

**Investigation into the circumstances surrounding the death  
of a man at HMP La Moye in January 2007**

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

**April 2007**

This is the report of my investigation into the death of a man at HMP La Moye, Jersey, in January 2007. The man was found hanging in his cell. He was aged 39.

I offer my sincere condolences to the man's parents on the loss of their only child. I understand their trauma has been greatly exacerbated by the nature of the reporting in the local media of the death and the subsequent trial of their son's co-accused.

Since April 2004, my office has been responsible for investigating all deaths in prisons, probation hostels (Approved Premises) and immigration detention centres in England and Wales. I do not have any jurisdiction in Jersey, but was invited on 30 January by the Minister for Home Affairs to conduct this investigation. This is the second death at La Moye that I have investigated, the first having occurred just five months earlier in September 2006. On both occasions, I have received every courtesy and full cooperation from the prison authorities.

I must also mention the huge assistance I have received from the Jersey Police. They conducted a comprehensive investigation of their own which addressed all the issues upon which I myself would have focussed. As a consequence, I have judged my role to be to consider the facts the Jersey Police have uncovered to determine whether any opportunities were missed to prevent the man's death, and to make recommendations accordingly.

I am conscious that my principal recommendation - that all cells at the prison should be made safer - has significant resource implications. However, given that this was the second self-inflicted death in five months at La Moye on the part of a prisoner not identified as being at risk of self-harm, I have no hesitation in making it.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman for England and Wales**

**April 2007**

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## SUMMARY

The man who is the subject of this report was received into HMP La Moye, charged with indecent assault and other offences, on 23 July 2006. He was immediately located on the vulnerable prisoners unit. He settled well at the prison, was popular amongst his peers, and was described by staff as a model prisoner. Apart from one episode in October 2006 following a break up with his long-term partner, he was never considered to present a risk of self-harm.

The man was due to be sentenced on Monday 29 January 2007. On Friday 26 January, he saw his advocate (legal representative). She advised him that she hoped he would be sentenced to between 18 months and two years imprisonment. The man was apparently agitated during the meeting, but according to the advocate he became calmer at the end.

The following day started much as normal, with the man having breakfast and going about his normal cleaning duties and attending the gym. On his return from the gym, he made several phonecalls as a result of which some prisoners say he was visibly upset. He had lunch and was locked in his cell over the lunchtime period. An officer reported hearing a response from him when he (the officer) unlocked his cell door at about 1:15 pm. At about 2:45 pm, the same officer returned to the man's cell to deliver some fruit he had ordered. He found him hanging from the bars of the cell window with a bag over his head.

Staff and paramedics attempted to resuscitate the man, but sadly to no avail. He was pronounced dead shortly after his arrival at hospital at 3:49 pm.

Police initially suspected the man might have been murdered and put significant resources into their investigation. Several prisoners were taken into police cells overnight. However, the police quickly concluded that the man's death was in fact self-inflicted.

The man's parents had a number of concerns about his death. These were that:

- This was the second death at La Moye in a very short period, suggesting a lack of proper care at the prison;
- Their son was physically able to hang himself (that is, the cell was not safe and he was allowed to retain in his possession a very long belt);
- He was allowed to make too many phonecalls, thereby upsetting himself;
- His phonecalls should have been monitored by staff;
- Staff should have recognised the greater vulnerability of a prisoner approaching sentencing and afforded their son closer supervision in the days before he was due to be sentenced;
- The prison told them by telephone of their son's death; and
- Some four weeks later they had still not received his property.

As is my usual practice, I have put the family's concerns at the centre of my investigation.

### ***Examination of the issues***

I note that F2052SH procedures were not properly followed when the man was identified as at risk of self harm in October 2006, and that the form itself was poorly completed.

The man did indeed use the phone a lot, but I cannot criticise the prison for allowing this. Indeed, ready access to family and friends is something to be desired and I would be concerned if it was constrained. It is important that prisoners do not have all personal responsibility taken away from them, and this includes the ability to decide on the amount of contact they have with the outside world – even if that contact is upsetting. Stopping the man from phoning people would have done nothing to allay the concerns that prompted the calls. On the contrary, it is likely this would have made matters worse or precipitated a crisis.

Prisoners' phonecalls are recorded at La Moye, but staff do not routinely listen whilst they are taking place. To do so indiscriminately would be disproportionate and perhaps unlawful. But it would also be intrusive and the knowledge that they were being listened to would undoubtedly impair the quality of prisoners' contact with the outside world. Notwithstanding the possibility that, had his calls been listened to, the man's state of mind might have been identified in time to save his life, such a procedure would not be appropriate.

It is recognised that there are a number of points at which prisoners may be more vulnerable to self-harm. These include the first few days in custody and court appearances, particularly those at which the prisoner's fate is likely to be determined. However, these are just two of many so-called risk indicators. Taking all such indicators into account, the majority of the prison population might be considered to be at risk for most of the time. Identifying risk is by no means a science, but determination of risk must focus on the specific individual rather than on all the possible indicators. I do not consider it would be appropriate or practical to afford closer supervision to all those approaching potential 'trigger' points. Having said that, it would be good practice for a prisoner's personal officer<sup>1</sup> to maintain closer contact during such periods to enable him or her to monitor and offer support.

As part of my methodology for all deaths in custody, I commission a separate review of clinical matters. The clinical review of this man's period in custody has concluded that the healthcare afforded to him was entirely appropriate.

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<sup>1</sup> Prisoners are allocated to officers who take particular responsibility for forging a relationship with the prisoner and attending to his or her needs. However, the personal officer scheme operates in a much more informal way at La Moye than it does in prisons in England and Wales.

There is some doubt about the exact time at which the man apparently took his own life. Nothing was heard or seen of him after 1:15 pm. Indeed, nothing was actually seen of him after 12:15 pm. There is some uncertainty whether unlocking procedures were properly followed. This is of concern in relation to the timing of the man's death, but also raises security issues.

The ligature by which the man hanged himself was a fabric belt. I note the family's concern that he was allowed to retain such an item in his possession, but I do not criticise the prison for that. With the exception of a very short period in October, the man was never considered to be vulnerable to self-harm. There was no reason to suppose that he would harm himself, and the prison must balance safety with affording prisoners dignity and respect and the ability to lead as normal lives as possible. This includes allowing them to wear, within reason, the clothes of their choice.

I wholly agree with the man's parents that the cell, like others in the prison, offered ridiculously obvious ligature points. No cell can be made completely safe, but cells should be designed to offer those spontaneously contemplating suicide few ready opportunities for doing so. Delay in identifying a means may well bring the prisoner past a crisis point. I recommend that urgent action is taken to make safer all of the cells at La Moye.

Although the officer who discovered the man's body acted promptly in cutting him down and summoning help, he did not attempt any first aid. I do not consider this had any impact on the outcome, but unless rigor mortis has clearly set in resuscitation should always be started immediately. The fact it was not in this instance is of concern. In other respects, the prison implemented its contingency plans very professionally.

Referring to the concern of the man's parents about a lack of care at the prison, I note that it may be relevant that both their son's death and that of the prisoner to die in September 2006 occurred on a Saturday lunchtime in the vulnerable prisoners unit. The Governor will wish to consider whether this represents coincidence or something more significant. However, I have not uncovered any specific failings by staff or shortcomings by management that contributed to the man's death. It is also clear that the prison has taken such action as it identified as being immediately necessary and practical following the earlier tragedy.<sup>2</sup>

Finally, I record the man's parents' concerns about the way they were treated by the prison following the loss of their son, and make recommendations accordingly.

Overall, and aside from my concern about the safety of the cells at La Moye, I have not identified any opportunities missed by staff for preventing the man's sad death. Having said that, I make 13 recommendations that, together with

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<sup>2</sup> Another man was found hanging in his cell in the vulnerable prisoners' unit on 2 September 2006. I investigated the circumstances surrounding his death and issued a draft report for comment on 26 February 2007.

those I made in my earlier report, I hope will help reduce the chances of further fatalities.

## HOW I WENT ABOUT THIS INVESTIGATION

The Minister for Home Affairs in the States of Jersey wrote to me on 30 January 2007 asking me to investigate the man's death. She 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 individual 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 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 (in line with obligations arising out of Article 2 of the European Convention on Human Rights).

An Assistant Ombudsman conducted the investigation on my behalf, assisted by my Senior Family Liaison Officer (FLO). A Deputy Ombudsman (also a registered clinician) conducted a clinical review of the man's care.<sup>3</sup>

It is my office's usual practice to visit a prison where a death has occurred within 72 hours to meet key figures, obtain an initial brief from the Governor and to establish the physical location of the death. However, as part of my investigation of the earlier death at La Moye, I had only recently visited the prison and met the Vice Chairman of the prison's Board of Visitors and the Chairman of the Prison Officers' Association. I had also met the Minister and the Chief Officer of the Home Affairs Department and the Deputy Viscount. For that reason, and given that the Governor was due to come to England, the Assistant Ombudsman did not make the customary initial visit to La Moye, but instead spoke to the Governor in my office in London. The Governor kindly delivered the man's custody records at that time.

