

**Investigation into the death of a prisoner
at HMP Guys Marsh in February 2006**

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

April 2007

This is the report of an investigation into the death of a man who was found in his cell at HMP Guys Marsh on 14 February 2006, with a ligature around his neck. Despite evidence that rigor mortis had set in, healthcare staff attempted resuscitation but without success. The man was aged 63.

I would like to extend my condolences to the man's family and to all those touched by his death.

The investigation has been undertaken on my behalf by two of my investigators. A clinical review of the healthcare the man received whilst in custody was conducted by the South West Dorset Primary Care Trust. My thanks are due to the clinical reviewer and to the Governor and staff of Guys Marsh for their assistance during the course of the investigation. I regret the delay in completing this report.

The man's death was the first self-inflicted death to have occurred at Guys Marsh. Not surprisingly, therefore, it came as a great shock to both staff and fellow prisoners. This report shows that the man had close and supportive relationships with staff and other prisoners at the prison, and that every effort was made to provide a trusting environment in which he could share his concerns.

I have made just one recommendation.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man who died had been sentenced to seven years imprisonment for the attempted murder of his neighbour. At the time of his death, he had served just under two years. It was the man's first time in custody.

On reception into prison on remand in February 2004, the man disclosed that a year before he had attempted to kill himself by placing a shotgun in his mouth, but could not go through with it. Shortly before sentencing, he told staff that if he received a long term of imprisonment he would commit suicide. After spending some time in other prisons, he was transferred to HMP Guys Marsh on 16 November 2004.

The man was taking a number of prescribed medications for the conditions he suffered from, including diabetes, heart disease and asthma.

On 13 April 2005, the man appeared depressed. He was tearful and expressed fears that he would die in prison. An F2052SH document (a form used by prison staff to monitor prisoners at risk of suicide or self harm) was opened. The man told the doctor that he was feeling low and that there was no future for him. The F2052SH document was closed three days later after the man appeared more settled.

Throughout the man's time at Guys Marsh, he expressed concerns to staff about his elderly mother's poor health and worried that his victim had begun legal proceedings against him for compensation. He was also anxious about the possibility of not being able to return to his home area after release.

Although it was known that the man was suffering from depression, staff felt that he was able to talk about issues that were troubling him. He had formed supportive relationships with both staff and fellow prisoners,

On 14 February 2006, shortly after his cell was unlocked in the morning, the man was found with a ligature around his neck. Although rigor mortis appeared to have set in, healthcare staff still attempted resuscitation.

INVESTIGATION METHODOLOGY

1. Two senior Investigators from my office carried out the investigation into the man's death.
2. Notices were displayed throughout HMP Guys Marsh informing staff and prisoners of the investigation and inviting them to contact the investigators should they wish.
3. My colleagues visited the prison over several days. They met with the Governor and Deputy Governor, and with the prison's Family Liaison Officer. They interviewed a number of staff and prisoners. They also spent time on the man's residential unit and saw the cell in which he died. The investigators were given access to all his prison records, including his medical records. The prison's Independent Monitoring Board and the local branch of the Prison Officers' Association were given the opportunity to raise any issues surrounding the man's death.
4. The clinical reviewer was asked to provide a clinical review on behalf of South West Dorset Primary Care Trust. Healthcare staff at Guys Marsh were interviewed jointly by my investigators and the clinical reviewer.
5. My investigators spoke with Dorset Police who were acting on behalf of the Coroner. The police confirmed that they had no concerns about the circumstances of the man's death. On completion of my report, a copy will be sent to HM Coroner to assist him with his enquires into the man's death.
6. One of my Family Liaison Officers contacted the man's family at the beginning of this investigation. I hope that this report addresses any concerns they may have.

HMP GUYS MARSH

7. Guys Marsh is a category C training prison and young offender institution. It originally opened as a borstal in 1960. The prison has grown considerably over the years and is modern in design.
8. The prison has nine residential units. Jubilee House, where the man was located, is one of two units in the prison for adult prisoners on the enhanced level of the prison's incentives scheme. It was opened in 2002 and is capable of holding up to 40 prisoners in single cells. There are two landings made up of 20 cells on each. All cells are of a good size and have en-suite shower room facilities. The unit has a laundry and an association room for recreation and dining. It is staffed daily by two officers and managed by a Senior Officer.
9. As part of the prison's strategy to alleviate distress that could lead to thoughts of self harm, a Listener scheme operates on a 24 hour basis for prisoners in need of support. The scheme is a peer support system, with each Listener receiving training from the local Samaritans. Listeners wear badges to identify themselves and a prisoner should be able to talk to a Listener whenever they feel the need.
10. In the introduction to her report of an unannounced inspection of Guys Marsh in October 2004, HM Chief Inspector of Prisons, Ms Anne Owers, said:

"Overall, Guys Marsh was a prison that was liked by both staff and prisoners: it was in general a safe and respectful environment. It was clear that there had been recent improvements both to the physical environment and to elements of the decency agenda. Eighty-seven per cent of prisoners said that there was a member of staff they could speak to about a problem: only 18% had ever felt unsafe."

