender manager that he was finding it difficult to settle at St Joseph's and preferred to be in prison.
28. On 7 September, Mr Gibney did not attend his appointment with the community mental health team, it is not clear why not. That evening, he arrived back at 9.25pm, past his curfew time of 9.00pm. A residential services worker gave Mr Gibney a breathalyser test, which was positive for alcohol. She suspected that Mr Gibney had also used drugs and reported this to his offender manager.
29. Later that night, between 11.00pm and 1.20am, staff recorded that Mr Gibney behaved very oddly, including setting off the fire alarm, throwing his bedding down the stairs, leaving a sink tap running until it nearly overflowed and headbutting a window. The staff were concerned about him and, at 2.00am, a residential services worker called the police and the ambulance service. An ambulance arrived at 2.25am, and Mr Gibney told paramedics that he had taken ecstasy (a psychoactive drug that alters mood and perception). Paramedics considered that Mr Gibney was fit to stay at St Joseph's and the worker reported his behaviour to his offender manager again.
30. On 8 September, after receiving the reports about Mr Gibney's behaviour, the offender manager decided that he had breached his licence conditions and began procedures to revoke his licence and recall him to prison. A senior probation officer countersigned his recommendation and sent the request to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).
31. At 9.15pm, a residential services worker recorded that Mr Gibney had breached his evening curfew again. She considered that he was under influence of drugs because his speech was slurred, his reactions were slow, and he swayed when he walked.
32. That night, between 10.20pm and 1.35am, Mr Gibney behaved strangely again. He went outside, came back shortly afterwards covered in scratches, and said that he had been assaulted. He ironed a number of £20 notes on the corridor floor and asked another resident whether he had his diazepam (a benzodiazepine used to treat anxiety and often misused to get a 'high'). He accused another resident of taking £600 in cash from him.
33. The next morning, at 11.00am on 9 September, Mr Gibney did not attend his appointment with a psychiatrist. At 3.30pm, the PPCS revoked Mr Gibney's licence and emailed the Police National Computer Bureau of Greater Manchester Police to ask them to arrest Mr Gibney and return him to prison custody.

34. At 3.55pm, a resident told a member of staff that he was concerned about Mr Gibney. He said he had phoned Mr Gibney who appeared to be having a panic attack and had said that he would not attend a probation meeting. She called Mr Gibney but he did not answer.
35. Mr Gibney breached his evening curfew on 9 September by arriving back at St Joseph's at 9.12pm. Although Mr Gibney's licence had been revoked earlier that afternoon, no one called the police to inform them. At an 11.00pm check, a residential services worker could not find Mr Gibney. Another resident told him that Mr Gibney had left, as he was worried that he would be recalled to prison in the morning. The worker checked CCTV footage, which showed Mr Gibney leaving St Joseph's at 9.45pm.
36. At 11.20pm, the residential services worker telephoned Mr Gibney and asked him where he was. Mr Gibney said he was too busy to talk and ended the call. At 11.30pm, the worker phoned the local police who said that the details of Mr Gibney's recall had not yet been added to the police's database so they were unaware that his licence had been revoked.
37. Mr Gibney did not come back to St Joseph's again. Mr Gibney's father later told the police that he had met Mr Gibney on the afternoon of 10 September, near the approved premises. He said that his son was worried about being recalled to prison and he thought he was under the influence of drugs at the time.
38. On 11 September, police found Mr Gibney drowned in the Manchester Ship Canal.

Contact with Mr Gibney's family

39. The police informed Mr Gibney's father of his death. From 14 September, the district manager for Approved Premises in Greater Manchester acted as the Probation Service's family liaison officer but did not phone Mr Gibney's father until 15 September. She did not get a reply until 17 September. She offered her condolences and arranged to meet Mr Gibney's father that day. After this, she maintained contact with Mr Gibney's father for support.
40. Mr Gibney's funeral was on 7 October. The Probation Service paid for the funeral in line with national instructions.

Support for prisoners and staff

41. After Mr Gibney's death, the district manager and a senior probation officer offered support to the staff and residents at St Joseph's who might have been affected by Mr Gibney's death.

Post-mortem report

42. A post-mortem examination concluded that Mr Gibney had died by drowning. A toxicology report found that Mr Gibney had used cocaine, heroin, alprazolam, and phenazepam (both benzodiazepines) before his death, but none at a level that, alone, would have caused Mr Gibney's death. The pathologist considered that it was possible that the use of these drugs had caused Mr Gibney to fall into the canal or prevented him from getting out.