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

Following initial contact by phone, the Assistant Ombudsman and the FLO visited the man's parents at their home on 22 February to explain the purpose of my inquiries and to enable them, if they wished, actively to engage with the investigation. The couple kindly shared with my colleagues their principal

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<sup>3</sup> 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.

concerns in relation to the loss of their son in the hope that this would help to prevent further such deaths.

The FLO also spoke to the man's partner on the telephone and noted his concerns. These replicated those raised by the man's parents and so, like theirs, have informed my investigation.

I had previously agreed arrangements with the States of Jersey Police for the sharing of information in line with the protocol between my office and the Association of Chief Police Officers (ACPO). I am pleased to say that they have given my colleagues the fullest possible help with this investigation, readily and promptly sharing the many, comprehensive statements they had obtained, as well as other documents, including a very helpful 'time-line'.

The Assistant Ombudsman obtained from La Moye a copy of the man's medical record, copies of suicide prevention group meetings for the period September 2006 to January 2007, and a CD-Rom of the man's phonecalls.

A copy of the draft report was sent to the Governor of La Moye, who shared it with the Minister. This final report reflects comments on the draft which I received in a letter from the Minister dated 19 April 2007.

## **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. It is undergoing major refurbishment and building work and a new wing was opened last autumn. The Vulnerable Prisoners Unit (VPU) is made up of two wings - C and E. C wing, on which the man was located, has three levels, totalling about 23 cells. The normal daytime staffing level is three staff, although this is reduced to two at weekends.

La Moye has been inspected twice by HM Chief Inspector of Prisons. The second inspection was conducted between 27 June -1 July 2005 by the current Chief Inspector. In the introduction to her report, the Chief Inspector recorded that few of the recommendations the Inspectorate had made four years earlier had been actioned. Nevertheless, she praised three aspects of the prison relevant to this investigation. These were the strength of staff-prisoner relations; the approach to suicide prevention; and the clinical care given by staff in 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.

## EVENTS BETWEEN 23 JULY 2006 AND 27 JANUARY 2007

The man was received into HMP La Moye on 23 July 2006. The reception officer recorded that he was accompanied by an exceptional risk form.<sup>4</sup> The following boxes were ticked:

- Physical illness or mental disturbance;
- May be charged with serious offences; and
- Other. (Alongside this has been written “Vulnerable”.)

In the notes section, it was recorded that:

“[The man] charged with serious sexual offence against a minor and as such may be vulnerable to assault if placed in general prison population. Also has high blood pressure.”

The box denoting “May have suicidal tendencies” was not ticked.

The reception officer noted that the man had requested “38A”<sup>5</sup>, and that he had physical illness or mental disturbance and might be charged with serious offences. Next to “Personal Officer” the reception officer has placed a question mark.

The application for rule 38A gave the reasons for the application as being:

- “Because of the nature of my charges/offences
- Due to threats that I expect from other prisoners
- Any other reason.”

(None was given.)

The man was also interviewed on reception by a healthcare officer. No special watch provisions were considered necessary.

The man was located on C wing, one of two wings constituting the VPU at the prison. The first few entries in his wing history sheet indicate that he settled well:

30 July – “[The man] polite towards staff. Seems to have mixed well with others. No problems.”  
13 August – “[The man] no problems. Spends a lot of time with [named prisoner].”

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<sup>4</sup> This is a form used by the police and escorts to communicate possible risk posed by the prisoner. It includes risk to and from others, risk of self-harm and medical concerns. I recommended in my report on the earlier death at La Moye that that a system for sharing information about risk, akin to the Prisoner Escort Record (PER) form in use in England and Wales, is introduced as a matter of urgency. I understand work is ongoing on this.

<sup>5</sup> I assume this refers to requests for removal from association for the prisoner’s own protection, but it does not marry with my copy of the Prison (Jersey) Rules 1957.

19 August – “[The man] mixes well. Spends a lot of time reading. Always polite, works well. Has an interest in going to the gym.”  
29 August – “[The man] no problems, very polite, never complains. Model prisoner.”

On 4 September, the man was due to return to court. An exceptional risk form was completed once again. This reported that he was vulnerable to assault from other prisoners and “Other – nature of charges”. It recorded that he was located on the Vulnerable Prisoners Unit.

On 27 September, the man was given an induction interview with the prison probation officer. This covered alcohol and drugs, education, employment, family/social support, health, institutional behaviour, offending behaviour, resettlement, use of violence, vulnerability/self harm and victims. No particular issues were identified but it was recorded that the man reported “previous unintentional drunken overdose which required stomach pumping (approximately 6 years ago). No current concerns/ideations.” No targets of note were set, but the probation officer noted, “Staff to monitor mood. Support/refer as necessary.” No Personal Officer details are given in the space provided on the form.

### **Perceived risk of self harm**

At 4:55 pm on 6 October, an officer opened an F2052SH Self Harm at Risk Form.<sup>6</sup> She recorded that the man had “relationship problems. Overheard talks of suicide on phone, broke up with partner, trying to get back with him.” She recorded that he himself said he was having problems with his partner and was trying to sort it out. She suggested he be observed once an hour and given support by staff.

The Unit Manager indicated on the form that the man should be managed on normal location.<sup>7</sup> Under reasons for the decision, he wrote “7/10/06”, but something written immediately after the date appears from my copy to have been Tippexed out. The Unit Manager commented:

“He is very tearful after falling out with his boyfriend, and mentioned suicide during a phone call. [Officer who raised the form] worried about his safety ∴ this 2052.”

In section 2, the Unit Manager wrote, “1 per hour watch, support from staff, review 9/10 with doctor.” The bottom of this sheet is signed, dated 9 October and timed 9:50 am.

A healthcare officer completed the Nursing Staff section of the report at 7:15 pm on 7 October. He recorded:

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<sup>6</sup> F2052SH is a documented process for caring for and monitoring those identified as being at risk of suicide or self-harm.

<sup>7</sup> If he considers there are medical concerns, the Unit Manager can recommend the prisoner be admitted to healthcare.

“Denied any cause for concern – quite embarrassed. Said that he had a couple of lengthy phone calls with his partner that were not as bad as they were sounding.”

He decided that the man should remain in his single cell on C3 and be observed once hourly.

At 9:30 am on 9 October, a doctor noted, “Denies any DSH<sup>8</sup>/suicidal ideas. Understands why he was on F2052SH.” The doctor closed the form.

There are two entries on the daily Supervision and Support record. The first is by the healthcare officer who made the entry on the main form and was dated 7 October and timed at 7:10 pm. It said:

“Spoken to whilst open for hot water etc.<sup>9</sup> Said that there was no cause for concern and that he’s had a couple of lengthy phonecalls with his partner that were not as bad as they sounded. Smiling appropriately and content of conversation positive. For review with MO [medical officer] on 9 Oct.”

The second entry was made by the officer who opened the F2052SH. This was dated 8 October and timed at 4:30 pm. It said:

“[The man] has wrote a letter to myself this morning about a few things and his watch he assures me he is not going to self-harm, his life is more valuable to him and does not like been on a watch, is a lot more cheerful today and spent a lot of time on C2 with [named prisoner]. [sic]”

The Special Watch sheets show that the man was indeed observed at approximately one hour intervals, although I note that on a couple of occasions one and a half hours elapsed between watches. Almost all the entries record what the man was doing at the time he was observed. Only two record any engagement with him by the member of staff.

On 7 October, the man wrote a note to the officer who placed him on the F2052SH. It was addressed, “Dear [first name]” and said:

“I feel compelled to write this letter to you tonight in order that I may more clearly summarise my feelings, as sometimes, I find it easier if I lay my thoughts out on paper.

Firstly, I would like to thank you for your genuine concern for my well-being today. Although I would like to state, for the record, that I value my own life too much to pose a risk of self-harm to you whilst in your care, or the care of Her Majesty’s Prisons for that matter. However, I

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<sup>8</sup> Deliberate self-harm.

<sup>9</sup> Prisoners can take hot water with which to make hot drinks into their cells.

do appreciate that my general mood or outward appearance may have caused you concern as it deviated from my normal disposition today.

Secondly, I should be grateful if you would accept my gratitude for the personable approach which you have extended towards me. I am the first to admit that I do find life inside difficult and have found it hard to adjust to my new environment. However, I do try to adapt and will continue to do so. Whilst I fully accept my circumstances, it does not mask the pain I feel. I am desperately homesick and miss my partner Alwyn more than anything.

