

**Circumstances surrounding the death of a man at HMP La
Moye in September 2006**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

March 2007

This is the report of my investigation into the death of a man at HMP La Moye, Jersey, in September 2006. He had been received in the prison less than 24 hours earlier. I offer my sincere condolences to his family, friends and all those touched by his passing. The man was 29 years old.

Since April 2004, the office I lead has been responsible for investigating all deaths in prisons in England and Wales. My terms of reference also encompass the deaths of residents of probation hostels (Approved Premises) and those held in immigration detention. By September 2006, I had initiated over 500 such investigations.

I have not conducted this investigation under my formal powers – which do not extend to Jersey – but as a result of an invitation from the Minister for Home Affairs. Her letter made clear that, notwithstanding the absence of any official locus, I was to conduct the investigation in line with the policies and protocols I had developed over the previous 30 months in relation to the Prison Service of England and Wales. I should emphasise that I have been afforded the utmost assistance and courtesy from all the authorities and others in Jersey.

Both because I believe it is right in principle, and because it is required to ensure compliance with Article 2 of the European Convention on Human Rights, an important element of all my investigations is to involve the bereaved family. I am most grateful to the man's parents for agreeing to meet me at this most painful time in their lives. I have endeavoured in this report to address the many questions they raised.

I am also most grateful to the Governor of La Moye and to the Chief Probation Officer and their respective colleagues. I must also thank the staff at Silkworth Lodge, a residential treatment and rehabilitation centre for alcohol and substance abusers. They have all given most willingly of their time and, in turn, I have endeavoured to feed back my emerging findings to them. I should also mention the huge assistance I have received from the Jersey Police. They conducted a comprehensive investigation of their own, and this has enabled me to limit the number of additional interviews required and to concentrate on wider issues of policy and practice.

I am conscious that some of my recommendations have significant resource implications. I fear that is unavoidable. As in England and Wales, the majority of prisoners entering La Moye are drug users with all the vulnerabilities associated therewith. At the current level of resourcing, the prison cannot properly exercise its duty of care to those in its charge.

Stephen Shaw CBE

Prisons and Probation Ombudsman for England and Wales

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Summary

The man was found hanging in his cell in HMP La Moye at lunchtime on Saturday 2 September 2006. He was 29 years old and had been received into the prison the day before. This was by no means his first spell in custody and he was well known to prison staff and other prisoners alike.

The man had been released from a two year sentence on 7 July. He had gone from prison to Silkworth Lodge, a residential treatment and rehabilitation centre for alcohol and substance abusers. However, he did not adjust well to the strict regime there, and was asked to leave after just 10 days. He slept on a friend's sofa for a few days, but then found himself accommodation and secured a place at college to study for a degree. He soon reverted to drug use. He sought help from the Alcohol and Drugs Service (ADS), but they were unable to offer him an appointment until 4 September. In the interim, the man was arrested by the police in connection with allegedly receiving some stolen mobile phones. He spent two days at the police station before being remanded to prison.

The man was withdrawing from drugs at the time of his reception and had been given diazepam whilst in police custody. He was prescribed dihydrocodeine and diazepam at the prison.

No risk of self-harm was identified during the reception process at La Moye, but the man asked straightaway to be segregated from other prisoners as he feared repercussions from some of them. (He did not explain the nature of his problems with these other prisoners.) He was allocated to E wing, which serves as a vulnerable prisoner unit¹ (VPU) and a segregation unit. The man was given a meal when he arrived on the wing, but thereafter refused to leave his cell to collect food. In fact he left his cell just twice (both times escorted by an officer) - once to collect hot water and once to use the phone.

Nevertheless, a number of staff came into contact with him at various times. The man apparently seemed his normal self, if a little more subdued and quiet than usual. No one identified a risk of self-harm.

At about 1:00 pm on the day of the man's death, an officer went to his cell to give the man his medication. He found the cell door flap covered. On entering the cell, he saw the man hanging from a pipe running the length of the ceiling. The officer summoned assistance and staff tried for some time to resuscitate him. An ambulance arrived at 1:30 pm and took over the resuscitation attempt, but the man was pronounced dead on arrival at the hospital at 2:28 pm.

¹ The vulnerable prisoner unit in La Moye does not carry the same connotations as it would in an English prison, where it would largely (but not exclusively) signify a wing reserved for sex offenders and those who have committed crimes against children. The unit reflects the small island community that the prison serves in that many prisoners (and staff) will know each other and may well have reason to avoid one another. The VPU principally holds those who may face bullying on the standard wings. HM Chief Inspector of Prisons found that many of the prison's ethnic minorities (principally Madeirans) were lodged in the VPU.

The man's parents' principal concern relates to the period between their son's release from prison and his return there. They have asked questions about the support he was given to stay clean of drugs and stay out of prison. They have also questioned why their son was not watched more carefully on his return to prison, and have suggested that he might have been bullied by staff during his previous time there.

I have explored what happened between 7 July and the date of the man's death. I conclude that the man's release was well planned and that appropriate support mechanisms were in place. I have some concerns about the decision to ask the man to leave Silkworth Lodge² and the absence of a fall back plan. Having said that, I am satisfied that appropriate support was available to the man from the Probation Service and that they took steps to help him. However, I am critical of the fact that the ADS was unable to give him an appointment until 4 September.

A number of factors might have pointed to the man being considered at risk of suicide on his reception at La Moye – he had self-harmed several times in the past, he was withdrawing from drugs, he feared repercussions from other prisoners. He was also returning to prison just two months after being released, as he had said, for the last time, and he felt he had let everybody down. Nevertheless, I am satisfied that he was properly assessed for risk and it would not be appropriate for me to second guess the conclusions of the staff who saw and spoke to him at the time. Nevertheless, I am concerned about shortcomings in information sharing and that the man was not put on intermittent observations on account of his withdrawal from drugs. In addition, I am critical of the withdrawal process in operation at La Moye. I also note that the man did not have a television in his cell.

I have considered the family's concerns about bullying by staff, but have found no evidence to substantiate them. However, I consider whether the prison's response to the man's fears of repercussions from other prisoners was adequate, and whether they might have been expected to read more into the fact that the man took no food for some 20 hours. I suggest that staff might to some extent have been conditioned in their response to the man by their experience of him during his previous periods in custody.

I have nothing but praise for the response of staff after the man was found hanging. They acted promptly and professionally and I am satisfied that everything possible was done to try to save his life. Systems for giving the ambulance access to and egress from the prison also worked well. Finally, I commend staff at the prison for the way they have engaged with the family since the man's death. The man's parents were grateful to a particular member of staff who attended the prison on his day off to speak to them. In addition, they especially asked that I should single out another officer for praise and thanks. They told me that their son thought the world of this officer, and they particularly appreciated the fact that he and others attended the funeral. In the sad circumstances leading to this report, I am more than happy to record their comments here.

² Silkworth Lodge is a private organisation, and it is beyond my remit either to criticise or (directly to) make recommendations.

How I went about the investigation

On 7 September 2006, I received a faxed letter from the Minister for Home Affairs in the States of Jersey. The letter invited me to investigate a death that had occurred at HMP La Moye. It promised the full cooperation of the Governor and his staff and unfettered access to all prison information, documents and individuals.

The Minister advised that my investigation should follow the policies and protocols I had developed whilst investigating deaths in custody in England and Wales and asked that I should:

- Establish the circumstances and events surrounding the death, especially as regards management of the man by the relevant service or services, but including relevant outside factors;
- Examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence;
- Examine relevant health issues and assess clinical care;
- Provide explanations and insight for the bereaved relatives; and
- Assist the Viscount's inquest by ensuring as far as possible (in line with obligations arising out of Article 2 of the European Convention on Human Rights) that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice identified and any lessons from the death learned.

Given the nature of the request, I determined that I should conduct the investigation personally. I have been assisted in this by one of my Deputy Ombudsmen, who is a registered clinician and who conducted a clinical review of the man's care. Her review is annexed to this report. (The normal arrangements in England and Wales whereby the relevant Primary Care Trust commissions its own clinical review as part of my investigation do not apply in Jersey where all General Practitioners are in private practice.) I was also assisted by one of my Family Liaison Officers (FLOs) and an Assistant Ombudsman.

I first visited Jersey on 11 September. I met the Governor, saw part of the prison and inspected the cell that the man had occupied. I also spoke to other senior staff, the Chairman of the Prison Officers' Association and the Vice Chairman of the prison's Board of Visitors. I also obtained copies and originals of the man's prison records, including his medical record.

In line with my normal practice, I asked for notices announcing my investigation to both staff and prisoners to be posted. These explain the nature of my investigation and invite people who have any relevant information to contact me. (In the event, no-one did.)

I was fortunate to meet a Detective Inspector and a Detective Sergeant of the States of Jersey Police with whom I agreed arrangements for the sharing of information in line with the protocol between my office and the Association of Chief Police Officers (ACPO). With their agreement, I immediately took a statement from the Roman Catholic chaplain at La Moye.

The same day, I met with the Deputy Viscount of the Royal Court to explain the nature of my investigation, its likely timetable, and the contribution I hoped it would make to the inquest over which the Deputy Viscount would preside. He readily agreed to supply the post mortem examination and toxicology reports. In turn, this report and all the evidence upon which it is based will be submitted to him.

Finally, I met the Minister and the Chief Officer of the Home Affairs Department. I told the Senator that my investigation would need to look at the man's contact with police and probation, as well as his time in prison custody. She kindly agreed to facilitate this with the relevant authorities. Subsequently, the Minister chaired a press conference at which I spoke to members of the local media.

I returned to Jersey two days later when I received a dossier of the documents and statements that the police had gathered so far. I visited the custody suite at Rouge Bouillon Police Station where the man had been held following his arrest and received a very useful briefing. A meeting with a Superintendent was also extremely helpful in explaining the nature of the crime problems that Jersey faces. I also took the opportunity of returning to La Moye to collect additional documentation, to meet the designated liaison officer (a senior unit manager), and to share some initial thoughts with the Governor and his deputy.

Accompanied by the FLO, I met members of the man's family on Thursday 16 November. I am most grateful to the Family Liaison Officers appointed by the States of Jersey Police for making the arrangements.

On the same day, the Assistant Ombudsman visited the prison and interviewed three of the prisoners from whom the man had said he feared repercussions and who had been reported as threatening him between 1 and 2 September. She also interviewed the prison's drug counsellor.

The Assistant Ombudsman returned to Jersey on 29 November to visit Silkworth Lodge and speak to staff there. She also met the Chief Probation Officer, with three of his colleagues. They gave her a considerable amount of their time and provided a very useful briefing comprising background information and details relevant specifically to the man. The Assistant Ombudsman also obtained from them various documents relating to the period between the man's release and arrest.

Finally, The Assistant Ombudsman obtained statements from some staff at La Moye, and interviewed others, addressing specific questions relating to the man's care at the prison.

A copy of the draft report was sent to the Governor of La Moye and to the man's family. Relevant extracts were sent to the Probation Service, Silkworth Lodge and the Alcohol and Drug Service. This final report reflects their comments.

I should like to emphasise that I and my colleagues have received the very fullest cooperation from all the authorities in Jersey and from staff at Silkworth Lodge.

The man's history of self-harm

The man had some history of self-harm. The 2005 social enquiry report noted:

“What are of increased concern are issues relating to self-harm or suicide. He made a number of attempts to take his own life, during 2004, when he discovered that his partner became pregnant with a baby he knew (correctly) would be born addicted to heroin. [The man] said that he tried to hang himself in June 2004 and later attempted suicide by overdose. He said he is more tempted to do this when his problems become too difficult to deal with and it offers him some form of resolution to his difficulties. In 2001, he described again attempting suicide through carbon-monoxide poisoning. When in custody, [the man] said that he feels fine and has never attempted to self-harm or commit suicide whilst in prison. He states that this risk has reduced since last year as his relationship issues appear to have stabilised and he does not presently have suicidal intentions.”

The police statement given by the man's girlfriend and mother of his younger child is a powerful document. She recounts one of the 2004 instances of self-harm. She was pregnant and she and the man had had a disagreement:

“As I walked into the room, [the man] had a belt around his neck, he was standing on a step ladder and he was connecting the other end of the belt to the electric cable which hangs down from the ceiling and is connected to the light bulb. I had to climb up the ladder to loosen the belt which was getting tighter around his neck ...”

This turned out to be a chilling foreshadowing of what was to come.

The next day, the girlfriend asked the man why he had done this. He had replied that he got these thoughts, felt he was a bad person and that it would be better for everyone if he was not here. She had told no one else about this.

In August 2004, the man had told someone from the Alcohol and Drugs Service that “he was depressed and suicidal. No particular reason just woke up feeling that way. Says this sometimes happens and may not last too long ...”

On previous sentences at La Moye, the man had been subject to monitoring under the F2052SH system.³ The first time was in August 2005 after he was found to have inflicted a wound to his chest with a razor blade. He also threatened to swallow the blade. The F2052SH recorded that he self-harmed because he had been moved to the block [segregation unit] and felt victimised by staff. The form was closed after the man was adjudicated upon, given a suspended punishment and warning and returned to his cell. It was noted that the trigger for his self-harm had therefore been removed. The form was closed the day after it was opened.