Findings

Mr Gibney's mental health

43. Unusually for approved premises, St Joseph's has a mental health team permanently based on site. St Joseph's was regarded as particularly suitable for Mr Gibney because of the mental health support it offered.
44. When a new resident arrives at St Joseph's, appointments are usually arranged with the mental health team and a psychiatrist within the first two weeks. A psychiatric nurse quickly arranged both appointments for Mr Gibney but he did not attend either appointment. Staff at St Joseph's also arranged for him to receive appropriate antidepressant and antipsychotic medication.
45. Mr Gibney understood that attending his mental health appointments was one of his licence conditions. It was Mr Gibney's responsibility to attend those appointments and we are satisfied that staff at St Joseph's did what they could to provide support for Mr Gibney's mental health problems.

Mr Gibney's substance misuse

46. Toxicology tests found that Mr Gibney had used illicit drugs before he died. Although they were not the direct cause of his death, which was from drowning, it is possible that they contributed. Section 22 of the Approved Premises Manual recommends that during the induction process, staff advise residents on the risks of taking drugs, particularly after a period of abstinence in prison when tolerance levels are lower. We are satisfied that staff at St Joseph's complied with the guidance and warned Mr Gibney about the risks and that he was aware of them.

Recall process

47. Probation Instruction (PI) 27/2014, 'Recall Review and Re-Release of Recall Offenders', provides the national policy on the recall process. The policy confirms that the Probation Service must submit the recall paperwork to PPCS within 24 hours of the offender manager's decision to revoke the licence, and PPCS must then make a decision within 24 hours. Once a recall is authorised, the Joint National Policy, 'Supervision, Revocation and Recall for Offenders Released on Licence', requires the police to arrest an offender and return them to custody within 96 hours.
48. We are satisfied that the Probation Service and the PPCS processed Mr Gibney's recall appropriately and promptly. Mr Gibney was not assessed as a high risk to the public and his routine recall would not have been treated as a priority. However, Mr Gibney's licence was revoked on the afternoon of 9 September and we consider that, when he arrived back at St Joseph's on the evening of 9 September, someone should have notified the police immediately.
49. Instructions about recall note that after a licence has been revoked, the Probation Service has a duty to "Liaise with the police to provide any available information and intelligence, which may facilitate the offender's swift apprehension and return to custody". The Approved Premises Manual also requires premises to have

contingency arrangements with the police for arresting residents in support of recall decisions.

50. We recognise that earlier notification to the police on this occasion would have been unlikely to lead to Mr Gibney's detention, as the local police were not yet aware of the recall decision and Mr Gibney absconded from the premises very shortly afterwards. This was not an urgent recall but it is unfortunate in these circumstances that the police were unable to arrest Mr Gibney and return him to the relative safety of prison before he died. We make the following recommendation:

The Deputy Director, North West Division of the National Probation Service should ensure that approved premises staff inform the police immediately when they become aware of the whereabouts of a recalled offender.

Liaison with Mr Gibney's family

51. Mr Gibney's father told the police that one time when Mr Gibney had missed his curfew, staff at St Joseph's had telephoned him to ask if he knew where his son was. He was concerned that, after Mr Gibney absconded on 9 September, no one called him to alert him. When he saw Mr Gibney on 10 September, he did not know that he had left the hostel, but Mr Gibney had said he was in trouble and might be recalled.
52. As probation staff had begun the recall process on 8 September and his licence was formally revoked in the afternoon of 9 September, we consider that it was reasonable for the approved premises to leave it to the police to locate Mr Gibney when he was off the premises.
53. The Approved Premises Manual sets standards for family liaison after a resident dies. The organisation responsible for the premises should contact the family immediately, in most cases face-to-face, unless the police do this. The guidance says that the premises operator should then offer ongoing contact.
54. The police informed Mr Gibney's father of his death. At 5.30pm on 11 September, the police informed staff at St Joseph's that Mr Gibney had died. However, no one from the Probation Service tried to contact Mr Gibney's father until 15 September and the first actual contact was not until 17 September. The district manager told us that they did not think it was necessary to get in touch earlier, as the police had informed Mr Gibney's father of his death and would have provided all the information he needed. While the contact from 17 September was appropriate and Mr Gibney's father appreciated it, Mr Gibney was a resident of St Joseph's when he died and we consider someone from the Probation Service should have contacted his father much sooner to offer condolences and support. We make the following recommendation:

The Deputy Director, North West Division of the National Probation Service, should ensure that when a resident dies a family liaison officer contacts the resident's next of kin at the earliest appropriate opportunity to offer condolences, information, and support.

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