In closing I hope that you are able to draw some comfort towards my future with you, whilst in your care and charge.”

The prison probation officer told the police that she and the man had spoken about this episode. She said:

“During discussion he expressed surprise at the action that had been taken following what he described as a heat of the moment type comment, following an argument with his boyfriend. His surprise was compounded by the fact that the procedures had been initiated without anybody speaking to him, which he considered would have put his feelings into perspective and negated the need for a watch. He expressed no intention to self harm after making the comment.”

After 29 August, there are no further entries on the man’s wing history sheet until 8 October when it was noted that, “[The man] was put on a watch by myself. Is having relationship problems. Seems OK at the moment.”

On 15 October, the wing history sheet recorded that, “[The man] seems a lot better and is mixing with all the prisoners on C wing and is having regular visits.”

Two weeks later, it was recorded that, “[the man] is still concerned about his financial issues outside the prison, as he can’t get out to sort them out. He is also concerned that his [?dad] is still under investigation by the police.”<sup>10</sup>

The final entry, dated 20 November, recorded, “[The man] no problems on wing. Quiet, polite.”

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<sup>10</sup> The man told the writer of his social enquiry report that his partner had used up all his savings to meet mortgage repayments.

## Substance misuse group assessments

In December, the man attended a substance misuse group.<sup>11</sup> In assessing his psychological health for this purpose, the man said that, in the previous 30 days, he had often felt hopeless about the future and sometimes felt tense, suddenly scared for no reason, fearful, nervous, had spells of terror or panic, felt worthless and lonely, had no interest in things and felt extreme jealousy. He recorded that he had never had thoughts of suicide, heard voices or had hallucinations, paranoid ideas or delusions.

Under psychiatric/psychological problems, he recorded that he did not currently have any emotional problems or concerns that affected his life, had not been treated in the past for emotional problems and had never deliberately self harmed. Paradoxically, he also recorded that he had attempted to take his own life – “Yes. Once.”

On 16 and 23 January 2007, the Substance Misuse group conducted a peer assessment. The first explored blocks to recovery. Three of his peers thought the man was demanding of himself and four thought he was not open about his feelings. The second assessment focussed on resources for recovery. Three of his peers said he was honest/realistic about himself and problems, three said he had positive attitudes, three that he was trusting and sharing, and six assessed him as “Appears friendly, warm, caring.”

The man told the probation officer responsible for writing his social enquiry report that he suffered from high blood pressure but had lost almost a stone in weight during his imprisonment and the condition had virtually disappeared. He said he had never suffered from depression but sometimes had low mood periods. The man confirmed to the report writer that he did not have any suicidal thoughts and had never engaged in any self-harming behaviour.<sup>12</sup> He described himself as “resilient” and an “optimist” and said his regular visits from the prison chaplain helped him cope. (I understand that the man had re-discovered religion whilst he was in prison.)

A prisoner told the police that the man:

“... was a bit unhappy in there [prison] because he was having problems with his fella. He told me that he was worried his fella was going to leave him because he was in there. He said he’s been with

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<sup>11</sup> In his self-assessment, he said he felt he had at times abused alcohol when under stress and that his life would be better in the future if he was to abstain from drinking altogether. He said drinking had affected his judgement previously (though he said it had “no direct link to offence”), had worried his partner and caused him to “reveal a nasty side to my personality. Predominantly, jealousy, bitterness and unhappiness.” He noted that he first drank at 16 –17 years of age and drank heavily at weekends (he said at weekends on the boat he could consume a wine box in a day). He had tried cannabis once but did not like it. He said there had been three or four periods when he had drunk heavily, but he had always reverted to acceptable levels.

<sup>12</sup> On the day of the death of another man at the beginning of September 2006, the man who is the subject of this report phoned his mother to reassure her that he was fine. He had said, “what an awful state to get into, I wouldn’t get like that.”

his fella for ten years ... He never talked about suicide in the past. I wouldn't have said he seemed like the sort of person who might do it."

Another prisoner told the police that the man went to the gym everyday and "looked fit and healthy and well."

On 24 January, the man met the prison probation officer at his own request because he was anxious that he had not seen the social enquiry report prepared for the court. The probation officer told the police that the man took issue with certain aspects of the report as it related to his offending behaviour. He was apparently 'disgruntled' that he had not had the opportunity to discuss the report with its author. Nevertheless, he "expressed gratitude and relief that he had had the opportunity to read the report and was advised to discuss his concerns with his advocate, which he agreed to." In the meantime, the probation officer undertook to discuss the report with her manager. Some changes were made to the report as a result, and the probation officer met the man again on 25 January to go through these. She told the police that:

"[The man] was relieved with some of the changes and accepted the reasoning for all his points/comments not being used in the amended report. He did accept that with regards to the sentencing process, the relevance of his queries was questionable. He stated that he was going to discuss this further with his advocate."

She added that, "When discussing his feelings regarding his upcoming Court appearance, his feelings and anxieties were in my opinion typical for a sex offender waiting sentencing for his first offence."

The man's mother visited her son on 25 January at 4:10 pm. She told the police:

"Last Thursday 25<sup>th</sup> January 2007, he was noticeably withdrawn and agitated again re his partner and the coming Court case, on Monday 29<sup>th</sup> January."

At 3.00 pm on 26 January, the man saw his advocate. She said in her statement to the police that he, "seemed to be a fish out of water [in the prison] but seemed to cope with his situation remarkably well." She said she went through the summary of facts (including the conclusion) and the probation report with him. She said:

"[The man] was very unhappy with the probation report and he said it did not reflect the meeting he had had with the Probation Officer. The report had had some minor changes made to it prior to the final version being submitted, but [the man] was still unhappy with it.

I also discussed sentencing with him. I advised him that I hoped that he would be sentenced to eighteen months to two years imprisonment. He thought that this was manageable. The cause of any upset that day was the probation report as opposed to any sentence.

Throughout our meeting [the man] was agitated. I didn't find this particularly unusual for someone in his position. By the end of the meeting he appeared calmer and reassured that I would make efforts to counter the probation report in Court.

When we parted company I had absolutely no concerns for his well-being. He seemed no worse than I would have anticipated in the circumstances. He had always coped very well with being in prison."

The man's mother told the police:

"On the next day, Friday 26<sup>th</sup>, he phoned me in the afternoon again so worried [about] his Court sentencing on Monday. I tried to reassure him that he had not been sentenced yet and to keep strong."

A prisoner told the police:

"I was aware that on Friday 26<sup>th</sup> January 2007, [the man] had a meeting with his lawyer about his possible sentence. I spoke to [the man] that evening about that and he said he was looking at a sentence of maybe 2 ½ years. While he seemed a little bit surprised by this, but didn't appear depressed about it."

## **SATURDAY 27 JANUARY**

The man was expecting a visit from a friend in the afternoon. The friend told the police that:

“I was intending to take [the man’s] partner ... to the prison with me for a joint visit, on Saturday 27<sup>th</sup>, and [the man] told me that this had caused some friction. He asked me to come alone and that he had something to tell me and discuss with me.

Since [the man] has been in prison, his relationship with [his partner] has deteriorated badly and I am aware that there were discussions between [them] regarding their future and the possible sale of their property ... which I only became aware of today.

I am aware that [the man] rang me again, on Friday 26<sup>th</sup>, but I did not speak to him on that occasion. He spoke to my secretary ... He had requested some magazines and was looking forward to my visit the next day.”

A prison officer told the police that he recalled the man going down for breakfast some time between 8:15 and 8:30 am. He added:

“I only said hello to [the man] at breakfast and he just said hello to me. I have no recollection of what he was wearing at the time and he didn't appear any different to how he had been during the thirty-six hours I have been on duty and dealt with him over the last four days.

In fact over the previous four days I have spoken to [the man] at length on several occasions (sometimes for hours). He appeared to be resigned to the fact that he would be staying in prison for between 18 months to two years and that he was looking forward to being sentenced on Monday 29<sup>th</sup> January 2007 so that he could sort himself and get on with it. He said he realised he was an adult and done wrong in the community and needed to serve his time. I had absolutely no concern for his welfare ...

The only thing that I know he has been upset about is that after having had an interview with the Probation Service, he was unhappy about a few points that had been put in his probation report. I know that after speaking to [his probation officer], for a long time on Wednesday 24<sup>th</sup> January 2007, I think, or Thursday 25<sup>th</sup> January 2007, amendments were made to the probation report and that [the man] was very pleased with it and he no longer had concerns. The only thing on his mind was whether he would get a chance to see his lawyer before sentencing on Monday 29<sup>th</sup> January 2007. I told him that his lawyer had an appointment booked for 15.00 hrs, on Friday 26<sup>th</sup> January 2007. He was pleased with that.