³ F2052SH is a Prison Service process for caring for and monitoring those identified as being at risk of suicide or self-harm.

The second occasion was in April 2006, after he again inflicted (superficial) cuts to his chest and a cut to his head. The form recorded that he said he felt unable to cope – he was due to be released in 13 weeks and did not feel strong enough to resist drugs. He also said he felt under threat both within the prison and on the outside and was concerned about bullying by another prisoner. The form was again closed after about 24 hours.

Jersey Probation and After Care Service

Jersey Probation and After Care Service (JPACS) is a department of the Royal Court (the equivalent of the Crown Court in England and Wales). Some Jurats from the Royal Court form the Probation Board.

The Chief Probation Officer (CPO) told The Assistant Ombudsman that JPACS is a service that has not lost its traditional social work approach. It provides information to the courts and supervision to offenders via probation orders, community service orders and voluntary contact. Most of the probation officers are generalists, although there are a small number of specialists. JPACS has 38 employees (27 full time equivalents), and compiles 600 – 700 reports and administers approximately 200 Probation Orders and 200 Community Service Orders per year. Automatic prison throughcare started only on 1 July 2006. JPACS is also involved in family court welfare work for which they prepare about 24 reports a year.

HM Chief Inspector of Probation inspected JPACS in 2005. The Chief Inspector commented:

“We ... have been impressed by the willingness of managers and staff to be subject to external scrutiny. We see all this as very indicative of the service’s innovative approach to the supervision of offenders, improving wherever possible the current levels of performance, and continuing to enjoy the respect of government, sentencers and the various other organisations with which it works.

“The service has many strengths. It is well managed, has excellent information systems, and pays significant attention to the outcomes of its work.

“... The introduction of a computerised case management and management information system had been a very positive step, providing ready access to relevant data for both practitioners and managers. The service had achieved most of its KPIs⁴ in 2004 and was constantly looking to improve service delivery, arranging evaluations, inspections and reviews of its work, both internally and externally. Standards for the delivery of supervision had been introduced across most areas of practice. The service was also an innovator and had introduced a number of schemes such as mentoring, volunteer tutors and restorative justice to complement and add value to the work of busy probation staff. The extent of partnerships with other organisations - statutory, contracted and voluntary - was excellent, with partners and courts having a positive view of probation as a trustworthy, can do organisation.

“... There was a high completion of the assessment of reoffending using LSI-R⁵ and interventions were targeted accordingly.

“... Inter-agency work in terms of liaison with partners and the reinforcement of the work they had undertaken was a real strength, as was the range of

⁴ Key Performance Indicators.

⁵ Level of Service Inventory-Revised.

programmes available for a relatively small service. There was much positive work on reintegration issues but, on occasions, more direct work on offending behaviour both pre and post-programmes and with those not undertaking programmes would be desirable ... Alcohol has been identified both by the service and our inspection as a significant factor in crime, and we would suggest a review of interventions available for this need.

“... There were some good examples of work to reintegrate offenders back into the community, including linking them with partner organisations to achieve this ... The service had an excellent record of measuring progress through reductions in LSI-R scores and was able to both demonstrate success and identify who would be most likely to benefit from intervention. Work had been undertaken with sentencers to try to reduce the number of inappropriate cases being placed under supervision.”

Of probation orders closed in 2004, 81 per cent of medium to high risk probationers and 51 per cent of highest risk probationers reduced their risk of reoffending as measured by LSI-R.

HMP La Moye

La Moye is Jersey's only prison, and for this reason serves a wide variety of functions. It is a prison for both men and women, for adults and young offenders, and for both remand and sentenced prisoners. In total, it had 184 places at the time of the man's death (a new wing has since been opened). The Vulnerable Prisoner Unit is made up of two wings - C and E. C wing has three levels, totalling about 23 cells. E wing has two levels and 21 cells. The normal daytime staffing level is three staff for E wing and two for C wing.

The purpose of a death in custody investigation is quite separate from that of an inspection by HM Chief Inspector of Prisons. However, I necessarily audit policies on such matters as anti-bullying and safer custody, and I also review how far the findings and recommendations of the Inspectorate have been implemented. I have therefore reviewed those aspects of the Chief Inspector's reports that seem to me to be relevant to the circumstances of the man's death.

La Moye has been inspected twice by HM Chief Inspector of Prisons. The first inspection was carried out by a team led by the former Chief Inspector between 2 - 6 April 2001. The former Chief Inspector's report was written explicitly, "with the aim of providing a platform for further development".

Relevant to this investigation are the then Chief Inspector's findings that:

- A high population of prisoners felt safe on their first night in custody.
- "The suicide awareness policy was good and this was reflected in practice. There was a need for ongoing staff training in this important area."
- An anti-bullying strategy should be introduced throughout the prison.
- An exceptionally high percentage of prisoners said staff-prisoner relationships were either good or very good.
- Few cells had integral sanitation. This was "disrespectful to prisoners."
- The drug detoxification programme offered to prisoners "was not comparable with that provided in the outside community."
- Drugs offences accounted for over half the offences with which prisoners had been charged.
- The Inspectorate were impressed by the quality of many of the staff conducting reception procedures. "Prisoners identified as at risk of self-harm or suicide were risk assessed in Reception and all new receptions were seen by a member of the Healthcare Team as part of the initial reception procedures."
- Prisoners "did not always have access to a range of suitable activities to occupy themselves during their first night."
- "Prisoners should receive ... a comprehensive, multi-disciplinary induction programme, which should include useful information about: Anti-bullying ... Copying with custody ... Drugs Awareness ... Listeners Scheme/Samaritans ... Suicide Awareness ... [35 other subjects]"

- “There were many ligature points in cells ... we recommend examination of the ‘Safer Cell Project’⁶ established by the Prison Service of England and Wales.”

In para 4.06 of the Report, the then Chief Inspector noted in respect of drug using prisoners:

“On entry into the prison all prisoners were screened by Health Care staff for substance misuse. For those addicted to heroin or opiates there was a standard programme based on the use of dihydrocodeine to reduce the severity of withdrawal symptoms. While this was an adequate response for some prisoners, it was not sufficient for those who had been using larger quantities of drugs such as heroin or methadone ... in respect of drug using prisoners, prescribing decisions should be made according to individual need rather than to a standard formula ... Health Care staff should liaise with the Community Alcohol & Drug Service to develop new guidelines for the detoxification and treatment of those with substance misuse problems.”

On suicide and self-harm issues, HMCIP commented:

- “... we found a staff culture which implied that ‘suicide’ issues belonged primarily in the medical and nursing domain ... We recommend that refresher training in suicide and self-harm awareness be given to all staff at least once in every year following the year of appointment.”
- Entries in F2052SH (Self-Harm & Suicide Alert Form) were generally good. The Suicide Awareness Group should meet at least bi-monthly. Links with the Samaritans were strong but there was not a dedicated Samaritans telephone line.
- The immediate screening of all new receptions by Healthcare staff for self-harm risk was “an example of local good practice.”
- The Vulnerable Prisoner Unit was “well managed”. Only four out of the 24 prisoners held there were sex offenders. There was “absolutely no systematic and effective casework intervention to address the needs of the VPU prisoners nor any visible attempt to transfer them to normal location in the prison and both issues should receive urgent remedial action.”
- Healthcare services were rated highly by prisoners. The Chief Inspector said the introduction of a clinical computing system should be considered.

A second inspection was conducted at La Moye between 27 June -1 July 2005 by the current Chief Inspector. In the introduction to her report, she recorded that few of the recommendations the Inspectorate had made four years earlier had been actioned: “As a consequence, the safety and security of prisoners and staff, and the likelihood of prisoners’ rehabilitation, were compromised.” HM Chief Inspector reported:

- “La Moye lacked proper first night or induction procedures, and a large proportion of men and women felt unsafe on their first night.”

⁶ The objective of this project is to provide cell design solutions to minimise impulsive suicide attempts without stigmatising the occupant, so that, for example, all obvious ligature points and sharp edges are removed.

- “Prisoners told us that bullying was a serious problem, yet there were no systems to deal with it ...”
- “... the vulnerable prisoners unit ... was itself a location for bullying.”
- “Suicide and self-harm procedures were in place, though they relied too much on healthcare staff ...”
- “The detoxification protocols were not in line with best practice, and resources were insufficient to introduce methadone. The treatment regime was judged to be safe, if not ideal.” (I note that 41 per cent of the prisoners she surveyed reported experiencing drug problems on arrival at La Moye.)⁷

I judge these findings to be particularly relevant to this case. HM Chief Inspector’s report also repeats many of the other findings made by her predecessor four years earlier. I note, for example, the very limited extent to which prisoners’ resettlement needs are met. This again is relevant to this story, given the repeated nature of the man’s offending and periods of imprisonment.

HM Chief Inspector noted that the proportion of prisoners who said they felt unsafe on their first night had doubled since the earlier inspection to 30 per cent. She wrote as follows:

“An example of some of the comments we received was from an adult male prisoner who said: ‘the first night, I won’t forget for the rest of my life how depressed and painful I was in the cell.’”

She was also strongly critical of the physical conditions on E wing (the Vulnerable Prisoner Unit, in which the man was located).

Three aspects of the prison relevant to this investigation were praised by the Chief Inspector: the strength of staff-prisoner relations; the approach to suicide prevention; and the clinical care given by Healthcare.

A central plank in the Chief Inspector’s recommendations was the establishment of a Prison Improvement Plan. I understand this is now in place and work has begun, but the full-year costs are in the region of £1 million plus some ‘one off’ capital costs.

⁷ The Chief Inspector also recommended that a properly constituted complaints system be introduced. Although not relevant to this investigation, as an Ombudsman for prisoners I cannot let pass the fact that La Moye does not have such a system. I strongly endorse the Chief Inspector’s proposal.)

Previous deaths in custody in Jersey

Two prisoners who were known to each other killed themselves at La Moye in quick succession in 1995. One, aged 24, died by hanging on 18 July 1995. His friend, aged 21, died by the same means on 9 August. He had actually attended his friend's funeral.

I understand a 64 year old prisoner died in early 2006, following an accident at the prison when he broke his leg. He was taken to hospital and operated upon, but died as a result of complications arising from the operation several days later. My experience generally in England is that non-self-inflicted deaths also benefit from an independent investigation. In particular, such an investigation can consider whether the prisoner has received equivalent care to that he or she would have received in the community, as well as decisions about temporary release, access to hospitals/hospices etc. I recommend:

The States of Jersey should consider what arrangements are in place to review deaths in custody from natural causes.

The man's previous periods in La Moye

I have not felt it necessary to review all of the man's back records covering previous periods in custody. However, I am grateful to the prison authorities for providing me with a variety of papers that throw light upon his personality and character.

A note in his F2052A Record of Events (history sheet) of 27 March 2005 reads, "Hasn't taken him long to get back to his old ways i.e. trying to manipulate staff and constantly demanding." Other entries refer to the man being idle at work, argumentative, disruptive, "keeps trying to beat the system." Notes on 30 April 2005 and 3 May 2005 refer to allegations that he was bullying others. There are other references to disagreements with staff and prisoners, to threatening to assault a member of staff, and to climb on the roof. He faced several disciplinary adjudications. A not atypical entry reads, "Has had a fairly quiet week by his standards although we know he's probably up to something."

The man appears to have been by turns both bullied and bully and this was instrumental in determining where in the prison he was located. In a letter to the Minister for Home Affairs dated 14 July 2005, he refers to his location in the VPU "because I get bullied on the main wing."⁸

There are further references to bullying on 8 September 2005 ("He uses his [i.e. the victim's] religion, race and language as tools") and two on 13 September ("Bullying several other inmates for canteen and medication." "Due to threats from [the man] it has become necessary to move [named prisoner].") The man who died was removed to the segregation unit as a consequence. On 14 September, an entry reads, "I received information today that [the man] was planning to scald [another named prisoner] with boiling water."

Subsequent entries include:

- 25.12.05 "... demanding all day"
- 01.01.06 "Still trying it on all the time"
- 04.01.06 "Constantly disruptive and demanding"

There was also evidence of fallings out with other prisoners:

- 05.01.06 "[The man] ... said he was under threat on 'C' wing"
- 14.01.06 "... allegedly involved in a fight"
- 21.01.06 "[named prisoner] ... told me that [the man] had spat in his window"
- 25.01.06 "[The man] is trying to control the weaker inmates"

⁸ The letter, which concerned a relatively trivial matter that should have been settled much earlier, also contains the poignant line, "This is not my first time in prison, yet I hope it will be my last."

- 30.01.06 “[The man] is up to his bullying tactics again ...”
- 05.02.06 “[The man] has been bullying [named prisoner] ...”
- 15.02.06 “I was informed today that [the man] is down to his old tricks of bullying again”

These entries, which continued until his release, were made by a number of different officers.

The Record of Events (F2052B) indicates an unwillingness to be unlocked at the same time as another prisoner (21-22 March 2006). On 10 April 2006, an entry reads: “He made a comment about nobody listening to him and that he might have to cut himself to get listened to. I told him this was not the way to get people to listen to him. He agreed.” It is not apparent that any other action was taken. The same officer also records on 19 April: “Became very demanding. Trying to get me to do something for him (seemed like anything would do).”