KEY EVENTS

11. On 24 February 2004, the man who is the subject of this investigation appeared before magistrates, charged with the attempted murder of his neighbour two days earlier. A Suicide/Self-harm warning form was opened on the man by a Prisoner Custody Officer, based on information supplied by Dorset Police. It stated that the man seemed depressed and when asked how he felt, said he felt "gutted". The man also said he would feel better once he arrived at prison because of his previous occupation in a custodial environment.
12. The man was remanded in custody and taken to HMP Dorchester. On reception, he was seen by a healthcare worker who completed a First Reception Health Screen form. The man was asked about his physical health. Although he said that he had several worries about his general health, these were not specified on the form. He said he was suffering from a foot ulcer and was taking a number of medications for medical conditions including diabetes and asthma.
13. When asked about his mental health, the man said he had attempted suicide in 2003 by placing a shotgun in his mouth but could not go through with it. Although he answered "yes" to the question "Do you feel like hurting yourself at the moment?" he said he was not feeling suicidal.
14. A Cell Sharing Risk Assessment was also completed. As the man had been charged with a violent offence and said that he got frustrated, he was initially assessed as medium risk to other prisoners. This meant that there was no immediate risk but the situation would need to be reviewed regularly. However, after he was seen by a member of the Healthcare Team, he was re-assessed as presenting a low risk. Nevertheless, due to the nature and seriousness of the charge, it was decided he should spend his first night in custody in the healthcare centre as a precaution.
15. On 25 February, the man was prescribed seven types of medication. An entry in his medical record that day reads, "May need watching, very despondent at his situation. No suicidal thoughts at the moment."
16. On 2 March, the man was transferred to HMP Winchester. He was interviewed as part of the induction process, and the officer noted in the Record of Events that he was "confused and in a state of shock. Numerous domestic problems i.e home, pets, aged mother."
17. On 16 March, the medical record noted that the man was worried about other prisoners finding out about his previous occupation. He himself recognised two prisoners that day.

18. On 27 March 2004, an entry in the Record of Events described the man as being tearful and, although not suicidal, he said that if he received a significant prison sentence he might feel differently.
19. On 2 April, an officer noted in the man's Record of Events that he had been "crying profusely", and was concerned about his elderly mother and his dogs. He said that he would not harm himself but, if his mother died and he lost his dogs, he would have nothing to live for and would "do it."
20. On 13 April, a Senior Officer (SO) noted in the Record of Events that the man said he had a couple of problems with other prisoners but had managed to cope. He told the SO that, if his mother died whilst he was in custody, he would kill himself. Over the following months, several entries in the man's history sheets and medical notes record him feeling tearful and worrying about his mother. However, during the summer of 2004, a number of more positive comments were made indicating he was working well and being both polite and helpful to staff.
21. However, this period of relative stability for the man appears to have been interrupted by his subsequent appearance at court. On 16 July, it was recorded on his Prisoner Escort Record that he was placed on a five minute watch after he told Crown Court staff that he would commit suicide if he received a substantial sentence. He added that he would assault a member of staff so that he would be taken to the segregation unit and would be able to kill himself there. The man was observed by staff every five minutes whilst he was at court. He was convicted of attempted murder that day but sentence was adjourned for reports. On return to Winchester, no F2052SH (a self-harm monitoring document) was raised. The man was admitted to the healthcare centre for observation of his diabetic symptoms as he had not eaten for two days.
22. Over the following days, two entries were made by healthcare staff with regard to the man's state of mind at this time. On 17 July 2004, a healthcare officer at Winchester recorded in his medical record that he had:

"Spoke at length to this man. Mood remains low and very tearful at times. He denies that he is actively suicidal in that he has made no plans, does not think about it as a very real option and has not thought about the method. He is adamant that being in healthcare is detrimental to his mental state - wants to be in a single cell, get back to the wings to the people he knows. I am aware of concern expressed by others about this man's state of mind - believe mood is objectively low and has been for 4 months - therefore risk of self harm is moderate - believe he should return to wing where he knows people and feels secure."
23. The following day it was recorded that:

"I feel he [the man] is at some risk from locating back to a single cell. I did not commence a 2050SH as felt it would be detrimental to him and push him even lower. I do believe in holistic approach and his well being, currently poor, does have a direct effect on his thought process, reasoning and mood. His prospects are poor and he is in a single cell on the house block. I do not believe a risk of suicide is limited to only those people who show obvious signs of mental illness. Despair is very relevant in the case of suicide. I believe a careful assessment should be made, with serious consideration given as to his sentencing next week and being in a single cell."