With regards to his personal life, I am not aware of any specific problems he had. He sometimes was upset if his boyfriend didn't visit, but I had no concerns for his welfare. He seemed happy that he was going to be sentenced and he could get on with it.”

In his prison Incident Report, the officer said he had a quick chat with the man by the breakfast trolley at about 8:25 am. He said they talked about the advocate’s visit the previous day and the man said everything was looking good. The officer said he did not see the man carrying out his cleaning work but knew that he had done it because the recess area was clean and the floor wet.<sup>13</sup> At about 10:00 am, he had a further chat with the man, this time about numbers needed for the gym. The man said that if the officer needed him he would go. The officer added:

“All morning he was polite and in good spirits as he has been for the last few days that I dealt with him, looking forward to Monday and getting his sentence out of the way as he said to me a few times.”

The officer told the police:

“I had been dealing with prisoner [the man] all week and at no time did he give me any reason whatsoever for me to think he was bothered with something. In fact he was happy that he was in court on Monday as his lawyer told him that he would get between 18 months to 2 years and he was asking me about going to the UK to do a sex offenders course.”

A prisoner said he saw the man at breakfast time, “and he seemed fine ... he seemed fine and normal, and we spoke about life in general.”

Another prisoner told the police:

“I think I did see [the man] on Saturday morning as he passed me on the stairs as he was returning with his breakfast.”

A further prisoner said in his police statement that he and the man mopped the cells together and “he was his usual self. He was no different from any other day.” He also said:

“I would not say that he was particularly depressed. I was aware that he was due to be sentenced on Monday 29<sup>th</sup> January 2007 and he was obviously concerned and anxious about that. I am aware though that he knew the likely outcome was going to be. The Samaritans come on to the wing a couple of times a week and I have never known [the man] to speak to them.”

A healthcare officer, said in her police statement:

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<sup>13</sup> The shower and toilet area.

“On Saturday 27<sup>th</sup> January 2007, I was on C wing between 08:40 hrs and 08:50 hrs. [The man] came and collected his Co-Codomol<sup>14</sup> from me during that time. [He] was deemed (having been assessed) to be safe to have ‘daily in possession’ of Co-Codomol. This meant that he did not have to take the drugs in front of me and could take them away with him.

When I saw [the man] that morning, he seemed entirely normal. He was always clean, tidy, courteous and polite. He was articulate and chatty.”

A prisoner told the police:

“I didn't actually leave my cell until about 10:40, to go to the toilet. When I got there [the man] was there and we said ‘Good morning’ to each other. He seemed to be his usual self. There was not[hing] different about him from any other day. [the man] then left the toilet area and I then went back to my cell for a short time.”

At the gym, the man asked the officer referred to above why he did not weigh himself as the prisoners were doing and they had had a laugh about it. The officer left the gym and did not see the man again until 12:15 pm, when he locked him up.

A prisoner told the police:

“I was sitting having my lunch by the pool table, which is right next to the phone on our landing. I saw [the man] make a call, but didn't get a reply and after a couple of seconds, put the phone down and walked off to [another prisoner's] cell. After a couple of minutes, he came back to the phone. I was sitting right next to the phone, still having my dinner. He made a call and this time seemed to get through to whoever it was he was calling. I did not really hear any of the conversation but was aware he was talking to someone. I went to take my plate and cutlery back downstairs and [the man] was still on the phone when I came back to the landing a couple of minutes later. I went to my cell to get my flask and when I came back out, [the man] was off the phone and out of sight. I wasn't sure where he had gone, but assumed he had gone back to his cell. I noticed that while [the man] came back to make the second call, he looked as if he had been crying. His eyes were red and puffy, although I do not know why he had been crying, or appeared upset.”

(The prisoner also said:

“As I said earlier, I didn't know [the man] that well and I am unable to say whether he would be the type to do something like this. I am aware that he had been on suicide watch once before, during his time

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<sup>14</sup> A pain-killer.

inside. I believe it was as a result of a 'bad' phone call, although I do not know the exact reason for it.")

The man's co-accused, told the police that he saw the man on the phone at about 11:25 am and that he was still on the phone when he passed again about five minutes later. However, he did not hear what he was saying.

A prison officer said he spoke briefly to the man at around 9:00 am. He said there was nothing different about him at that time. At 11:30 am, the officer delivered the food trolley. He said [the man] did not come down for his dinner, so he shouted upstairs for him. Still getting no response, he went upstairs and found him on the phone. [The man] still did not respond when the officer told him it was dinner time, and another prisoner offered to fetch his dinner for him. The officer said the man was still on the phone when he went back downstairs, but he could not hear what the conversation was about.

The prisoner who fetched his dinner for him and with whom the man was particularly friendly, said in his police statement:

"The first time I saw [the man] today Saturday 27<sup>th</sup> January was ten o'clock, well about quarter past ten. He was coming to the gym like he usually does. At the gym he was sound, no problem at all, in a good mood. [The man] was fit and healthy and looked after himself."

At about 11:30 - 11:45 am, the prisoner saw the man on the phone. He said, "He didn't look too happy ... I couldn't hear the conversation and I didn't want to know who he was on the phone to." The prisoner said he went to collect some dinner for his friend and when he returned, "I didn't hear anything but I could see he was upset." The prisoner continued:

"It must have been then minutes later, he came into my cell, he sat on my bed. He was really upset. He said, '[My partner] dumped me.'

He looked tearful. I said, 'These things happen.' I tried to cheer him up but there was no getting through to him. He was more upset than angry. I knew something had hurt him.

I've got no idea what time this was. He said he was getting a coffee and I said I'd pop up and see him later. That was the last I seen of him ...

I think the phonecall, whatever it was about pushed him over the edge.

Talking about suicide in prison is a 'taboo', if I had any idea I would have gone straight to a Prison Officer."

Another prisoner said he saw the man on the phone shortly after 11:30. He then saw him walking with his plate to his cell, but at 11:45 he was on the phone again. The prisoner said he did not think there was anything unusual about the man being on the phone twice in so short a space of time.

Another prisoner said he went to use the phone at 11:45 am, but the man was already on it (there is only one phone for prisoners' use located on C2). After about five minutes, the man put down the phone but immediately made another call. He finally came off the phone at about 12:00 noon. The prisoner said he did not hear any of the conversation. He said the man walked past him, but did not reply to his greeting and seemed to be upset.

The man's mother told the police that her son phoned her 'mid morning' and that he was 'distraught' about a phone call he had just had with his partner about selling their house. She said he asked her several times to please phone his partner, but she refused, telling him he must face up to things as far as he was concerned. She said, "He was upset but said 'I will phone back Mum', but as you [know] he didn't."

At about 12:15 pm, the officer with whom the man had engaged during the morning locked up all the prisoners. He wrote in his incident report that he said he would see the man after lunch and the man replied, "Yes you will ...". The officer added that:

"... as always he was polite, just sitting on his chair having a cigarette, nothing different in his attitude or mood, seemed to me that everything was fine and I had no idea what was to happen next as no signs were given to myself."

After lunch, the officer and his colleague unlocked all the prisoners. He said he reached the man's cell shortly after 1:15 pm. He told the police that he said 'Hello, hello' to the man as he unlocked the door and opened it halfway. He said the man just replied '[name]' in acknowledgement and that he moved onto the next cell before eventually going down to the ground floor (C1). The officer clarified, "When I opened [the man's] cell door half way, I did not actually see [the man] in person. I just heard his voice."

A prisoner told the police:

"As I walked along the landing, I had to pass [the man's] cell. The door was unlocked and open maybe 4 or 5 inches. I glanced in as I passed and believed I saw [the man] near his cell window. It was just a quick glance as I passed his cell and do not know what [the man] may have doing, or whether he was standing or sitting. I heard nothing from inside the cell, so don't know at all what [the man] was up to. I would estimate that it was about 14:30 hrs, by this time, although I can't be certain of the time."

The man's co-accused also said he noticed the door was slightly open when he went past at about 2:35 pm. He did not see the man on this occasion, nor when he returned a short time later.

At about 2:15 pm, the officer with whom the man engaged during the morning started to deliver the fruit.<sup>15</sup> Having delivered to a number of other prisoners on the unit, he reached the man's cell. He noticed that, "the cell door was pushed but not locked, this was different from when I unlocked it, so I pushed the door and I saw prisoner [the man] with a plastic blue bag over his head and a belt around his neck coming down from the window."