The man spent at least two periods in segregation, one of which lasted for several months. It is not clear whether this was as a result of his bullying others, his attitude to staff (the reason he was apparently given for being segregated), or for his own protection (the reason Unit Manager gave The Assistant Ombudsman for his segregation). An entry on 10 April 2006 reads:

“He is under threat from [named prisoner] and possibly [named prisoner] and others, he has bullied [two named prisoners] on ‘E’ wing. He is under threat from [named prisoner] and has threatened [named prisoner] on ‘C’ wing.”

During June, two entries record that the man had given up his work because of fears for his own safety.

On 20 June, he was due to meet the prison probation officer but, seeing people from the VPU in the yard, the man refused to walk past them. The escorting officer said he could not lock everyone up just so that the man could have a visit and so he decided to return to his cell.

He was released from La Moye on 7 July.

The man kept a diary whilst he was in prison. This provides an interesting counterpoint to the official record. The diary mainly sets out issues and concerns the man faced rather than detailing his daily life at the prison. It records the many small irritations and frustrations that follow the loss of liberty. For example, the man devotes quite a lot of space to the delay in issuing him an aerial for his television as well as difficulties in resolving a complaint about his laundry having gone missing. He also refers to a long running saga over the wearing of work boots which he said were too small. The diary describes his interactions with various other prisoners and members of staff and his thoughts about them. At various times, he appears to have been in conflict with different people (both staff and prisoners). A strong sense of frustration and injustice also permeates the diary, and it is clear that the man thought

some staff were unnecessarily rigorous in their application of the rules. He also complains that people failed to get back to him when they said they would, and about being given different information by different people.

The diary and the wing record together provide a telling account of a challenging relationship as seen from both sides.

The Unit Manager told The Assistant Ombudsman that by the end of his sentence, the man was not coping well with imprisonment. Staff and prisoners alike were familiar with his scams and ruses and he found it more difficult to manipulate them. He had also caused a lot of friction with prisoners throughout the jail, so that wherever he went he was likely to face a degree of hostility from some quarter or other.

Preparation for release

In her police statement, the prison's drugs counsellor spoke of her role at La Moye and of first meeting the man in October 2003. She said he participated in both group work and one-to-one sessions on drug and alcohol awareness. This included relapse prevention work, leading her to be quite sanguine about his prospects on release:

“Before he left in July 2006, he had improved dramatically, he was focussed on his goals to remain drug free, make a life for himself and return to higher education ... I really felt when he left he was ready for life outside prison and to achieve the goals he had set himself ... [The man] had been so positive planning his future, he had not shared or shown any suicidal tendencies at all.”

She told The Assistant Ombudsman:

“I had known [the man] for three or four years. My first contact with him was in prison. We did some one-to-one work and I also treated him with acupuncture. In addition, he attended group work, completing all the assignments. The course consisted of 12 sessions and included talking about addiction, neuro-biology, relapse prevention, blood borne viruses, sexually transmitted diseases and the impact of drug use on the family.

[The man] genuinely engaged with the programme ...

He had made plans to prevent his relapse following his last release from prison. He had worked on this during the previous five months and completed a large number of assignments very well. I was not expecting him back at all. When I heard he was back, I thought it was perhaps the final small relapse before he finally got himself sorted out. One of the things that convinced me of [the man's] genuine intent to sort himself out was that he never once said that he would never go back to prison. Lots of the drugs users said this, but [the man] never did. I got a strong sense from him that he had had enough of being the way he was. This was perhaps a sign that if he did relapse, he would not be able to cope with it ... He had stopped smoking and was hyperactive in setting up plans for his release.

[The man] had a place to live on release and was going to work on the 12 step programme. This included assignments, one-to-one counselling and group sessions. At first, he was nervous about going to Silkworth Lodge because it was a very structured environment. However, I talked to him at length about it and prepared him thoroughly for the move.”

In her police statement, the prison’s psychologist also refers to the man’s positive approach at the end of his two year sentence: “He was at the end of his sentence saying that this would be his last sentence as he had to now change and knew his biggest hurdle was the heroin problem.” Like every other witness, she had no concerns about self-harm.

On 2 May, a RAMAS⁹ meeting was convened, as probation staff were aware that the man had a history of domestic violence and that he was planning to live with his girlfriend on release. They therefore wanted to assess the degree of risk presented. The meeting was attended by representatives from probation, psychology, the prison, housing and Midvale Road (a halfway house). A note of the conference (which the man attended) recorded amongst other things that he was “highly institutionalised” and that there were indications of personality disorder. It was proposed that he should be formally assessed. It was noted that he had used heroin since 1998 and that he minimised or did not acknowledge his alcohol use. Apart from the proposed treatment at Silkworth Lodge, the man was reported as saying he would maintain contact with ADS. His probation officer was also to chase up the man’s application to attend Highlands College, while Midvale Road was to assess him whilst he was at Silkworth Lodge. The man was assessed as being at medium (level 3) risk of self-harm/suicide with high (level 4) risk of seriousness (that is, that if he self-harmed or attempted suicide it would be serious).

The plan drawn up at the meeting was that the man would complete the programme at Silkworth Lodge (paid for by the States of Jersey) before moving to a halfway house for a further period before he was released fully into the community. In addition, the man had applied for, and been granted, ‘voluntary aftercare’.¹⁰ This is essentially a support mechanism for those who are in some way vulnerable. It would have meant a probation officer helping over securing welfare benefits, visiting him at Silkworth Lodge and monitoring his substance misuse.

⁹ Risk Assessment, Management, and Audit Systems. The Probation Service uses RAMAS for risk assessment, partly because it looks at both risk to the self as well as risk to others.

¹⁰ Voluntary aftercare or supervision is a client led arrangement, which continues for as long as the client feels it has value.

The man's short period at liberty

Silkworth Lodge

Silkworth Lodge is an in-house rehabilitation centre. Its programme follows the AA 12 step model, which provides a model for living. It takes a holistic approach to alcohol and substance misuse. Clients stay for around eight weeks, completing four or five of the steps. The programme mainly revolves around group therapy (three sessions a day are held, dealing with different issues), but there is also individual counselling. All potential clients are carefully assessed beforehand. Part of the purpose is to establish whether their motivation is sufficient to complete the course. It claims a high success rate amongst those who do so.

The man had the option of a 'celebratory weekend' after leaving prison, but chose instead to go directly to Silkworth Lodge.¹¹ The Assistant Ombudsman spoke to a counsellor at the Lodge. He told her that every day is completely structured and there are fairly strict house rules. These are set out in detail in writing, but a member of staff also goes through them verbally with each new resident. Clients are required to sign up to the rules because they form part of the therapy – they help to provide structure and discipline to people whose lives can be chaotic. It is about re-establishing moral standards and providing a bridge to normal living.

The counsellor said the man was clean and sober when he arrived and was initially quite positive, even enthusiastic. However, within a week, it became clear that he was not fitting in with his peer group. The work involved delving into honesty levels and, while the man was sometimes honest, he did not always tell the whole truth. He was challenged about this by his peer group, but there was never any sign that this annoyed him - he was quite laid back and would apologise to the group for whatever he had or had not done. The counsellor said the group accepted this for a while, but soon tired of it. In addition, the man was not keen on doing his TDs (Therapeutic Duties – housekeeping tasks around the Lodge, which all clients were expected to carry out as part of the regime). Although he started to engage with the programme, it was quickly apparent that it was not working for him.

Commenting on a draft extract of this report, a Senior Counsellor at Silkworth Lodge advised that disruption, "which may involve a client's lack of commitment to the treatment programme, can have a damaging and negative influence on the whole peer group." She said this was addressed by the counselling team and a clinical decision was made to discharge the man. She added that, "transition from a prison environment can always be a difficult period for a client and every effort from the staff at Silkworth is made to address this crucial 'settling in time'".

The discharge summary from Silkworth Lodge said:

¹¹ The placement was (swiftly) facilitated and funded by ADS. The Director of ADS, advised that the national picture for access to residential rehabilitation would normally be three months or more, but that the man who died was admitted to Silkworth Lodge on the day of his release.

“Response to treatment

[The man] appeared at first to settle in quite well. He had no problem with his stepwork but could not or would not adhere to the disciplines set down at Silkworth and constantly challenged staff.

In the end he was asked to leave the group who all agreed with the decision.

Treatment outcome

[The man] was asked to leave Silkworth on Monday 17 July 2006.

Prognosis

If [the man] wishes to remain clean he must attend AA/NA¹² meetings, without this the prognosis for [the man] is not good.

Follow up support

[The man] has the fellowship of AA and NA.”

The man’s parents had a number of concerns about why their son was “expelled” from Silkworth Lodge. His explanation for his eviction was that he did not report someone else for leaving the hostel via the window when they should not have been going out.

The family had also heard that the manager who agreed to their son’s enrolment was off sick so was not there to advise on his management. They had also heard that the decision might have been made by a vote taken by the other residents. They wondered if their son had refused to do group work within the hostel as residents were permitted to smoke during these sessions, whereas their son had recently given up smoking.

The Assistant Ombudsman asked about each of these. She was told that the man constantly flouted house rules. The counsellor said the man continually had to be asked to do things or not do things and was told the same things day after day. This had a negative impact on the group and that was why they voted for him to go. (The senior Counsellor said in her letter that it he was discharged as the result of a clinical decision, not a client group vote.) The counsellor also said that the activities of another resident had absolutely nothing to do with the man’s departure (in fact, he was accommodated in a single room).

The counsellor advised that the Director was absent from the Lodge at the time due to ill-health, but said all the staff were fully qualified (one was a trainee) and they were overseen at the time by the Board of Trustees. Nothing was done any differently in the man’s case from what would normally happen.

¹² Alcoholics Anonymous and Narcotics Anonymous.

Finally, the counsellor said there were no issues about people smoking in the group session. There was only one small area in the Lodge where people could smoke. The whole of the rest of the building is non-smoking. If anything, it would have been the smokers who suffered.

Contact with probation

The Assistant Ombudsman spoke to the Chief Probation Officer and his colleagues (including the man's most recent probation officer) at Probation Service HQ. They said that successful completion of the Silkworth Lodge programme was an important element of the man's post custody care. The man's probation officer met him and the programme co-ordinator at the Lodge on his first day there and visited him again on 10 July. She recorded:

"He looked well and said that his first weekend, at liberty, had gone very well ... We had a general discussion about [the man's] situation and, as usual, he said all the right things – he does not wish any contact with [his girlfriend] or the baby whatsoever as he feels that he will be lured back into his previous lifestyle, including drug misuse – he said that when [the boy] is old enough he will try to seek him out and he is ok with that. He does not wish any distractions whilst he is at Silkworth and wants to concentrate on maintaining abstinence and focusing on his college course. I agreed to write to [named person] Highlands, giving her the information she needs ... Although, this is a voluntary arrangement, we agreed on weekly contact, in the first instance."

On 17 July, the probation officer received a letter saying the man had been asked to leave Silkworth Lodge.

The man went to Probation on the day he was discharged, and was seen without an appointment. He said he felt he was victimised at Silkworth Lodge as he was the only drug user – all the others were alcohol users. He did not consider he was getting the same service as everybody else. Staff at the Lodge said he was not ready to go through the programme, but the man said this was not the case. He said he was motivated. However, he had issues with some people there who queried why he was taking up valuable resources when he had just come out of prison and was clean and sober.

The Probation Service offered the man help to find accommodation but he declined it, saying he wanted to sort something out himself. On 21 July, he called at the office with his son (his girlfriend had offered him contact) and said he had found a rented property but did not have enough money for the deposit. He had saved a significant sum whilst in prison but needed an additional £40. The Probation Service lent him the money and also provided him with an Active Card, which gave the holder free access to a gym and pool. They wanted to help the man use his time constructively.

He attended the probation office as agreed on 24 July and then again unplanned on 25 July and was still actively engaged in sorting out his accommodation and pursuing arrangements with the college. However, on 31 July, the man missed a pre-arranged

appointment and was sent a letter on 8 August offering him another appointment for 14 August.¹³ He duly attended but said he had relapsed.

The man had approached ADS following his release in July. He wanted an appointment so that he could get a prescription but was told he could not have one for three weeks. On 14 August, the probation officer took the man to see a colleague at the Probation Service¹⁴, as he said he was using again. (The probation record of contact said, “he feels [his ADS appointment] is too far away and that he will be in prison before this appointment”). The colleague contacted the Alcohol and Drugs Service on his behalf, informing them that the man had reported that he had been using a £50 bag of heroin a day for the last three weeks. He explained that the man had been given an appointment for 4 September, but that he said he could not wait that long. The colleague added that the man had contacted a doctor, but the doctor could not help until the man had been seen at ADS. ADS advised the next day that, “We are down in staff and people on holidays. This is the first available appt. If there is a cancellation he can have it but otherwise he will have to wait. Everyone else is the same.”

The colleague suggested that the man should provide a sample so that he could be given a prescription on the day of his appointment (ADS will not prescribe without a positive sample¹⁵). The man had not been able to provide a sample at the time, but had surprised the colleague by going back later and giving one.

The man’s girlfriend described to the police his strong feelings for his son but the pressures he was under:

“[The man] was saying he was getting sorted, he had his flat which he was proud of. He was going to college and was wanting to go on the subutex, which he had to wait three weeks for ... He was fully aware he had to prove he was getting himself sorted before I would fully take him back.”

“I know [the man] was back on heroin ... Even though he was upset about getting sorted, the heroin was just an infill until he got the subutex, he was counting down the days. He had a future and had a future with his son if he got himself sorted.”

She confirmed that the man was under the influence of heroin when he was arrested.

¹³ Some time between 31 July and 8 August, the Assistant Chief Probation Officer met the man by chance in the street. The man indicated that all was well and said he was grateful for the probation officer’s help.

¹⁴ The colleague straddles the Probation Service and the Alcohol and Drugs Service (ADS), spending three days each week with the former and two with the latter. The role ensures there is a strong working relationship between the two organisations.

¹⁵ The issue of prescribing methadone and subutex in Jersey has been very controversial because of concerns that they would become available illicitly. However, DF118s (dihydrocodeine) had been a huge problem in itself and it was eventually agreed that methadone and subutex may be prescribed in very carefully regulated circumstances. ADS may prescribe the drugs. They are administered daily under very tight supervision, and always washed down with water thereby preventing ‘spits’. The strategy has proved successful so far with no ‘leakages’.

Despite this, she said she had no reason to fear the man might take his own life on his return to La Moye. However, he had expected “to get probation once arrested as we spoke about this before the police arrested him.”

The man was arrested on 29 August. Following his arrest, he phoned his probation officer twice from the police station. He was coherent and not upset or crying, but was concerned about having let everyone down. He was disappointed in himself.

The probation record of contact said:

“[The man] was very apologetic and said that he had tried everywhere to get help with his heroin addiction but no one wanted to know. He felt that he was going to end up back in prison and would lose his accommodation. I said that ... he should tell the Magistrate that he has been seeing me on a voluntary basis. The Magistrate may then bail him and ask for background reports (this is a bit of a long shot but may help prevent him being remanded in custody).”

The probation officer briefed the Probation Service court duty officer about the man’s circumstances so that the Magistrate would be aware that the Service was providing support to him (the man) should he (the Magistrate) decide to grant bail.

A last chance

A statement from the Roman Catholic chaplain helpfully offers details of the man’s short period at liberty.

He had first met the man on C wing in March 2006. The man was not religious but the two men had gone to the same school (Victoria College). The chaplain had visited the man in the segregation unit and they had talked about what would happen on his release. The man had indicated a wish to remain in touch.

The man had been very positive about Silkworth Lodge at first, but after 10 - 14 days he had been discharged and called at the chaplain’s house. With assistance from St Saviours’ Parish, the chaplain had helped him find a home (a single room in a house).

The two men then lost contact until Sunday 27 August when the man arrived at the chaplain’s door, obviously in a bad way and asking for money. That evening he returned, agitated and distressed.

The chaplain’s statement says that the man regarded this period of liberty as his last chance. However, the chaplain says that, despite his swings of mood, he never indicated to him a desire to self-harm.

Police custody

Following his arrest, the man spent 48 hours in police custody before being remanded to La Moye. (I am struck that people spend far longer on average in the police custody suite than would be the case in England.)

I visited the custody suite. Although I have no expertise in policing matters, it appeared clean and fit for purpose. However, I am told it is very busy at the weekends with intoxicated/addicted prisoners and there may be staffing implications therefrom.

According to the police custody record, the man was arrested just before 9:00 pm on 29 August on suspicion of breaking and entering, larceny and receiving stolen goods. He arrived at Rouge Bouillon Police Station just before 10:00 pm. He told the police he had a “banging headache”. As is normal practice in police stations, his belt was removed from him and placed in a sealed bag. It was returned to him on transfer to court.

The Risk/Medical Assessment form recorded under question 7, ‘Have you ever tried to harm yourself?’: “In 2001 attempted suicide by carbon monoxide poisoning.” However, the custody sergeant judged there were no present concerns regarding self-harm.

The medical form recorded, “He is on diazepam.” The man was prescribed two 5mg tablets of diazepam and a paracetamol for his headache. The medicines were dispensed at 10.42 pm. The diazepam was repeated at 12.50 pm on 30 August with a further single tablet at 9.30 pm. The man continued to request medication and further single dosages of 5mg of diazepam were dispensed at 10.35 am and 7.20 pm on 31 August.

In her police statement, the police surgeon who treated the man on 29 August said that he had told her he was on diazepam detox and was taking six 5mg tablets daily. He told her he had taken two tablets that morning as well as two Neurofen plus. The following day, she ascertained that the man was only actually prescribed four 5mg tablets daily and was due to be reduced to three. (However, as noted, he was actually prescribed less than this reduced dosage while in police custody.) In a second statement, the surgeon said the man had denied using any non-prescribed illicit drugs. She said that, from previous dealings with him, she knew he was a poly-drug user but she was “unable to confirm this at that time as he would, or could, not produce a urine sample.”

By chance, the same doctor also examined the man after his death. Her statement concludes: “[The man] was seen on the 29th August 2006 whilst in custody and he did not overtly or covertly make any mention or suggestion of self-harm. I was therefore surprised and saddened to examine his body ...”

A statement from the Forensic Medical Examiner who saw the man on 30 August, reports that the man said he had never self-harmed or taken street drugs since 2004. When the man gave a sample of urine for testing (he had declined to do so when asked by the police surgeon the previous day), it was positive for cannabis, opiates

and benzodiazepines. The man claimed that he could have been exposed to cannabis accidentally and accounted for the finding of opiates by saying he had taken two Neurofen Plus. The doctor's statement doubted that the threshold for the opiate test would have been met by Neurofen Plus. He said of his assessments of the man: "I have no reason to believe that [the man] was at greater risk of self-harm than any other prisoner."

The police officer who gave the man his breakfast on 1 September also recorded that he had no undue concerns and was "quite shocked to find out what had happened to him." The officer on duty at court (who had known him for ten years) also said he showed no evidence of wanting to take his life.

Whilst in police custody, it was recorded that the man made repeated use of the cell buzzer and that, "It was made clear that this behaviour was unacceptable and that he needed to realise and understand that whilst his needs will be catered for that will be done at our pace and not his." He also frequently requested cigarette breaks but declined meals on a number of occasions.

On Wednesday 30 August, the man phoned the chaplain. The chaplain noted in his statement to the police that the man's attitude to the police could be confrontational and he kept ringing the bell. The chaplain offered his help and advised the man to tell the police the truth.

In his conversation, the man was worried about his accommodation and offered the chaplain the keys. (The chaplain declined after consulting with police.) He made a further call asking for motorcycle magazines and puzzles. The man asked the chaplain to attend court and he saw him there at 9.45 on Friday 1 September. He recorded that he had no sense of any suicidal ideation at that time. (The chaplain did not know what amount of heroin the man was using or what detoxification he was receiving.) Unfortunately, the man's case did not come before the magistrates before the chaplain had to leave some 1¼ hours later.¹⁶

The man was charged with five counts of larceny. He pleaded not guilty to all the charges and was remanded in custody by the magistrates until 15 September.

So far as I can judge from police statements, he ate a police breakfast (a bacon roll and a cup of tea) on the morning of 1 September, and had two cups of tea while at the Magistrates' Court.

¹⁶ The chaplain's police statement includes the following: "At no time whilst with [the man] did I get the impression of suicidal ideation ... Again, whilst at the police station on Thursday did I not get any impression from [the man] of suicidal ideation."

Reception at La Moye

In her police statement, the man's mother said her son was not expecting to go to prison so soon after his release a month earlier and that he was not expecting to be kept in custody when he went to court on Friday 1 September.¹⁷ She added:

“When I spoke to [the man] he said everything had gone wrong. His Probation Officer did not attend [court]. He thinks she may have gone to the Royal Court and [the chaplain] who had been there for him had to leave because his case was so late. The court did not believe he had a flat, and that he had asked for help at probation and drug and alcohol as he knew he was slipping.”

On arrival at La Moye at about 1:00 pm, the man was first processed through reception by an officer. The officer said: “[The man] is moody but I've never considered him to be depressed. I certainly never thought he would take his own life.” Because he was not subject to an Exceptional Risk Form (a form that comes with the prisoner from court or the police), he returned to the man the bag of possessions that had been taken from him at court. These included his leather belt. He said in his police statement, “On the say so of the Healthcare Team, I issued [the man] with his belt back.”

In a second police statement, the officer said he was not aware of live self-harm forms on the man's personal records, as these files were not kept in the reception area. No reference is made by (discipline) reception staff to existing prison records during the reception process.

The man signed a Private Cash/Property Handing Out form to hand out two sets of keys to clear property from his flat. The keys were to be picked up by his mother or by the Roman Catholic chaplain. He had the clothes in which he had been arrested and £2 in cash. He gave telephone details of his mother, the chaplain, probation, St Saviour's welfare and a friend.

During the reception process, the officer opened a new prison record for the man. He noted that the man was using drugs and would be seen by healthcare. Under 'any other comments' he noted the following:

“Stated he cannot go onto normal location and has been threatened by friends of the residents of E-wing.”

The officer listed four named prisoners from whom the man said he expected repercussions. The man completed a Request for Segregation form. The segregation under Rule 38A form was witnessed by the officer and countersigned by the Unit Manager. The reason for segregation was given as “Due to threats that I expect from other prisoners.” Further detail is given as follows:

¹⁷ The police advised me that no other outcome was likely. However, it is possible that the man might have been influenced by his probation officer telling him that he should apply for bail on grounds of his voluntary contact with the service, his placement at the college and the fact he had secured accommodation for himself. Her view when Miss McMurray spoke to her was that the decision could have gone either way, but that the court were probably swayed by his recent release from prison and his offending record.

“Expects repercussions [repercussions] from prisoners: [four named].”

The man explained in his police statement that ‘Senior Management’ considered that the safest location to place the man would be an area on E landing, which was part of the VPU. He said this was judged to be the most appropriate area as the man could mix with other prisoners but, if there was trouble, his area could be made safe by closing a dividing gate between it and the rest of the unit. I understand that the governing Governor was present by chance during this discussion and that he agreed.

The Assistant Ombudsman asked why the man had not been placed instead on C wing, given that several of the prisoners from whom he feared repercussions were located on E wing. She was told that the man had on other sentences been involved in various problems with prisoners located on C and E wings, and it was felt that E wing was the best option at that point in time, partly because of the ability to gate off part of the corridor and partly because of the higher staff to prisoner ratio. The Unit Manager told The Assistant Ombudsman that staff would have expected that the man would gradually integrate with the prisoners (including those with whom he had difficulties) over time. He said it was not possible to overstate the man’s interpersonal skills and that he would have been able to overcome any antipathy towards him.

The man went from the officer to a healthcare officer for a health screen. (All Healthcare Officers are nurse-qualified; the prison’s doctors are from a local GP practice.) The healthcare officer’s incident report form, following the discovery of the man’s hanging, included details of the first reception health screen:

“... I was satisfied that [the man] showed no subjective signs of low mood, and he denied any thoughts of self-harming or suicide ... he maintained good eye-contact ... there was no indication or symptoms to suggest low mood. In addition, there was no Exceptional Risk Form from the police ... I did not deem it necessary to place [the man] on an F2052SH ...”

In his police statement, the healthcare officer said he conducted a drug/alcohol history with the man in which he admitted to using half a gram of heroin a day which he smoked: “He denied cannabis use, but he did say he used Benzodiazepines, specifically Valium, which he was prescribed 20mgs a day by his GP, and all illicit supplies he could get hold of.” The man had said he had been treated for depression in the past (as an in-patient) but denied being low in mood or having suicidal thoughts.

In a separate police statement, the healthcare officer said he was aware of two self-harm forms held on the man’s personal records file but, from his overall assessment and based on his interview with the man, he did not consider it was necessary to place him on special observations.

The healthcare officer advised The Assistant Ombudsman that, during reception healthcare screening, he would refer to previous Inmate Medical Records (IMRs), Bomic (the healthcare database) entries, any correspondence from police/probation

and previous custodial records - either paper or electronic, where available. He said Exceptional Risk Forms were listed on Page 1 of the database and that all events (including self-harming) are held on Bomic.

The healthcare officer repeated that the man came over as generally pleasant and “his usual self”. His only concerns were with regard to his medication/detox the healthcare officer said the man did not mention previous instances of self-harm but that he asked him if he had any thoughts of harming. The man denied any such thoughts. The healthcare officer said he would have recorded if he observed any objective symptoms of low mood (guarding, poor eye-contact, monosyllabic responses), but none of these was noted. He added that the man was coherent and his speech was not slurred (the reception officer concurred with this).

The Governor told me that the prison does not offer methadone as it does not have the resources to administer it properly. The main GP is not convinced that methadone is clinically the best method of detoxification. The man was therefore prescribed dihydrocodeine and diazepam. (I understand that this prescription differed from that the man was given in police custody because he admitted at the prison that he had been smoking 5g of heroin per day – something which he had not admitted to the police surgeon. A urine sample also tested positive for benzodiazepine and opiates.)