In his statement to the police, the officer said:

"The door was pulled to, but not shut locked. On opening the door by pushing it into the cell, I saw [the man] low down on the floor with his feet outstretched in front of him. His back was up against the wall below the window but his bottom was not sat on the floor. It was approximately one foot off the floor level. I saw that he had a blue plastic carrier bag placed over his head and that there was a light brown patterned belt tied around his neck. His head was leaning over to the right shoulder. His right arm was outstretched towards the bookshelf and his left arm was across his body. I could see that the other end of the belt to the buckle was tied/wound around the centre vertical bar across the window on the lowest horizontal bar. When I subsequently cut the belt I cut it halfway between the knot and his neck. The belt was made of fabric as opposed to leather and the buckle was not a usual belt buckle, but one where you slide the loose end into the buckle and an internal mechanism fastens it shut."

In his incident report, the officer said he had to move a chair that was on top of the man's legs before cutting the ligature with his cut-down scissors. He removed the bag and placed the man in the recovery position.

To the police, the officer said:

"I rushed towards [the man] but I could see no movement. I could see that the belt sealed the bag or bags round [the man's] neck. The buckle of the belt was to the left side of his throat.

I immediately tore open the plastic bag(s) around the mouth and nose area hoping that [the man] would take a gasp of air but he didn't. I then took a hold of [the man's] head supporting him in my left arm so that I could cut the belt off him with my scissors. As soon as I did this, the buckle became loose and I undid it and threw it on the bed to the right of me.

As soon as I had done this I edged [the man] towards the door and laid him in the recovery position facing the bookshelves."

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<sup>15</sup> Prisoners may order fruit to keep in their cells. They order it on a Friday and it is distributed on a Saturday. The man had apparently ordered a large quantity. (Prisoners also select their meals for the following week on the Friday. The man had submitted his request the day before his death.)

The officer called healthcare over the radio. The time was 2:50 pm. He said two healthcare officers arrived straightaway. (In his police statement, he said it took them less than a minute to arrive.) He said that, whilst he was waiting, he stood at the cell door to see what was happening to control the landing. The officer said that when the healthcare officers arrived, they asked him to call an ambulance. He therefore radioed the control room.

The male healthcare officer said in his police statement:

“I met [the man] within the first few days of his arrival at the prison. I found him to be a pleasant, well-spoken person who seemed to be pretty consistently in good spirits. I have never in fact seen anything to the contrary. I would have seen [the man] most days that I was working, because I dispensed his medication to him.

To my knowledge there has only been one occasion when there has been concern for [the man’s] welfare while at the prison. [The man] was placed on suicide/self harm watch for one night shortly after his arrival. I recall that this related to a letter that he had written which Prison Officer [name] had read and felt concerned over. Speaking to [the man] after the event, I remember that he told me he was pleased people were concerned about him but emphatically denied any intention to self harm.”

The healthcare officer said he was on duty in the Healthcare Department at 2:50 pm, when he answered an urgent response call from the officer asking him to attend cell 17, on C3 landing. Another healthcare officer went with him. He said it took him about a minute to get to the cell. His colleague had brought the emergency first aid bag. On entering the cell, he found [the man] lying on his side in the recovery position on the floor with his feet nearest to the door. The officer was standing by the door to the cell. The healthcare officer said he immediately conducted a head to toe survey of the man and established that he was not breathing and was cold to the touch. He could not find a pulse at his left wrist and noted what appeared to be a ligature mark on the skin of his neck. He then turned the man on to his back and started to give mouth to mouth with the use of a ‘Dynamed’ CPR mask. His colleague assisted him by conducting compressions. They continued with the CPR at a ratio of two breaths to 30 compressions. There was no response from the man. The healthcare officer said that about five minutes later he was handed an oxygen cylinder by a senior officer and connected the supply to the face mask in an attempt to increase the oxygen going into the man’s system. He continued to give mouth to mouth until the paramedics arrived at approximately 3:05 to 3:10 pm. The man was then moved into the corridor.

The female healthcare officer told the police:

“At about 14.50 hrs ... we had an urgent radio message from [officer], No. 113. This message was that he required urgent medical assistance on C wing, level 3 (floor 3). I cannot remember any other content to this message. [A colleague] went ahead of me and I

followed seconds behind him as I collected our 'grab bag' and secured the office. Our grab bag contains first aid equipment. In order to get from the Healthcare Department to C wing, we had to pass through seven doors, six of which were locked but all seven had to be secured. To speed up the process, [my colleague] would unlock them and I would lock them. When I got to C wing, I then had four flights of stairs to climb to get me to the 3<sup>rd</sup> floor."

The female healthcare officer inserted an airway into the man, before starting chest compressions. She said they had asked for an ambulance as soon as they realised there was no pulse. She said she and her colleague continued with CPR until the ambulance arrived – that is, for about 10 - 15 minutes. They then continued to assist once the paramedics arrived.

An officer said he became aware via "radio chatter" at about 2:50 pm that something was going on. He phoned to see if he was required and was instructed to meet the ambulance. This arrived at the double gates beside A wing, escorted by two prison officers, at about 3:04 pm. The officer and the other officers helped the paramedics with their equipment up to C3 landing. On arrival, he saw the two healthcare officers attempting to resuscitate the man. He subsequently helped to lift the man out of the cell and on to the landing to give the paramedics more space in which to work. He noted that the man was very pale and cold and there appeared to be no signs of life. Afterwards, the officer escorted the man to hospital, he and another officer helping with trying to resuscitate the man in the ambulance.

A Unit Manager was one of the Duty Managers on 27 January. In a report to the Governor, he said he was contacted by another Unit Manager at about 2:50 pm and asked to attend C3, cell 17. On arrival, he heard an officer radioing for an ambulance and saw healthcare officers administering first aid to the man. He could see that the cell door was hindering further entry into the cell. He asked the officers if they needed oxygen and then instructed an officer to fetch oxygen and the reverse door kit.<sup>16</sup> He also arranged for a log of events to be maintained. Once the door had been reversed, the Duty Manager went to the centre to ensure everything was in place to enable the ambulance to enter and to arrange an escort to the hospital.

After the man had been taken to hospital, the Duty Manager made arrangements for the cell to be sealed and any evidence secured. He told the two senior officers not to talk about the incident to other prisoners and to open the wing back up, as visits and tea were due shortly. He instructed that the man's co-accused and another prisoner who had previously lost friends in prison to suicide should be placed on F2052SH. The Duty Manager also instructed that two prisoners who were refusing to come out of their cells should be observed and assessed, and any concerns they had reported back to him.

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<sup>16</sup> Cell doors are capable of being opened in both directions. This is to forestall barricading from the inside.

At about 5:25 pm, he debriefed staff and praised them for the professionalism they had shown.

The log shows that the officer raised the alarm at about 2:50 pm. He radioed a request for the ambulance to be called at 2:52 pm and the Emergency Services were called at 2:53 pm. At 2:54 pm, the Emergency Services were re-contacted and given details about the nature of what had occurred. The ambulance entered the prison at 3:03 pm and paramedics arrived at the cell at 3:05 pm. The man was removed from the landing at 3:19 pm and placed in the ambulance at 3:21 pm. The ambulance left the prison at 3:31 pm. At 3:50 pm, an escorting officer reported that the man had been pronounced dead.

A note was found in the man's cell after his death. It appears to be either a note of a telephone call or preparation notes for a telephone call. It said:

"I know u didn't say it was over  
gave [name]<sup>17</sup> the same  
chance – please keep my chance open  
What I said to [name] was taken the wrong way

Please give me the strength to get thru this

I have never tried to dis [name]. Talk to [two other names] [?] etc

Who can tell keep things in your mind open  
Start shutting doors & they will shut  
I want to help so much

You have no idea how hard it is for me

5 months apart also

U are the one who can bring [name] to expect what will happen to me

I understand it's not like I can just walk back in ...  
But please try for me as I love you genuinely.

I trust you to do your best

I am also going to be a diff person ..." [sic]

The Assistant Ombudsman listened to some of the man's phonecalls, particularly the last ones. He was clearly very low when he spoke to his mother after seeing his advocate. He said the advocate had told him that the Crown were pressing for a sentence of 2½ years and that he thought it was likely the Court would take note. His principal concern was that his partner would not wait that long for him. He told his mother he would not give up and would not do anything silly.

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<sup>17</sup> There were apparently tensions between the man and his partner over a third party.

During his conversations with his partner on the Saturday (the first one lasting 26 minutes), the man spoke about having messed up both their lives and having lost everything. He pleaded to be allowed to return to their home after his release. He referred to the shame he had brought on his parents and said he could not get any lower. Nevertheless, he was making plans for “getting the ball rolling” over the sale of the house and said he would phone his partner back at 2:00 pm.

### **Post mortem and toxicology reports**

The post mortem concluded that the cause of death was hanging and that the injury to the neck conformed with self suspension. There were no marks of violence.

The toxicology report said that no alcohol was detected in the man’s blood or urine and that nothing of significance with regard to pharmaceuticals was identified.

## WHAT THE MAN'S PARENTS TOLD US

The man's parents said their son was remorseful and that he would have served his sentence. He had been teaching other prisoners to write and sorting out their finances. Up until his last week, he seemed to be coping. The man's mother felt that something happened to her son on the Saturday morning. She said she had asked the Police Liaison Officers what was said but they told her she would not want to hear it.

The man's mother said that her son had phoned on the Friday after seeing his advocate and was "distraught". He had thought he would get 18 months but was told it might be two and a half years. She thought this was what started to tip her son over, and then there was a call on Saturday from his partner. The man's mother said she thought his hanging was impulsive. She said that if it had been premeditated, he would have left a note. She said he must have been at "rock bottom".

She said that they simply could not understand how her son had managed to hang himself whilst in custody, and asked how this had happened a second time after the death in La Moye just six months before. Both parents felt strongly that ligature points in cells should be removed. The man's mother was particularly concerned that her son was allowed to wear a long belt (the belt he later hanged himself with).

She said that she thought her son was allowed too many phonecalls and that he was "always on the phone to his partner", after which he was "often in a state". The man's parents said that the chaplain at the prison had advised their son to stop making so many calls, because his mood was getting lower. They were also concerned that the content of his phonecalls on the Saturday should have alerted staff to possible risk. They said that, if calls were not routinely monitored, they should be.

The man's mother said that her son was upset on the Saturday that she had said she would not speak to his partner. She told him there was no point. She said he was angry and upset when she spoke to him.

She added that when she had last seen her son four weeks previously, he was in "low spirits" which she thought was because of his impending trial. The man's mother was also concerned that her son had lost a lot of weight. She did not think this was because he was using the gym a lot, as he had done so regularly before he was imprisoned. Both parents felt that their son should have been monitored more closely as he came up to his court appearance. The man's mother said that he appeared thin and gaunt and was "very low" on the Thursday (25 January) when she saw him.

At 3:45 pm on the Saturday, they had received a phonecall from the prison telling them there had been "a terrible accident". At the time, the man's mother had been expecting a phone call from her son. She considered this to have been an unacceptable way of informing them.

They had gone to the hospital to see him, but were told they were not allowed to see the body. She said she just needed to know for herself that it was indeed her son.

The Governor had written to them asking if they wanted to see their son's cell. They were appalled at this suggestion, which they felt was insensitive.

They were also angry that, four weeks later, they still had none of their son's personal possessions. They had spoken to a manager at the prison who had said the possessions had gone to the Viscount. Accordingly, they approached the Viscount, but were told that they were with the police.

The parents were angry about the Governor "squealing" in the media that he did not have enough money and it was not his fault. There had been two deaths in the past six months and the man's father felt the Governor should accept responsibility. They could not believe that there had been two hangings on the same floor, and they felt the buck must stop with the Governor. They did not consider him competent and thought he should be removed.

The man's parents were critical that I had not yet produced a report of my investigation into the death at La Moye in September. They said it should not have taken six months to write a report, but that the Governor should not be waiting for my report to make improvements since the last death.

The man's parents praised the two Police Liaison Officers, and have since written to the Chief of Police to acknowledge this.

## EXAMINATION OF THE ISSUES

### F2052SH processes

Prison Service Order 2700<sup>18</sup> says that the member of staff initiating F2052SH procedures must complete page 1 and then pass the document to the Unit Manager who, on receipt, must speak to the prisoner and the initiating officer. It is the Unit Manager's responsibility to determine how and where the prisoner should be managed. An officer opened a form at 4:55 pm on 6 October because of her concerns about the man. One of the Unit Manager's entries has a date of 7 October, but it is not clear to what this date refers as an entry that was alongside it appears to have been Tippexed out. The bottom of the page is signed and has a date of 9 October. It is a matter for some concern if the Unit Manager did not become involved in the F2052SH procedure until three days after it was raised.

The doctor completed his section of the form at 9:30 am on 9 October. Next to Review Date, he has written, "Closed". Although the Unit Manager had directed that the position should be reviewed on 9 October "with doctor", there is no indication on the form that anybody other than the doctor was involved in the decision to close the form. This is contrary to the instruction in PSO 2700, which says that the form "will be closed at a case review" (case reviews should be multi-disciplinary). It adds, "The case review will agree after-care or follow-up requirements."

I do not suggest that the decision itself was wrong, but am concerned that the proper procedures were not followed. The underlying intention of the F2052SH process is to de-medicalise responsibility for suicide and self-harm in recognition that those who harm or kill themselves are by no means always clinically depressed. In fact, situational factors are far more likely to play a part than clinical depression. It is for this reason that staff from a range of disciplines should be involved in assessing and determining the appropriate management of those deemed to be at risk of self-harm.

PSO 2700 also directs that, "The reasons for closure and any aftercare plans must be recorded in the F2052A (history sheet) and in the report of the case review in the F2052SH. The front cover of the F2052SH must be noted, and the closed F2052SH must be securely stored in the core F2050." In this instance, no case review form was completed, the closing of the form was not recorded in the man's wing history sheets, and the front of the form has not been annotated to record the closure.

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<sup>18</sup> La Moye is not of course formally bound by Prison Service Orders relating to the Prison Service in England and Wales. However, since the prison has adopted the F2052SH procedures, it is sensible to judge its performance by reference to the PSO that incorporates those procedures. In any case, many of the instructions to which the PSO refers appear on the face of the form itself.

In my report on the earlier death in September 2006, I welcomed the fact that sufficient resources for implementation of ACCT (Assessment, Care in Custody and Teamwork)<sup>19</sup> have now been identified, and recommended that the Governor personally drives forward arrangements for implementing ACCT prison-wide. In the interim:

**I recommend that the Governor takes steps to ensure that staff fully understand and follow the F2052SH procedures.**

**I also recommend that, in line with PSO 2700, he instructs Unit Managers to monitor the implementation of F2052SH, including proper completion of the form.**

The Special Watch sheets show little evidence of positive contact between the man and staff who carried out the hourly checks. The contact and moral support provided by staff charged with watching a prisoner is as important as the physical checks to make sure he or she is safe. Such contact can also provide more information about the prisoner's developing state of mind.

**I recommend that staff charged with carrying out special watches be instructed to speak to the prisoner as often as possible, except where this is clearly not welcomed or not appropriate. They should record details of any relevant conversations.**

I also note that on a couple of occasions one and a half hours elapsed between what were supposed to be hourly watches.

**I recommend that the Governor reminds staff that checks must be carried out at intervals not exceeding that stated on the F2052SH.**<sup>20</sup>

### **Phonecalls**

The man's mother was critical that her son was allowed such free access to the phone. She considered that being able to make so many phonecalls was not helpful to her son's state of mind. She said that the chaplain had advised him to reduce the number of his calls.

The man's particular friend in prison said, "[The man] seemed to over-worry about his boyfriend ... I even told [the man] not to ring [him] so often, to calm

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<sup>19</sup> In England and Wales, the F2052SH is being replaced with a new system to help identify and care for prisoners at risk of suicide or self harm. The replacement is known as the ACCT Plan (Assessment, Care in Custody and Teamwork). This was successfully piloted at five establishments in 2004. ACCT encourages staff to work together to provide individual care to prisoners in distress, to help defuse a potentially suicidal crisis, or to help individuals with long-term needs (such as those with a pattern of repetitive self-injury) to better manage and reduce their distress.

<sup>20</sup> I note from the minutes of the suicide awareness group meeting held on 4 October that a number of issues relating to the operation of the F2052SH procedures, included composition of case reviews, daily supervision records and practice on closure, were identified and action taken to address them. I consider it important nevertheless that I should formally record my recommendations in this respect.

it down and be in a good mood when you phone him. He seemed to take my advice.” He added that, “[The man and his partner] had a house together ... He said they had a lodger, a Polish guy, don’t ask me his name. I got the impression he was worried about [his partner] straying. I think he was worried about the Polish guy and [his partner]. He seemed pleased when he said the Polish guy was going back to Poland.”

I wholly understand the man’s mother’s concerns about the effect that the phonecalls appear to have had on her son. However, her son was a grown man who, like any other, had the right to make choices in the way he conducted himself. I do not consider it would have been appropriate to restrict his time on the phone, and I do not consider it was the prison’s responsibility to do so – unless there were clear indications it was having a negative effect on his mental health. Although he clearly worried about his relationship, I have seen no evidence of concern about the man’s mental health.

In any case, it is arguable that restricting his access to the phone might have had an equally deleterious effect on the man’s state of mind as he would simply have been left in the dark for long periods, prey to his own fears. Not having ready access to the phone might have increased his anxiety, frustration and sense of powerlessness.