The healthcare officer told The Assistant Ombudsman that staff would have been advised verbally that the man was on a detoxification programme, as this would have imposed restrictions on the patient, such as limited access to gym and sport. Details of a prisoner commencing detoxification would also be included on the Healthcare Daily Report, which was available to all staff. He said prisoners undergoing detoxification for alcohol were placed on observations, due to the potential physical dangers of withdrawing from alcohol, but these dangers were not present in opiate and benzodiazepine withdrawal. Those on substances detoxification were therefore not placed on special observations.

According to his incident report form, a senior officer who escorted the man from reception to his cell. In his police statement, the senior officer said this happened at between 4:00 and 4:30 pm (the reception officer’s statement said it was between 3:00 - 4:00 pm), and that the man was quiet and had asked if people on the wing had been talking about his return. The senior officer said he gave the man a meal and subsequently went back to give him a phone call to his mother. The man had to leave a message, and the senior officer promised he could try again later. The senior officer then went to get the man a tea pack. The man apparently asked for water, and the officer told him there would be an opportunity to get some later. He added:

“[The man] had given me no cause for concern at any time, I was very shocked when I came back to find out what had happened. I am not aware of any self-harm or attempt to take his own life previously. Although [the man] was quiet on arrival, this struck me as being because he was worried about his reception with other inmates, but he hadn’t been popular before he left last time round ...”

In his statement to the police, an officer said there was nothing on the VPU board about any special requirements for the man (for example, extra observations for detoxification). He said he saw him to speak to at about 3:30 pm when he opened his cell for showers and to get ready for tea. He said he could not remember the man saying anything to him and that the door was pushed or kicked closed from the inside.

The officer spoke again to the man later on when the latter rang his bell. The officer told him he could come and go as he pleased, but the man told him that he did not feel comfortable with some of the other prisoners on E wing because of previous incidents when he was last in prison. The officer reassured him that there would always be an officer on the landing when the cells were unlocked. (The Unit Manager confirmed to The Assistant Ombudsman that he insisted that his staff maintained a presence in the corridors at all times.) He said he knew the man well and that what he said caused him no concern.

The officer offered the man the opportunity to collect his tea from the dinner tray at about 4:20 - 4.25 pm, but he declined because he did not want to come out of his cell. The officer explained to the police that, "Dinners are not taken to prisoners who refuse to collect them, so [the man] went without." The officer said the man rang his bell a couple of times during the evening, but he (the officer) could remember nothing more particular.

At about 5:00 pm, a healthcare officer gave the man his medication.

The prisoner in the neighbouring cell said he heard the man talking to himself at about 6:30 pm.

An officer said in his police statement that he was aware that the man did not want to associate with any other prisoners and that he was frightened of reprisals. At about 7:15 pm, he collected him from his cell to facilitate the phonecall to his mother. They initially tried the pinphone in the segregation unit as "[the man] was frightened to use the pinphones next to gate 8 or on the landing of E2." However, the phone did not work and so the officer allowed him to use the office phone. The man asked his mother to collect the keys to his flat and remove his possessions as he did not expect to get bail. (The man's mother said in her police statement that she thought her son's speech was "quite slurred" but that he did not express any intent to harm himself. She told me that what he said was quite muddled.)

The healthcare officer from reception spoke again to the man at 8:00 pm¹⁸ when administering his medication. He also provided a ventolin inhaler.

An officer said that, later that evening, the man was "clearly frightened and paranoid of other prisoners," although he did leave his cell briefly to get some hot water.

The prisoner next door told the police that he and the man chatted through the doors at around 10:00 pm. He said the man sounded really paranoid, saying that "people were out to get him". The prisoner said the man was upset about coming back into

¹⁸ 7.45 pm in his police statement.

the prison “and his head was fucked”. However, a short time later he sounded a lot calmer. The prisoner said they spoke for about half an hour and then fell asleep.

An officer saw the man lying on his bed, apparently asleep, during roll count at 8:00 am the next day. He said he knew the man felt threatened by prisoners on the main wing and that he had no friends on E wing either.

Another officer said the breakfast trolley was parked about 14 feet from the man’s cell door. He said the man said he would like breakfast, “but basically he wanted it delivered. He refused to come out and as such did not have breakfast.”

At about 8:15 - 8:30 am, the man asked an officer if the gate separating his cell from the others could be locked so that he could shower. The officer explained that he could not be given special treatment, and assured him that he and another officer would remain on the landing whilst the man showered. The man did not take a shower and re-secured his door. The officer said, “He was clearly frightened of coming out while other inmates were unlocked.” He added, “At no time did [the man] show any signs of self-harm or suicidal tendencies ... The only thing I picked up ... was his paranoia and fear of other inmates.”

The Assistant Ombudsman asked why the gate was not closed off, given the man’s fears. She was told that the area in which he was located was not closed off from access by other prisoners as at least one other prisoner was housed there. It was the practice that prisoners were able to access the accommodation, landings and cells when unlocked for work and recreation. However, the man was seen by the duty Unit Manager and healthcare officer in order to address his concerns. In addition, the residential staff were very familiar with the issues the man had with other prisoners located on both C and E wings.

Staff could not recall whether any prisoners hung round the man’s cell, and could only say that during unlock for work and recreation prisoners were able to move freely in the accommodation areas.

The healthcare officer who had seen the man on reception spoke to him at about 8:45 am. He said, “He had no complaints about the withdrawals, but asked when he would receive his next dose [around 1:00 pm] ... On both these occasions ... I at no point saw any indication that he was low in mood or preoccupied in any way.”

The prisoner next door said he and the man chatted for about half an hour at about 9:00 am. He told the police that the man was saying things such as, “Tell my parents that I’m sorry for everything I have done and also that I love them.” He also said he was sorry for everything he had said and done to the prisoner. The prisoner said these comments made him think the man was unstable. He said the man said he was “pissed off” with the world. The man stopped speaking when there were officers around and waited until they had gone to start speaking again. (Self-evidently I have no way of verifying this man’s account and it is possible he may have mis-remembered what was said.)

An officer spoke to the man at about 9:30 am, when the latter rang his cell bell and asked the officer to get him some hot water so he could make himself some tea. The

officer said in his police statement that he refused to do this, “as I wouldn’t wait on him but I offered to escort him to get water if he wanted.” The officer said he suspected the man did not want to get any verbal abuse. The man told the officer that he did not want to see anybody, but eventually accompanied him to the kitchen area. On the way, the man spoke to another prisoner (the prisoner’s police statement revealed nothing of note). On his return to his cell, the man asked the officer if he could go into the segregation part of the VPU, but was told he could not.

The officer unlocked the man with all the other prisoners at about 10:00 am. He said the man pulled the door shut again straightaway. (The observation hatch was clear at this point.)

At about 11:20 am, the officer went to the man’s cell to tell him that lunch was being served. He said the man told him that he did not want to see anyone, and asked the officer to get it for him. The officer said in his police statement that he:

“would not be manipulated by [the man] to be at his beck and call, so told him I wouldn’t. I explained three staff were on hand should he be intimidated or threatened in any way. He refused to come out. He [name], Head of Security, had told him his meals would be brought to him. He then shut the cell door again.”

This was the last time the man was seen alive.

The officer told the police that, “Today I found [the man] to be quite quiet. If he had been under threat genuinely, he would have asked. He had never complained about being threatened whilst he had been in prison on this occasion. He didn’t want to be in E wing, he wanted to go on C wing, as the inmates are quieter and more timid ... There was no indication to me that he was suicidal.”

The discovery of the man hanging

The healthcare officer who saw the man on reception recorded in an incident report form that he was administering the lunch-time medication at 1:15 pm. He said he went to the man's cell, noticed a "cloth/towel" obscuring the observation glass, entered the cell and found the man hanging from a pipe that traversed the cell ceiling. He said he immediately summoned help from an officer who was in the corridor at the time. He said he instructed him to get an ambulance and to summon an officer from Healthcare. The healthcare officer said the officer who had first seen the man in reception arrived and he (the healthcare officer) instructed him to take the man's weight, whilst he cut through the belt that the man had used as a ligature. The healthcare officer reported that the man was placed on the bed and that he could not observe any breathing or pulse. He said he began CPR and was joined by another healthcare officer who had brought the emergency equipment. He added, "From the point of opening his cell to commencement of CPR, I would suggest was no more than one minute." The healthcare officer said they continued to perform CPR until the paramedics arrived and that they continued to do so under the paramedics' direction until the man was transferred to hospital.

The healthcare officer's account in his police statement differed slightly, although probably not significantly. In his police statement, he said the bed had been moved out from the wall at an angle and it was apparent the man had used it in hanging himself. The healthcare officer said he hit his personal alarm and asked an officer, who was between the man's cell and the corridor to the main VPU, for his scissors. He said that, at this point, another officer arrived and he instructed the first officer to get an ambulance and another healthcare officer. He said he cut the man down whilst the officer supported him and that they laid the man on the bed and started CPR. The healthcare officer could not recall whether the gate separating the man's cell from the rest of the corridor was open or closed when he arrived.

According to the officer near-by's incident report, he saw the healthcare officer open the man's cell at approximately 1:14 pm. After he opened the cell, the healthcare officer shouted to him to push his alarm. The healthcare officer asked a second officer to assist him while the first officer secured all prisoners on E1 and E2 landings behind their doors. (The officer confirmed in his police statement that the gate capable of dividing the man's cell from the rest of the unit was open at the time that the healthcare officer arrived at the cell.)

According to the second officer to arrive, he was on duty on E2 landing when he responded to the first officer's alarm. He thought, but was not sure, that the gate between the man's cell and the rest of the wing was closed. The officer said when he entered the cell he saw the man hanging from the ceiling by his belt. He said he jumped on the bed, drawing his cut down scissors, but the healthcare officer told him to support the man's weight and he (the healthcare officer) would cut him down. When the belt was cut, the officer laid the man on the bed and removed the ligature from around his neck. "I could see [the man] had no colour and wasn't breathing." (In his police statement, the officer said the man's lips were blue (cyanosed).) He said he started breathing for the man while the healthcare officer started chest compressions. Thereafter, with the second healthcare officer, they continued CPR, rotating the roles. The officer timed the departure of the ambulance as 1:54pm.

The second healthcare officer said in her incident report that her personal alarm sounded at approximately 1:15 pm. She immediately attended cell 4 on E1 landing and found “approx 3” officers outside the cell. The man was on his bed “very pale and appeared unconscious.” She ran back to healthcare to collect the emergency equipment, shouting for someone to call an ambulance.¹⁹ She returned to the cell with an officer and took over the airway and ventilations while the first healthcare officer and the other officer took turns with the cardiac massage. The paramedics arrived at approximately 13:25. (I judge this was more likely 13:30, as the ambulance service recorded the time of arrival as 13:29.) The officers continued with CPR while the paramedics attached a defibrillator, cannulated, intubated and administered drugs. The healthcare officer said in her police statement that she knew the man and was surprised he had taken his life. She said she could not recall ever dealing with him for self-harm issues.

In his incident report, an officer said that at 1:15 pm, he attended an alarm bell raised by the officer nearest the man’s cell. On entering the man’s cell, he saw an officer cutting the belt from around the man’s neck. The healthcare officer and another officer helped place the man on the bed. The officer said he asked staff to inform the second healthcare officer to bring an oxygen bottle and mask (this is a slightly different account from that of the healthcare officer herself). According to the officer, the first healthcare officer commenced CPR and an officer used his oxygen mask to do the breathings. The officer then left the cell.

Another officer said in his incident report that he attended following the nearby officer’s alarm bell. He entered the cell to assist but left once CPR was commenced.

Another officer timed his arrival at the cell at 1:05 pm (I think this must be in error) and recorded the healthcare officer as taking charge and ordering everyone but the officer assisting him out of the cell. The officer then ran with yet another officer to the gate to help with the arrival of the ambulance and the locking mechanism was overridden to ensure easy access for the ambulance.

Another officer said he had run to the cell at approximately 1:16 pm. He said, “I asked [the healthcare officer] if he needed a hand to put [the man] on the floor, instead of on the bed he said he was fine where he was.” He says it was he who radioed for an ambulance at 1:19 pm.

The Unit Manager said he responded to a personal alarm from the healthcare officer (I think he might be mistaken in this). He said he told all but four officers (including the two administering CPR) to return to their posts. He briefed another Unit Manager and asked him to check the arrangements for the ambulance. The second Unit Manager said he would supervise the incident from now on.

According to the police statement of one of the paramedics, when he arrived the man appeared cyanosed and was not breathing. His heart rhythm was asystole (a straight line). Attempts to cannulate him were also unsuccessful and atropine and

¹⁹ According to the police statement of the paramedic, for some reason the ambulance crew initially understood that they were attending an assault.

adrenaline were eventually administered via endotracheal intubation (directly into the airways). Further adrenaline was administered en route to the hospital. The man was transferred to the ambulance and taken to Jersey General Hospital at 1:50 pm.

Another officer's incident report adds that he assisted with the medical equipment, started an event log (at the request of the second Unit Manager) and accompanied the man on the ambulance (where he also assisted the paramedic with CPR).

The second Unit Manager's own incident report adds a little more detail. He said Officer Blake called a Code Red²⁰ at 1:19 pm and that two officers maintained a log after the first record keeper left the prison. The Unit Manager secured the man's cell with a device (colloquially known as a boot) and padlock. He said the Scenes of Crime Officer attended at 3:40 pm.