The man’s parents also asked whether their son’s calls should have been routinely monitored in real time. While I accept that this would have enabled staff to pick up the difficulties their son was having, within limits related to security and victim protection issues, prisoners rightly enjoy the right not to have their conversations listened to. The quality of their contact with family and friends can be key to their emotional wellbeing. The knowledge that someone was listening into personal calls would severely impair the quality of the contact. Although I see the benefits in terms of information gathering, I do not advocate an increase in routine contemporaneous monitoring of prisoners’ phonecalls.

However, it is important that staff are aware of information that is relevant to risk if they are to be able to care effectively for those in their custody. Care for those in custody is ultimately the responsibility of the state, but it is something in which all those associated with prisoners – friends, family, legal advisors, probation officers, other prisoners – should play a part. It is important therefore that they are aware of actions they can and should take where, for example, someone has received bad news.<sup>21</sup>

**I recommend that the Governor places notices around the prison reminding those associated in any way with prisoners to convey any possible concerns to staff.**

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<sup>21</sup> Some prisons in England and Wales have notices in the visits area asking visitors to let staff know if they have had to break difficult news to a prisoner, or if they have any concerns in relation to possible self-harm.

## **Vulnerability approaching sentence**

The man's parents were also concerned that staff should have been aware that their son was likely to be more vulnerable as he approached his court appearance. Such events can indeed prompt suicidal crises, but of course they will not do so in every case. Staff should be aware that impending court appearances can cause greater vulnerability to self harm, but it would not be appropriate for them to treat all those facing such events as actually at risk. Each case should be assessed on its own merits and according to the disposition of the particular prisoner. In this man's case, staff were clearly aware that he was due in court on the Monday and were also aware of his concerns in relation to sentencing. An officer referred to spending hours talking to the man. Even so, staff saw nothing in his demeanour to suggest that he was at risk as a result. On the contrary, the man appears to have perceived it as the point at which he could move on. Prisoners too saw no cause for concern.

Having said that, it would be good practice for a prisoner's personal officer to maintain closer contact during such periods. I note that the officer<sup>22</sup> spent considerable time with the man, but I consider it would be a positive step to formalise this contact to make sure it happens in every case.

**I recommend that personal officers be instructed to be particularly alert to vulnerable points and increase their contact with the prisoner during those periods.**

## **Clinical care**

One of my Deputy Ombudsmen, a registered clinician, conducted a clinical review of the man's care at La Moye. She concluded after examination of his medical record that he received healthcare that was appropriate to his identified clinical needs, and that nothing in the healthcare afforded him impacted on his death. In the circumstances, she decided it was not necessary to produce a formal report.

## **Unlocking procedures**

It is a matter for concern that the man may have been dead for some time before the officer found him.<sup>23</sup> The officer said in both his incident report and his statement to the police that he spoke to the man and heard a reply when he unlocked him at 1:15 pm. However, with one possible exception, no-one

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<sup>22</sup> The officer was not the man's personal officer. This role was undertaken by the officer who (coincidentally) raised the F2052SH.

<sup>23</sup> The available evidence is inconclusive and the post mortem does not give a likely time of death. Two prisoners referred to the man's cell door being open sufficiently for one of them to see to the window when he went past. However, the officer who found him said that when he took the fruit to the cell, the door was pushed to. Unless the door was blown closed after the prisoners saw it, this seems to suggest that the man himself closed it after 2:30 pm. On the other hand, the officer and a healthcare officer said that by around 2:50 pm the body was cold, suggesting that the man had been dead for more than just a few minutes.

else saw or heard the man after lock-up.<sup>24</sup> It is clear that the police made inquiries into this point, as several prisoners refer to unlocking practice in their statements. No clear picture of the procedure emerges.

The officer who unlocked the cell told the police:

“On opening each door I say something different to each inmate, but always seek acknowledgement that the door is open. We are duty bound to get a response from them in whichever way.”

However, the evidence of the prisoners is less clear cut. One prisoner said,

“I heard the door flap being opened, which was obviously the prison officer looking in to check on me ... In normal circumstances there would be a brief conversation but it was just I was so engrossed in my game ... I should clarify that I did not hear if the prison officer spoke to any of the other inmates when he unlocked the cells after lunch. This will have been due to the noise of my PlayStation.”

Another said that when he was unlocked at 8:10 am, “I am unsure if [the officer] said anything to me at this time, but he did not put his head around the corner.” He said that, when he was unlocked after lunch, “Nothing was said and the door was just opened slightly. When the prison officers open the doors they do not look in, nor do they say anything, unlike when they lock us in.”

Another told the police that, “When the officers open the cell doors after being locked in, they sometimes pop in to see you and say hello and they sometimes don’t.”

Yet another said in his police statement:

“I can't recall if on Saturday if the guard popped his head in the room but usually they just open the door a few inches and walk off. This is so that I can open the door myself. Sometimes they say ‘Good morning’ but I can't recall if they did or not that day.”

Another said an officer opened his door just enough so that he (the prisoner) could see him. However, “We did not speak to each other or even acknowledge each other. After he walked away, I pushed my door closed and remained watching television. I could not hear if the officer spoke to any other of the inmates, or anything else that was happening outside my cell due to the noise of the television.”

Another said, “With me, the prison officer, [the officer], generally opens the door and speaks to me. I do not know if this is the case with everybody.”

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<sup>24</sup> The prisoner reported that he thought he saw the man by his window, but since this was where he hanged himself and the prisoner could not say what the man was doing or even whether he was standing or sitting, I cannot be certain that the man was alive at this point.

And another said:

“When the cell doors are opened, the prison officer usually just opens the door a few inches. They don’t always open the door fully and check us and they don’t always look in and speak to us, so as not to disturb anyone in a cell who doesn’t want to be disturbed. It depends on the prison officers I suppose ... I am not aware of either of the prison guards speaking to anyone as they unlocked the cell doors [after lunch on Saturday].”

A training officer explained to the police the procedure to be followed when unlocking cells. He said:

“At the end of the period of ‘lock up’ the prison officer would commence the ‘unlock’. This is as follows:

The prison officer would open the Judas flap and look through to ascertain the location of the prisoner within the cell ...

Should the prisoner not be seen through the flap, the prison officer would try and make verbal contact with the prisoner asking them to show themselves.

On receiving the acknowledgement either visually or verbally, the prison officer would then unlock the door leaving it ajar. There is no specific instruction as to how far the door must be opened.”

Quite apart from the safety and wellbeing of prisoners, security considerations demand that officers must ascertain that the right prisoner is in the right cell at unlock. This can only be achieved by the officer looking into each cell as he opens it.

**I recommend that the Governor reminds staff of the need to physically check that the right prisoner is in the right cell during unlock.**

### **Availability of ligature**

The man’s mother was concerned that her son had been allowed to retain in his possession the long belt with which he hanged himself. Of course, the opportunities for prisoners to harm themselves must be kept to a minimum – but that minimum must be consistent with what is respectful and humane. It is important that prisoners retain their self-respect, and this is achieved to some extent by ‘normalising’ their lives in prison – so that, for example, they are able to retain their personality and some individualism by wearing their own clothes. Given that the man was not assessed as being at risk of self-harm, I cannot criticise the prison for allowing him to retain his belt.

## **Cell design**

I was appalled during my earlier investigation by the ready availability of a number of ligature points in the cell in which the man died, including a conduit running across the ceiling. The man died in a similar cell (although there was no corresponding conduit).

As part of the prison improvement plan, funds were found for the conversion of some cells to what are known as 'safer cells'.<sup>25</sup> I understand that safer cells have now been created in each part of the prison. This is greatly to be welcomed. However, the man (like the prisoner who died in September) was not identified as being at risk of self-harm or suicide. As such, he would not have been located in a safer cell. I consider it likely that the man's action was wholly spontaneous, and prompted by the difficult phonecalls he had had (together with the added anxiety of his impending sentencing). Certainly, the facts that he had ordered a large quantity of fruit the day before his death, and selected his meals for the following week, are not suggestive of pre-meditation. It is for just such an eventuality that safer cells are designed. It is not possible to design out all possibility of someone harming themselves, but it is possible to make it very difficult so that only a planned attempt is likely to succeed. This man's death emphasises the urgent need to render all cells at the prison as safe as possible. I therefore repeat here the recommendations I made in my earlier report:

**I recommend that all measures to reduce the ready availability of potential ligature points are taken as soon as possible.**

**I recommend that 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.**

### **Action following discovery of the death**

I do not underestimate the trauma of finding someone hanging, and I commend the officer for his quick thinking in ripping the bag that was over the man's head and releasing the ligature. In the circumstances, I hesitate to imply any criticism of him. Nevertheless, I am concerned that, having cut the man down, the officer simply placed him in the recovery position without attempting to resuscitate him. I do not consider the outcome would have been different in this case had he done so, but in other circumstances the commencement of resuscitation just a few seconds earlier might mean the difference between life and death. However, I do not know if the officer had the necessary training to administer this sort of first aid. (I note that lack of training in this respect was identified as an issue at an extraordinary meeting of the suicide awareness group following the death in September.)