The logs maintained at the man's cell referred to a number of items discovered and removed by the police. They were a piece of elastic, a small broken brown plastic bottle, and a piece of cling-film found in the man's slop bucket. Police records show in addition one white bottle top and a piece of cling-film. The suspicion must be that these items were drugs paraphernalia of some kind although I see little merit in speculating upon how they came into the man's possession, how they came into the prison, or their purpose. In the event, the toxicology report found nothing of significance.²¹

After his arrival at hospital at 2:07 pm (2:05 pm according to the ambulance records and 2:08 pm according to the attending doctor), staff in the Accident and Emergency Department continued resuscitation attempts until 2:28 pm. The doctor's report said that the man was in cardio respiratory arrest on arrival and that his pupils were fixed and dilated. He said, "he had ETT, IV access and neck collar was placed. CPR as per ALS protocol for asystole was continued for a further 20 minutes. At 14:28 [the man] was pronounced dead."

Contingency plans

The paperwork I have seen indicates that the contingency plans for a death in custody were put into effect very well. Comprehensive logs were maintained, all those who needed to be informed were contacted very speedily, and the cell was sealed as a potential crime scene. The police were in the prison just 80 minutes after the man was found. I judge this to have been very professionally handled and I would wish the Governor to share that sentiment with all concerned.

²⁰ Code Red requires all designated staff to respond immediately.

²¹ The man's blood was found to contain only 1.2 micrograms per millilitre of dihydrocodeine and 0.16 micrograms per millilitre of diazepam. The blood had been further screened for the presence of other drugs and pharmaceuticals but nothing of significance was detected. The blood concentration of diazepam was within the range generally accepted as being therapeutic while the blood concentration of dihydrocodeine was greater than would be expected for analgesic use but was, I understand, within the range that would be readily accepted by somebody with opiate tolerance.

Post mortem

The post mortem found no evidence of significant injuries beyond those consistent with hanging and nothing to indicate that the man had been forcibly restrained or involved in a struggle. The cause of death was given as hanging.

As noted above, the toxicology report identified small amounts of dihydrocodeine and diazepam but nothing of significance in relation to other drugs or pharmaceuticals. No alcohol was detected.

Multiple linear scars consistent with previous self-inflicted injuries were noted on the front of the man's left forearm. A small volume of partially digested food was discovered in his stomach (suggesting that he had eaten not too long before his death).

Family liaison

Following the discovery of the man hanging, the Senior Unit Manager telephoned his parents so that they could attend the hospital. While there they met the chaplain.

The Governor told me that he had met the man's father following the death of his son. The family had been offered the chance to visit the cell where the man had died, but had declined.

The Senior Unit Manager, along with the Deputy Governor, the reception officer who helped with the resuscitation (who had been separately texted by the man's brother), and the drugs counsellor (who had been invited by the man's mother), all attended the funeral on 13 September.

The Governor has since written to the man's parents to offer assistance with the funeral expenses.

I judge that family liaison was handled well and was an example of good practice.

The follow-up within the prison was also managed well. The six staff directly concerned were offered independent counselling. They also received an e-mailed message of thanks and offered further support a week later.

Prisoners were assessed for risk following the man's death. A couple of days afterwards, arrangements were made to ensure all prisoners now have in-cell television on their first night in custody.

The Governor told me that he would have arranged a memorial service at the prison had one been requested, but none was. He also said he had heard that both staff and prisoners had made inappropriate comments following the man's death. He was not certain this was the case, but nevertheless took prompt steps to address staff on the matter.

Examination of the issues

Resettlement

Like HM Chief Inspector of Prisons, I am struck by the absence of effective resettlement and aftercare services in Jersey. Despite substantial intervention and support by the Probation Service and some drug counselling work, nothing appears to have been effective in addressing the man's offending behaviour or his re-settlement needs, leading to successive periods of imprisonment.

I understand that voluntary aftercare has been bolstered since 1 July 2006 by the provision of funds to enable a Probation Officer to be allocated at the point of sentencing. This makes it more likely that prisoners will elect to continue the relationship after release. This is to be welcomed (although it falls some way short of a structured system of post custodial supervision). In addition, I understand that progress is being made on facilitating prisoner re-settlement with the setting up of a sentence management unit. This too is to be welcomed. Nevertheless, work on resettlement needs to be driven forward and effective joint working is the key to effective resettlement.

I recommend that the Governor at La Moye works closely with the Probation Service in setting up offending behaviour and resettlement programmes for prisoners.²²

In addition, and notwithstanding progress currently underway:

I also recommend that the States of Jersey should review resettlement, aftercare and offender management services for released prisoners.

I was initially surprised to learn that the Prison and Probation Services are not currently brigaded together under the Home Affairs Department. (I am aware that the then Chief Inspector of Prisons made a formal recommendation on this issue in the report of his 2001 inspection.) I understand that the Probation Service itself considers that it is best placed where it is, but I believe this is a matter that should receive continuing attention.

I recommend that the States of Jersey considers what structures would best facilitate consistent and seamless offender management.²³

F2052SH

The man was not considered to be at risk of suicide or self-harm during his final stay at La Moye, but I have nevertheless reviewed the prison's response to previous instances where he was considered to be at risk.

²² I understand that, following two one-day workshop reviews by prison and probation staff, a review is planned for July 2007.

²³ Commenting on my draft report, the Chief probation Officer disagreed with this recommendation. He said the matter of where the Probation Service rested had only recently been considered and that good progress was being made towards consistent and seamless prisoner management.

The first time was on 8 August 2005. On that occasion, I have discovered that the F2052SH paperwork was not completed satisfactorily. It is not clear when the form was closed, either the doctor or the unit manager did not complete the closing report, the observations were limited in scope and the special watch sheets included entries for 22 May 2005 that I do not understand.

I recommend that the Governor should review a selection of F2052SH booklets to satisfy himself that they are being completed to a satisfactory standard.

It would appear that the man was placed on the F2052SH at 5:00 pm on 8 August 2005 because he cut his chest with a razor blade after being moved to the segregation unit, a move he considered unjust. The officer responsible also recorded, "... stated that he would [word unclear - ? swallow] the blade. Informed him that he would have to do so and we would deal with the situation afterwards." If this was a fair description of the conversation, the Governor may wish to draw my concern about its contents to the officer concerned.

The healthcare officer's contribution to the Healthcare Assessment recorded that the man told the doctor, "he has recently had fleeting ideas of suicide/self-harming and he feels victimised by the wing staff; says he has had enough." The doctor's own note recorded that the man would not discuss the reasons for his actions and the words "Feeling suicidal" appear in quotation marks.

The man was placed on two observations an hour. He was due to be reviewed on 12 August and it seems probable he formally came off the monitoring at that stage, although there are no observations after 3:50 pm on 9 August. The closing report (which, as noted, has been completed only by one hand) reads:

"Adjudicated, given suspended sentence and warning, given his job back and clear parameters and returned to his cell (11:00 - 09.08.05). The trigger for his self-harm has now been removed, I do not consider him to be at risk."

I think this was a fair judgement.

The second time a F2052SH form was opened was on 3 April 2006. A healthcare officer opened the form at 3:40 pm. The man was again held in the segregation block. The healthcare officer recorded her concerns as follows:

"[The man] has self-harmed, superficial cuts to chest and cut to left side of head; has previous history of self-harm."

"[The man] feels unable to cope, he is out in 13 weeks and doesn't feel strong enough to resist drugs. Also states he feels under threat both within the prison and outside."

The doctor's assessment was similar:

"Self-harmed with superficial cuts. Anxious about discharge from prison in 13/52 [thirteen weeks]. Main problem appears to be bullying and threats from others. Grandfather very ill."

This time the paperwork does show that the F2052SH was closed the following day. It is not clear if the man himself attended the review. There are references to the man's anxiety about his release – and his hope to be accepted by Silkworth Lodge – and to his being bullied by a named prisoner. The support plan was to email the drugs counsellor and someone at ADS and to discuss the bullying issue with the Deputy Governor. I consider that this too was an appropriate response. Since both the drugs counsellor and the person from ADS were involved in the RAMAS meeting on 2 May which formulated a strategy for the man's release, it also seems the plan was properly followed through.

In England and Wales, the F2052SH is in the process of being replaced by a strategy known as ACCT (Assessment, Care in Custody and Teamwork). In the view of my office, ACCT is a significant step forward on F2052SH and is helping to save lives, but proper staff training is undoubtedly key to its success. The Governor at La Moye told me he would only want to introduce ACCT if he had adequate resources, and I understand his caution. I note from the minutes of a Suicide Awareness Group meeting on 4 October 2006 that sufficient resources for implementation had now been identified. I welcome this development and recommend:

The Governor personally drives forward arrangements for implementing ACCT prison-wide.

Alleged bullying by staff

The man's parents told me that, since their son's death, they had read the diaries and notes he made during his last sentence. These talked of bullying by prison staff. An example they gave was regarding their son's work footwear. He complained that he had been given boots a size too small and, when he complained to staff, they told him to use Vaseline to squeeze his feet in. This resulted in him not being able to go to work. The man's mother described the diaries as upsetting to read. She and her husband were clearly very concerned by the allegations of staff bullying and gave copies of the diaries to the police.²⁴

I have reduced the length of what follows compared to my draft report in light of a suggestion that it was disproportionate to the conclusions I reach. However, I should stress that, when speaking to my Family Liaison Officer about the draft, the man's mother continued to attach considerable importance to this issue and remained concerned that she had received, unprompted, two separate accounts of her son being bullied by staff.

I have examined what documentary evidence there is relating to the man's complaint about staff's attitudes over his boots. An investigation was conducted, during which

²⁴ I have seen a copy of a letter the man's mother wrote to the Minister for Home Affairs following her son's death. She said her son telephoned her often during his previous imprisonment, "despairing of his unfair treatment and bullying." She said the treatment he received had destroyed his confidence and self-esteem and that he had been close to suicide then because of this bullying. The man's mother added that another prisoner had told her that her son was bullied often and treated unfairly. Someone else had reported that he was "bullied unmercifully".

The man and three prisoners he named as witnesses were interviewed. One of the prisoners confirmed that the officers picked on the man, but added that he brought a lot of it on himself. The second said the man should not speak to the officers the way he did and that, if he did, he had to be prepared to take the consequences. The third said the officers were “quite petty with him; they seem to go out their way to be on his case.”

When The Assistant Ombudsman asked the Unit Manager about this episode, he said the man was given the size of boots he had asked for. Of course, if these turned out to be too small, they should have been changed even so – but contemporaneous prison records do not suggest that the man raised this as an issue with staff.

I suspect this is a case of six of one and half a dozen of the other. I find telling the measured response of the prisoners who were interviewed. I consider it likely that staff did not cut the man any slack where they might have done with other prisoners, but that this was because his reputation preceded him. It is clear from his history sheets that he was a challenging young man and that he was often ‘up to something’.

Nevertheless, I was concerned to find amongst the investigation papers a note from the investigating officer, setting out details of a complaint by a prisoner about the man bullying. The man was re-interviewed on 12 July and this time he was asked if he had been bullying other prisoners and to account for the “43 entries on his wing history sheet between the 18th of April 2005 up to date and not one of them being positive.” He subsequently dropped his complaint.

I am very concerned about the way the man’s legitimate complaint was apparently deflected by allegations of bullying against him. The two issues should have been kept entirely separate. As it is, the prison response has every appearance of trying to intimidate the man into withdrawing his complaint – which he did. Whether staff merely applied the rules (albeit rigorously in the man’s case) or over-stepped the mark was therefore not established. This is of concern in itself, but may also have led the man to believe he could expect little support from them during his final period at La Moye.

I recommend that the Governor personally supervises the investigation of all complaints about members of staff and that the prisoner is given a finding one way or the other.

I found only one other complaint of bullying by staff. In a note to the Deputy Governor dated 14 February 2006, the man accused two named officers of “bullying”. Much of the letter relates to the officers’ attitude towards other (named) prisoners, but the man complained about an officer locking up the wing up early and making him go straight to work from gym without first having a drink. The man also referred to having spent three months in segregation for bullying other prisoners. He said he thought events had been exaggerated due to staff resentment of him and felt he had been dealt with very unfairly.

It is not clear what action, if any, was taken about this complaint.

The Assistant Ombudsman asked the Unit Manager about the man's complaints of bullying. The Unit Manager advised that, "because that was quite a long sentence, we had verbal complaints against every member of staff including myself on occasions. Basically, if he couldn't get what he wanted, he would play up a member of staff." He said he told the man to put his complaints in writing (policy was to investigate only written complaints about staff) but he never did so. Instead, he withdrew his complaints after a couple of days and turned his attention to someone else. The Unit Manager was certain he had been firm but fair with the man and that his staff had been the same.

I have not identified any specific instances of bullying behaviour that warrant independent investigation. It seems to me that staff might have been harder with the man who died in some respects, but that this was as much a response to his own behaviour, which staff found demanding and sometimes arrogant. The staff at La Moye whom we and the police have interviewed advised that they related well with him. They said he could sometimes be very trying, but that he was always dealt with professionally.

Discharge from Silkworth Lodge

I commend prison and Probation Service staff for the way the man's release in July 2006 was planned. Despite the fact that he was apparently clean and sober in prison, the plan recognised the need for him to address his drug misuse. A placement for him at Silkworth Lodge was duly set up, and he was to go afterwards to sheltered accommodation to ease himself fully back into the community. He was also given the support of 'voluntary probation' which ensured regular ongoing contact with the Probation Service.

Successful completion of the Silkworth Lodge programme was the gateway to addressing all the man's post custody care. Unfortunately, the plan fell apart very early, when he failed to comply and was discharged. His parents are very critical of the way this was handled.

The man went to probation on the day he was discharged. He said he felt he was victimised at Silkworth Lodge as he was the only drug user – all the others were alcohol users. He did not consider he was getting the same service as everybody else. Probation Service staff suggested that it was possible that he was simply too articulate for the staff there to deal with when he challenged them. They said there had been a lot of staff changes at the Lodge – those there at the time had not had so much training and some were not long out of rehab themselves.

The counsellor at Silkworth Lodge said that staff challenged the man repeatedly about his failure to conform. He explained that adherence to the rules and regime of the Lodge was a key element of the programme itself, since it served to establish discipline and a structured life-style. Hence, failure to conform undermined what they were trying to achieve. In addition, the other people on the programme had tired of the man's non-conforming behaviour. The counsellor said staff were trained in handling people such as the man and that, notwithstanding the absence on sick leave of the Director, everything was done as it normally would be.

The Probation Service took the view that the key issue was the lack of an exit strategy from Silkworth Lodge. They said there had been no attempt to address practical issues, such as finding somewhere for the man to stay, or the emotional difficulties he would have experienced as a result of being rejected yet again when he was not even using drugs. The man's needs were complex and Silkworth Lodge should have appreciated that they could not act in isolation. Anything they did would have far-reaching ramifications.

The Assistant Ombudsman asked the counsellor about this. He said that copies of the discharge summary had been sent on the day of the man's departure to the Probation Service, the drugs counsellor at the prison and the ADS, so all the relevant agencies were alerted to what had happened. In addition, he said it had been arranged that the man would be discharged to his mother's address.²⁵

The man's probation officer told The Assistant Ombudsman she did not consider this was sufficient. Although she received a telephone call from an administration worker at the Lodge, she considered that any discharge should have been preceded by a meeting between Silkworth and the Probation Service in order to consider whether discharge was inevitable and, if so, to allow alternative arrangements to be put in place.

It is of course simply not possible to know what, if any, difference such an approach would have made. It is also important to bear in mind that Silkworth Lodge is not part of the criminal justice community and that its responsibilities are quite different. Apart from any moral duty it had towards the man, it also had a responsibility to safeguard the interests of the other residents, whose own recovery programmes were liable to disruption due to his challenging behaviour. I think Silkworth Lodge could have taken a different approach with the man and that other organisations charged with his care might have stuck with him for longer. But that is probably to apply the wrong parameters.

Nevertheless, I hope the Director at the Lodge will consider carefully whether there are any lessons to be learned from the man's death.

The man's missed appointment with the Probation Service

In light of the man's relatively fragile state and the recognition that this further rejection would have had an emotional impact on him, I was surprised to note that no immediate action appears to have been taken when he missed his first probation appointment. Instead, it was one week before a letter was sent to him asking him to attend at a later date. I appreciate that the contact was purely voluntary, and that the Probation Service had no formal responsibility for him at that time, but it is difficult to avoid speculating whether earlier intervention would have prevented or curtailed his relapse.²⁶

²⁵ The man told his probation officer that he could not stay at his mother's address.

²⁶ Commenting on my draft report, the Chief Probation Officer emphasised the substantial contact the Probation Service had had with the man following his release. He believed they had provided him with an "excellent service" and that the probation officer in particular had provided considerable assistance to him. He continued:

ADS

The man's parents have expressed their concern that their son was not able to get an earlier appointment with ADS following his discharge from Silkworth Lodge.

Commenting on the draft of this report, the Director of ADS advised that they were a small community based service that operated Monday to Friday. They were not in a position to provide an emergency prescribing service. He accepted, however, that the response time of one month in this case was unusually long and explained that it was due to pressures and staff shortages at the time of the referral. He said ADS was normally able to offer an appointment within 1 – 3 weeks (which was within national treatment guidelines).

The man who died might not have benefited long term from his contact with ADS²⁷, but early contact and, importantly, a prescription for subutex might have alleviated some of his immediate problems and certainly removed the driver for him to engage in acquisitive crime. In short, it might have helped to keep him safe. Given his recent rejection by Silkworth Lodge, it is not difficult to see that he might have felt that his life was spiralling back out of control and that, notwithstanding the support he was receiving from the Probation Service, there was no-one to whom he could turn for help. The Probation Service contact log for 30 August reported that the man said he had tried everywhere to get help with his heroin addiction but no-one wanted to know.

I have not engaged with ADS during the course of this investigation (other than to disclose extracts from my draft report), but I hope a copy of my report will be passed to them. I also hope that, in light of my observations on this matter, they consider how they might better - and more quickly - respond to those seeking their help.

I was struck by the large percentage of Jersey's prison population who have been convicted of drugs offences or whose offences were drugs related. The drugs counsellor told The Assistant Ombudsman that she discovered through one-to-one interviews the previous year that some 70 per cent of prisoners had problems with alcohol or drugs. She described the prison's attempts to address the issue:

"Whilst the comment about the missed appointment is perhaps justified by hindsight, it could equally have been argued that a swift failure to report letter could have been counter productive. It could be stated with equal justification that 'despite [the man] failing to keep his appointment, and being encouraged to keep in contact verbally, a further written appointment was given to him which he kept.'"

The Chief Probation Officer added that the probation officer knew from the Assistant Chief Probation Officer's chance encounter with the man that he was apparently doing okay.

²⁷ The Director of ADS helpfully outlined the man's contact with ADS over the years. He said:

"He was first seen in July 1999 and commenced a treatment programme for opiate addiction. During that episode of treatment, he failed to attend six of fifteen appointments. He subsequently had in-patient from the service for each of the years between July 1999 and August 2006 with the exception of 2004 when he was seeing [name] (Court Officer) on condition of a Treatment Order. I can confirm that during his contact with the ADS, [the man] commenced a number of detoxifications from both alcohol and opiates."

“The prison practises only detoxification. It is an eight day programme with a choice of two medications. We do not have the resources for maintenance programmes.

I provide one-to-one counselling. I am self-employed and used to be part-time but am now full time.

We provide education into the harm caused by substance abuse. We also provide group work, including an awareness course that lasts three months. We deliver it to a different wing each day. We also provide detox acupuncture and the AA visits on Thursdays. We also ran a course on relapse prevention and another course for drug importers. This was discontinued, however, due to lack of resources. Drug and alcohol advisers from the community come into the prison once a week and spend about three hours here. They help with the process of feeding people back into the community. Our links with doctors etc. are good and we ensure that relevant links are made and appointments set up before people are released ...

Unfortunately the quickest way to get a referral is in prison. Detox is also easier in prison because there are more constraints and people are away from their usual influences. It is not uncommon for people who decide that they need to clean up for a while to engineer a return to prison. They commit crimes right by the police station or their families set them up, because they will not comply with detox programmes at home. [The man who died] used prison in this way.

Jersey has been reluctant to admit to any problem with drugs, but is now beginning to get to grips. There were previously no rehabilitation or treatment programmes available in the community. Now both of these are as good as resources allow. There is still under-funding, however.”

I am pleased to note the links that have been developed between the prison and the community in addressing substance misuse and that the prison has increased its own activity in this respect. In light of the scale of the problem, however, I question whether it is yet enough. This man’s death suggests that it is not.²⁸

A States of Jersey Official Scrutiny panel review, Responding to Drug Use, was completed in 2004. The panel made 21 recommendations aimed at improving the States’ response to drug misuse and said it would seek to review the implementation and outcome of its recommendations in a year’s time. I have been unable to ascertain whether any further action was indeed taken. At any rate,

I recommend that the States of Jersey reviews the current position with regard to addressing drugs misuse to determine what further work needs to be done.

²⁸ During this investigation, I learned that another young man, released at about the same time as the subject of this report in July 2006, had died on 13 January 2007. The cause of death was thought to be a drugs overdose.

Sharing of information

The police knew (because the man told them) that the man had attempted suicide in 2001 by carbon monoxide poisoning. (The man told the police FME, however, that he had never self-harmed.) The Probation Service knew about the 2001 attempt and that he had made a number of attempts to take his own life during 2004. The prison knew about the two incidents of self-harm during his previous period of custody. But none of the organisations had all the information.²⁹

Indeed, the Police National Computer record for the man has no marker for suicide/self-harm. This is despite his 2001 attempt (about which they were aware).

I understand that information from the police to the prison about risk of self-harm is communicated via an Exceptional Risk Form or sometimes on the court committal. No other procedure exists for other agencies, but work is ongoing to introduce a system similar to the Prisoner Escort Record (PER) form used in England and Wales. This is to be welcomed.

I recommend that a system for sharing information about risk, akin to the PER form, is introduced as a matter of urgency.

There are currently a number of initiatives to share information between the Probation Service and the Prison Service, but these do not yet represent a comprehensive system.

I recommend the Governor of La Moye jointly reviews with the States of Jersey Police and the Jersey Probation and Aftercare Service mechanisms for exchanging information on self-harm.

I also recommend that he ensures all staff are trained to access that information and actively encourages them to do so.

Reception at La Moye

Despite the fact that he was well known to staff, the man underwent the full reception procedure at La Moye – that is, he was seen first by the reception officer, who dealt appropriately with his desire to be segregated, and immediately afterwards by a healthcare officer to assess his physical and mental health. (I would say, however, that given the low intake of prisoners - I understand the prison receives only a handful a week - I am surprised the reception process took as long as it did. From the times given in police statements, it seems the man was received at the prison at about 1:00 pm but was not taken to a wing until some time between 3:00 and 4:30 pm (the timings given vary). Swift entry into prison can help to reduce levels of

²⁹ Commenting on the draft of this report, the Chief Probation Officer said the man had been 'red-flagged' on their IT system before 2004, including for self-harm. In addition, the 2002 Probation reports referred to self-harm attempts. He said the Governor had always received Probation reports that resulted in custody and had had full access to their IT system since 2003. He said the prison would therefore have had the relevant information before August 2005. He added that the prison, on the other hand, had not told Probation about the self-harm in custody in August 2005. He said the Probation Service had worked hard to share information, particularly risk information, with other agencies.

anxiety, particularly amongst those going into custody for the first time. Although it was by no means his first time in custody, the man was anxious about the reception he would get from other prisoners. The delay can only have served to exacerbate this. The Governor might wish to consider this further.)

Given that the man had twice before harmed himself whilst at the prison, it might be questioned why his belt (with which he was to hang himself) was returned to him by the reception officer. The officer specifically addressed this point in his statement to the police. He said that, given that the man was not accompanied by an Exceptional Risk Form, there was no reason for him to withhold the belt. I consider this was reasonable, notwithstanding subsequent events. Episodes of suicidal ideation can be short lived and the fact that someone has self-harmed in the past does not mean that he or she remains at risk indefinitely. The officer who assessed the man for risk of self-harm was experienced and knowledgeable. I have no reason to question his judgement. It is also important that prisoners – and perhaps particularly those who are most vulnerable – should be treated humanely and with dignity. Allowing them to dress normally is one way this can be achieved.

However, I am concerned that prison files appear only partially to be joined up – returning prisoners are given new prison numbers and a new record is opened each time. There is thus a lack of continuity of information from one sentence to the next. This has implications not just for the reception process, but also for the prisoner's management on the wings. This problem should to a large extent be overcome by the new IT systems. In the meantime, I consider that it should be possible in a prison the size of La Moye, with its limited turnover of prisoners, to establish systems that create greater continuity between separate periods of custody.

I recommend that the Governor considers how information about an individual might be joined up in a way that is readily accessible to staff.

The man's mother explained that she thought the prison would have automatically kept a closer eye on her son, as last time he was in the prison he had cut himself and had refused to let them treat the cuts. However, as noted above, whilst previous incidents of self-harm might point to a heightened risk of self-harm, it does not mean that such a risk necessarily exists. In this man's case, and given the particulars of the two incidents, it would not have been unreasonable for the prison to conclude that his ideation related exclusively to the particular circumstances that obtained at the time (though, as suggested earlier, knowledge of the two previous incidents might have influenced their judgement).

Nevertheless, I am concerned that the man was not placed under increased observations as a result of his being on a detox regime. I understand that policy at La Moye is for those withdrawing from alcohol to be placed on special observations, but the same policy does not apply to drugs withdrawal. The physical dangers of withdrawal from drugs are not the same as those for withdrawing from alcohol, but it is an unpleasant experience and many will find it difficult to bear. It is also likely that

the withdrawal will have some effect on the person's mental state and that this could heighten risk of self-harm.³⁰

I recommend that all those withdrawing from any substance are placed on special observations.

Detox

La Moye operates abstinence rather than maintenance programmes for drug users and uses dihydrocodeine to reduce the severity of withdrawal symptoms. The current Chief Inspector of Prisons commented on this in her report:

“While the current prescribing regime for opiate users was neither in line with the island-wide drug strategy nor the English/Welsh clinical management guidelines, it would be difficult for controlled drugs such as methadone and subutex to be introduced safely as the standard treatment, given the lack of resources and unsuitability of the environment.”