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<sup>25</sup> 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.

**I recommend that all staff receive training in resuscitation and that they be required to attempt resuscitation immediately upon discovering an incident of self-harm.**

### **Contingency plans**

I noted during my investigation into the circumstances of the death at La Moye in September 2006 that the contingency plans for a death in custody appeared to have been put into effect very well.

On this further sad occasion, I judge again that staff conducted themselves very professionally. I would wish the Governor to share that sentiment with all concerned.

### **A lack of care?**

The man's parents were very critical that there had been two self-inflicted deaths at La Moye within the space of five months. Deaths in custody may cluster on a random basis, but it is of course a matter of real concern that there have now been two self-inflicted deaths at the prison within a very short space of time (and after a period of 12 years when there was none). I hope the Governor will analyse all aspects of care offered to prisoners to identify areas for improvement. In particular, he will wish to consider that both recent deaths occurred in the VPU during lunchtime on a Saturday, and determine whether this was coincidence or indicates something more substantial. I note, for example, that just two officers staff the unit which is on three floors (which does not readily lend itself to close supervision of prisoners), and no staff are present during the staff lunch time.

Having said that, my earlier investigation did not identify any opportunities missed by prison staff for preventing the man's death (other than very real concern about the ready availability in the cells of ligature points). The man who died was well known to the prison, and was properly assessed for risk of self-harm when he was received. He gave staff no cause for concern in relation to self-harm and suicide during his short time there.

Similarly, the design of the cells aside, I do not consider that staff missed any opportunities to prevent the man's death. Staff and prisoners alike have reported that he was his normal self in the days and hours before his death. He clearly had concerns about his court appearance on 29 January, but had specifically said he was looking forward to getting it out of the way. I have not found any suggestion that he presented any signs that meant staff should have identified him as being at risk.

The man's parents were critical that I had taken so long to produce my first report. I infer that they were concerned that lessons had not been learned quickly enough and no action had been taken to prevent a recurrence. In fact, there is evidence that a great deal of action was taken by the prison in the interim. The senior management team started to learn lessons and address issues from the afternoon of the death on 2 September, and some changes

(such as provision of in-cell televisions on the first night in custody) were made immediately. In addition, the Governor personally addressed staff meetings in the two weeks following the death to raise awareness. An extraordinary meeting of the suicide awareness group in early October identified a whole raft of areas where improvements in practice could be made. These included F2052SH procedures, inter-agency sharing of information, the availability of Insiders<sup>26</sup>, training and the purchase of a defibrillator. Action was immediately put in train.

I regret that it was not possible for my first report to be completed sooner. Nevertheless, I am satisfied that the prison has sought to learn its own lessons and improve policy and practice. I should add that of the 24 recommendations I made in my earlier report, only that relating to cell design would have helped to prevent the man's death had they been implemented.

### **Family liaison**

The man's mother told my Senior Family Liaison Officer that she was expecting a phonecall from her son when she received one from the prison to tell her he was dead. Both she and her husband are very angry about the way the news was communicated.

According to the Minister's letter of 19 April commenting on my draft report, the man's death had not been confirmed at the time of the phonecall. The Minister said the purpose of the phonecall was to give his parents every possible chance of reaching the hospital while their son was still alive. She added that the prison would rightly have been criticised had their son survived for a short while but his parents had been delayed while arrangements were made for someone to break the news in person.

I cannot be certain what exactly was communicated to the man's parents – or perhaps more importantly how they interpreted what they were told. I appreciate that, in the circumstances described by the Minister, time is of the essence. But, wherever possible, news of a death should be given in person. Given the size of Jersey, I cannot imagine why this would pose any practical difficulties.

**I recommend that the Governor includes in contingency plans procedures for giving bad news to relatives in person, involving the police if this is considered appropriate.**

**I also recommend that the Governor considers training some members of staff to act as Family Liaison Officers.**

The man's parents have also complained that the Governor offered by letter to show them "where their son was held, if they wished to do so." They were horrified at the suggestion and considered it crass and insensitive. I have to

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<sup>26</sup> Insiders are prisoners whose role it is to 'induct' new receptions into prison life and support them during their first few days in custody.

say I have read the letter the Governor sent and do not find it so. Many families take comfort in seeing for themselves where their loved one died and it can help the grieving process. Of course, it is not something that everybody would want. The difficulty here may be in the fact the invitation was extended by letter rather than in person with an explanation of why the offer was being made. This reinforces the importance of personal contact very soon after a death has occurred.

It is beyond the reach of this investigation, but I am also concerned that, having travelled to the hospital to see their son, the man's parents were not allowed to do so. His mother said she only wanted to check for herself that it was indeed her son. This is entirely understandable and I cannot see why it should not have been possible. This treatment seems harsh and insensitive. I hope my feelings on the matter (not to mention theirs) will be conveyed to the appropriate quarters.

Finally, almost four weeks after the man's death, his property had still not been returned to his parents. I understand that, given early suspicions of a possible homicide, it was necessary for the police to seize it. But I regret that it was not returned as soon as those suspicions were allayed. In fact, the man's parents had been given conflicting stories about where it was, the prison having informed them that the Viscount had it whereas in fact it was with the police. In the circumstances, it might have been kinder if the prison had pursued the matter more energetically on the parents' behalf.<sup>27</sup>

**I recommend that the Governor includes in the prison's contingency plans the actions to be taken to ensure that all property is returned respectfully to the next of kin as soon as possible.**

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<sup>27</sup> According to the Minister's letter of 19 April 2007, the prison did attempt to pursue the matter, but unfortunately the man's parents were not recorded as the man's next of kin.

## CONCLUSIONS

It is generally recognised that there are a number of events or circumstances that might render prisoners more likely to harm themselves. And there were many reasons why the man might have been perceived as being at risk:

- It was his first time in prison;
- He was convicted of serious sexual offences;
- He was approaching sentencing; and
- He was having relationship problems with his long-term partner.

However, staff were aware of these issues but saw no reason for concern. I cannot say that this assessment was wrong. The account of both prisoners and staff was that on the morning of Saturday 27 January, the man was just as he always was. Some prisoners were aware that he appeared to be upset after his phonecalls, but this was not apparently unusual of itself. Even a prisoner who knew the man well and who knew the substance of the phonecalls, did not consider that his friend was at risk of self-harm. I do not consider that the man's untimely death could have been predicted or, in that sense, prevented.

Nevertheless, I am concerned that the cells at La Moye offer themselves so readily to spontaneous acts of self-harm. The man's death demonstrates how difficult it is to predict self-harm. This underlines the need to ensure that the environment is as safe as it can be. Whatever resources are necessary to achieve this should be identified and invested urgently.

## **RECOMMENDATIONS**

- 1) I recommend that the Governor takes steps to ensure that staff fully understand and follow the F2052SH procedures**
- 2) I also recommend that, in line with PSO 2700, he instructs Unit Managers to monitor the implementation of F2052SH, including proper completion of the form.**
- 3) I recommend that staff charged with carrying out special watches be instructed to speak to the prisoner as often as possible, except where this is clearly not welcomed or not appropriate. They should record details of any relevant conversations.**
- 4) I recommend that the Governor reminds staff that checks must be carried out at intervals not exceeding that stated on the F2052SH.**
- 5) I recommend that the Governor places notices around the prison reminding those associated in any way with prisoners to convey any possible concerns to staff.**
- 6) I recommend that personal officers be instructed to be particularly alert to vulnerable points and increase their contact with the prisoner during those periods.**
- 7) I recommend that the Governor reminds staff of the need to physically check that the right prisoner is in the right cell during unlock.**
- 8) I recommend that all measures to reduce the ready availability of potential ligature points are taken as soon as possible.**
- 9) I recommend that 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.**
- 10) I recommend that all staff receive training in resuscitation and that they be required to attempt resuscitation immediately upon discovering an incident of self-harm.**
- 11) I recommend that the Governor includes in contingency plans procedures for giving bad news to relatives in person, involving the police if this is considered appropriate.**
- 12) I also recommend that the Governor considers training some members of staff to act as Family Liaison Officers.**
- 13) I recommend that the Governor includes in the prison's contingency plans the actions to be taken to ensure that all property is returned respectfully to the next of kin as soon as possible.**