She went on to say:

“Specialist advice should be sought before there are changes to the clinical management of opiate users, as current healthcare resources are insufficient to introduce the prescribing of controlled drugs safely.”

I do not dissent from the value of specialist advice, but my own view is that urgent consideration should be given to introducing more appropriate detox medications and other treatments. In her clinical review, the Deputy Ombudsman makes a similar recommendation.

I recommend that consideration is given to introducing more appropriate detox medications and other treatments.

First night arrangements

No first night arrangements – whereby prisoners newly received into the jail are placed in an area of the prison specifically designated for new arrivals and where they can be monitored more closely – exist at La Moye. The first few days in custody are the time when prisoners are at their most vulnerable. Statistics show that the most likely time for prisoners to kill themselves is in the first days or weeks after arrival. Ensuring that newcomers are given additional support, are monitored and are provided with a full induction into the prison are therefore of vital importance. For this reason, I welcome plans to establish a First Night Assessment Unit at the prison. I understand that even those such as the man who died, who have spent previous periods at the prison, will be accommodated on the Unit for the first night at least, “so that any changes to their circumstances can be identified and managed”. This is a significant and important development.

³⁰ Given the agitation that can be caused by withdrawal, I am concerned that practice at La Moye is to put prisoners who are withdrawing in shared cells with those who are not. This must be extremely unpleasant and distressing for both parties.

However, I have some concerns about the Unit designated for this purpose. In the first place, there is no office space either for interviewing prisoners or for storing records. In the second, and more directly relevant here, the design of the cells is potentially unsafe. The cells are new and well appointed, but each one has its own toilet and shower area, which is entirely closed off from the rest of the cell, with the door facing away from the main cell door. This is of particular concern, given the heightened risk of self-harm amongst those newly received into prison.

I recommend that the Governor reviews the configuration of the cells in the new induction unit to ensure they facilitate easy observation of prisoners.

Few of the other cells at La Moye have integral sanitation.³¹ While I fully appreciate the resource constraints, this is simply not acceptable in the 21st Century. It is not decent for either prisoners or staff.

I recommend that the States of Jersey allocate funds to providing in-cell sanitation at the earliest opportunity.

The man's cell

On my initial visit to La Moye, I visited the cell the man had occupied (cell 4 on E wing). I noted that it was comparatively large by English standards, with a high ceiling. I also saw that it contains many potential ligature points, including pipework and the window and frame. Most strikingly, a pipe containing electrical fittings snakes across the ceiling. This is a frankly ludicrous weakness in the cell's design. It was from this pipe that the man attached the ligature, using his bed to climb up to attach it. I recommend:

In any future refurbishment of cells at La Moye, the pipes containing electrical fittings should be removed and the wires chased into the walls and ceiling.

I also recommend that any other measures to reduce the ready availability of potential ligature points are taken as soon as possible.

As part of the Prison Improvement Plan, funds have been found for the conversion of some cells to what are known as 'safer cells'. At the time of this man's death, the prison had no such cells. The Governor hopes that this work will be completed in early 2007 so that La Moye will have at least one safer cell for each part of our population. I welcome this news.

The man's cell contained no television or radio and it would appear he had no newspaper. Save for a selection of magazines that were on the floor when he was found, he had no other source of stimulation. On my initial visit to La Moye, I was particularly concerned that the man had spent his first night in custody without a television. (I understand that one would normally have been provided, but was not because he arrived just before the weekend.) The Deputy Governor had separately arranged that in future no prisoner should spend his first night without a television –

³¹ Some cells on the VPU do have their own toilets, but the design is such that it is not decent to use it when the cells hold two prisoners.

whatever day he arrived – and I commend his initiative in do so. Nevertheless, I recommend:

The Governor should ensure arrangements are in place that every prisoner has access to a television and radio on his or her first night in custody.

A white towel had been used by the man to cover the spyhole in his cell door and this prevented him being seen. He had attached it with sticking tape – presumably provided innocently by a member of staff for some other purpose. Obscuring the spyhole is a mainstream part of prisoner culture, and it is not hard to understand the desire for privacy. However, it inevitably raises concerns about security, control and safety, and staff must not condone the practice, even implicitly. One officer referred in his police statement to staff noticing that the man's spy hole was covered but being unconcerned because he was not considered to be 'at risk'.

I was concerned on my visit to La Moye that staff might, on occasions, be turning a blind eye to the obscuring of spyholes – I understand the use of disciplinary sanctions to discourage the practice is very rare. I was told this was not the case.

I recommend the Governor should remind staff that all objects used to obscure the spyholes should be immediately removed, and repeat offenders should be charged under the Prison Rules.

Food

I have also considered whether staff should have been more concerned about the man not eating. Although he was given a tea pack on the Friday evening, it seems probable he took little further food until his death. This is quite remarkable in a man whose history sheets refer repeatedly to cadging food off other prisoners. (He was also apparently told at Silkworth Lodge that he ate too much.) Food refusal can be an indicator of possible self-harm ideation (it can suggest either that the prisoner does not consider it worth eating or can itself be a form of self-harming behaviour), but nobody seems to have been alert to this, even though a number of officers and the Unit Manager were apparently aware of the situation. The Unit Manager told The Assistant Ombudsman that he would have been concerned about the man if he had been on duty.

In any investigation into a death in custody, it is easy to be seduced into identifying missed opportunities that could have changed the course of events and it is important that I maintain balance and perspective in drawing conclusions. For that reason, I do not make too much of the man's food refusal as an indicator in itself of possible self-harm. However, this was a man who normally ate a lot but who could not be enticed out of his cell for three meals. I consider that his behaviour provided a clear indication of the strength of his fear of repercussions from other prisoners. I think it likely that staff interpreted his behaviour as manipulative (some police statements corroborate this view) and that the more sinister interpretation of his behaviour was overlooked as a consequence.

I recommend the Governor reminds staff of the importance of identifying prisoners' behaviours, such as food refusal, that may indicate their state of mind.

Anti-bullying

The man had spent a considerable portion of his various times at La Moye segregated at his own request for his own protection. He appears to have feared different prisoners at different times and for different reasons. It is clear that he upset a number of people by his behaviour and made himself unpopular with some other prisoners. To some extent, therefore, the prison authorities may have become inured to this aspect of his behaviour and may have taken it on this occasion largely with a pinch of salt. (The Unit Manager was convinced when he spoke to The Assistant Ombudsman that the man would be able to talk his way out of his predicament.) I cannot say whether the man's behaviour on 1 and 2 September 2006 differed in any way from what prison staff were already long accustomed to and therefore whether they should have reacted differently. But staff reports of his refusal to come out of his cell suggest that he was genuinely scared for his own safety. I have to ask therefore – and even accepting the limited space available in the prison – why he was placed on the same landing as three of the four prisoners he specifically named when requesting segregation. The decision makes little sense to me, regardless of how well staff could protect him either by their presence on the wing, or by the ability to close the gate thereby separating the man's cell from the others. I do not doubt that managers were confident of their ability to protect him, but he may not have shared their confidence and the close proximity of those from whom he feared repercussions must have been unnerving for him.

More generally, I am concerned by the apparent inability of the prison to get to grips with bullying behaviour. The man himself was on different occasions both the victim and the aggressor, but no action appears to have been taken either against him or those who were allegedly bullying him. The Unit Manager told The Assistant Ombudsman that on occasion groups of prisoners were called into the office for a talking to, but no formal action appears to have been taken. Instead, the prison appears to have relied on separating the people involved (in itself a difficult task given the size of La Moye). This did nothing in the long run to resolve issues and to send messages to other prisoners that any form of bullying is unacceptable. I note that HM Chief Inspector of Prisons was also critical on this point. I am pleased to note therefore that the prison introduced a new Violence Reduction Policy in September 2006.

I recommend that the Governor monitors carefully the application and impact of the Violence Reduction Policy and quickly makes any necessary adjustments. I also recommend that he ensures adequate resources are provided to train staff.

The man's mother wondered whether there was any evidence of other prisoners making her son's life hard. She mentioned a prisoner whom he used to wind up and then back off just before he reached breaking point. She said it was like a game to her son.

After the man's death, a prisoner told a senior officer that he had heard two named prisoners make verbal threats to the man whilst he was in his cell the night before. The prisoner said the other prisoners told the man that if he went on the wing they were going to get him and if he stayed in his cell, they would burn him out. Asked if he was sure this is what he had heard, the prisoner said, "Pretty much so."

The Assistant Ombudsman interviewed the two prisoners referred to. She also interviewed a third mentioned by the man when he asked to be segregated from the main prison. Unfortunately, all three decided (one on the spot and two subsequently) that they did not wish to be involved with my investigation. For that reason, I am unable to refer to the notes of those meetings. Suffice to say that none of them was able to shed any light on this allegation and, as noted above, staff were not aware of prisoners hanging round the man's cell.

CPR

No criticism is intended here of the healthcare officer, who acted with speed, compassion and professionalism when the man was found hanging. However, good quality CPR should always be delivered on a firm surface, and it is not generally good practice to do so on a bed. My Deputy Ombudsman has advised that the bed was in fact "an appropriate hard surface". Nevertheless, it would be wise for the Governor to remind staff of what is best practice.

I recommend the Governor reminds staff that CPR should generally be delivered on a firm surface and not on a bed.

Conclusions

The man at the heart of this report was a prolific offender who appears to have become caught in a cycle of drug use and stealing to fund his drug use. By the time of his death at age 29 he had been in prison 29 times. Self-evidently, none of his many engagements with the criminal justice system had any impact at all on his drug using and offending behaviour or set him back on the right path.

It is clear that his death came as a surprise to those who had dealings with him during the previous three days following his arrest. However, it is also clear that no one person or agency was aware of the extent of his previous self-harming behaviour. Nor was any person or agency aware of the extent of his drug taking, and the likely pains of withdrawal given an unsatisfactory approach to detoxification. Finally, the prison was not aware of any specific threats against the man – although it seems likely that some were made.

It is also clear that the man had left La Moye in July 2006 with high hopes of ending the cycle of drug use and offending. Sadly, those hopes ended in failure within a matter of weeks. It may also have been that he had not anticipated being remanded into custody when he appeared at court on 1 September (although, given his record, I cannot see how any other outcome was likely).

This investigation and report has gone wider than many others I have completed. However, it seems to me that this man's death was not the product of a single rash moment in September 2006, but the culmination of many years of drug use and offending behaviour to support that abuse. In learning lessons from his death, therefore, it is necessary to look at these wider issues to identify what might be done differently to prevent another such tragedy.

Recommendations

- 1. The States of Jersey should consider what arrangements are in place to review deaths in custody from natural causes.**
- 2. I recommend that the Governor at La Moye works closely with the Probation Service in setting up offending behaviour and resettlement programmes for prisoners.**
- 3. I also recommend that the States of Jersey should review resettlement, aftercare and offender management services for released prisoners.**
- 4. I recommend that the States of Jersey considers what structures would best facilitate consistent and seamless offender management.**
- 5. I recommend that the Governor should review a selection of F2052SH booklets to satisfy himself that they are being completed to a satisfactory standard.**
- 6. The Governor personally drives forward arrangements for implementing ACCT prison-wide.**
- 7. I recommend that the Governor personally supervises the investigation of all complaints about members of staff and that the prisoner is given a finding one way or the other.**
- 8. I recommend that the States of Jersey reviews the current position with regard to addressing drugs misuse to determine what further work needs to be done.**
- 9. I recommend that a system for sharing information about risk, akin to the PER form, is introduced as a matter of urgency.**
- 10. I recommend the Governor of La Moye jointly reviews with the States of Jersey Police and the Jersey Probation and Aftercare Service mechanisms for exchanging information on self-harm.**
- 11. I also recommend that he ensures all staff are trained to access that information and actively encourages them to do so.**
- 12. I recommend that the Governor considers how information about an individual might be joined up in a way that is readily accessible to staff.**
- 13. I recommend that all those withdrawing from any substance are placed on special observations.**

- 14. I recommend that consideration is given to introducing more appropriate detox medications and other treatments.**
- 15. I recommend that the Governor reviews the configuration of the cells in the new induction unit to ensure they facilitate easy observation of prisoners.**
- 16. I recommend that the States of Jersey allocate funds to providing in-cell sanitation at the earliest opportunity.**
- 17. In any future refurbishment of cells at La Moye, the pipes containing electrical fittings should be removed and the wires chased into the walls and ceiling.**
- 18. I also recommend that any other measures to reduce the ready availability of potential ligature points are taken as soon as possible.**
- 19. The Governor should ensure arrangements are in place that every prisoner has access to a television and radio on his or her first night in custody.**
- 20. I recommend the Governor should remind staff that all objects used to obscure the spyholes should be immediately removed, and repeat offenders should be charged under the Prison Rules.**
- 21. I recommend the Governor reminds staff of the importance of identifying prisoners' behaviours, such as food refusal, that may indicate their state of mind.**
- 22. I recommend that the Governor monitors very carefully its application and impact and quickly makes any necessary adjustments. I also recommend that he ensures adequate resources are provided to train staff.**
- 23. I recommend the Governor reminds staff that CPR should generally be delivered on a firm surface and not on a bed.**