24. On 19 July 2004, an F2052SH was opened by the medical officer at Winchester. It stated that the man was tearful, depressed and vulnerable, although he denied being suicidal. It recorded that there should be regular observations, that he should share a cell, and that he should have access to the Samaritans. The support plan which should have been devised to support the man through his vulnerable period read merely, "Landing staff, Listeners." A member of the healthcare team and doctor agreed that, although the man denied having suicidal thoughts, he was vulnerable to tearful episodes. At a review undertaken on 22 July, it was considered that it was too early to close the form. However, after a review a week later on 5 August when it was noted that the man said he would "probably die in prison of natural causes and not by his own hand as his mother would not cope", the F2052SH was closed.
25. A psychiatric report was prepared for the court by Wessex Forensic Psychiatry Service. It said that there was no evidence the man was suffering from mental illness at the time the offence was committed, and that he did not have a mental illness requiring treatment. However, it concluded: "It will be important for the man's mood to be monitored, either in prison or in the community and I would advise that a referral be made to a visiting psychiatrist should there be significant concerns with regards to low mood and risk to self."
26. On 15 October, the man was sentenced to seven years imprisonment. His prison records described him as feeling low and upset as his defence team had told him he would "walk". He appeared to be more settled after talking to staff and a Listener.
27. On 16 November 2004, the man was transferred to HMP Guys Marsh. On arrival, a Cell Sharing Risk Assessment was completed. It recorded that the man presented no problems, but was a mature man who might find it hard to cope with his first time in prison. The man was assessed as presenting a medium risk to others. He was given a cell on Cambria House. An entry in the Record of Events recorded that the man had no immediate problems except the need to keep in touch with his elderly mother.

28. During a Further Reception Health Screen completed on the day of the man's transfer to Guys Marsh, and contrary to his reception health screen at Dorchester, he said that he had never previously attempted suicide.
29. On 1 December 2004, the man received a letter from his Probation Officer in the community. He was advised that the Victim Liaison Officer was seeking to have a condition attached to his licence which would exclude him from his home area on his release.
30. On 30 December 2004, due to his good behaviour, the man moved from an ordinary residential unit in Guys Marsh to Jubilee House, one of the two enhanced units for prisoners at the peak of the Incentives and Earned Privileges Scheme (IEPS). The man was described variously by staff as being polite, having a good sense of humour and keeping himself to himself.
31. On 10 April 2005, the man's Wing History Sheets recorded that he had become very quiet again, and on 13 April 2005, an F2052SH was opened by an officer. It recorded that the man was feeling very down and tearful and that he was not coping well with prison. He said he felt he would die in custody. Although it was not Guys Marsh's policy to allow prisoners on open F2052SHs to remain on Jubilee House because of the minimal staff supervision and prisoners being in cells alone, the decision was taken that the man should be supported and monitored hourly on Jubilee House. The man was said to be happy to stay on Jubilee and told staff that he did not wish to see a doctor. Although he was referred to the healthcare centre, no healthcare assessment was recorded in the F2052SH.
32. An entry in the man's medical record on 13 April, states that he was tearful and upset and that, after coping for 13 months, he was now feeling low. The man talked at length with an officer on the house block and agreed to see a doctor the next day.
33. On 14 April, he met with the doctor. The man's medical record states that he was upset, feeling low and tearful. He said he felt that he had no future at the age of 63, although he was currently not feeling suicidal. The man said, "if I had not done it in Dorchester I would not do it here, I don't want my mum to know that I have taken my life away." The doctor recorded that the man had good eye contact, and that his mood was normal and thoughts were clear. The man said he did not want counselling but agreed to take an anti-depressant. The doctor decided that he was to remain on hourly watch and was told help was available should he go through a crisis. The man replied "I won't do anything like that."
34. A case review of the man's F2052SH took place on 16 April. It was noted that he remained upset on occasion but had said he was not going to hurt himself in any way. The man talked about being brought

up to deal with his own problems and that he found it difficult when faced with a difficulty he could not solve himself. After reassuring the man that he should communicate with staff or speak to a Listener if necessary, the decision was made to close the F2052SH.

35. Through the remainder of 2005, it was recorded that the man continued to make good progress. He became happier, although on occasions he would suffer setbacks as a consequence of circumstances such as his mother illness. He also received a letter from his victim's solicitor advising him that a civil claim for compensation was going to be made against him.
36. On 2 January 2006, the man applied for Release on Temporary Licence (ROTL) in order to visit his mother in a local nursing home. The application was granted and an escorted visit took place on 14 January 2006. The man was said to have been happy that it went well.
37. On 28 January 2006, his wing record noted: "Another steady period keeps plodding along doing the wing Laundry and model making. Never gives staff any cause for concern."
38. In early February, the man wrote a letter to *Inside Time*, the national newspaper for prisoners, with reference to an article that had appeared about re-offending being one of the Government's core priorities. He wrote that, even though he had led a law-abiding past, he was dreading his eventual release. He expressed anxiety at having been told by the Probation Service that he would be banned from his home area until at least 2009, even though his family lived close to him and they were his only relatives. He commented, "I now need a bit of looking after. Yet upon release I will be going to an area I know nobody, after the bail hostel." He sought reassurance asking, 'Am I a normal type of prisoner? My worries make me feel that "I will be back", going out with no home, no contacts or family ...' The reply from the newspaper was posted a day before his death. As a consequence, the man never saw it.
39. On 10 February, the man placed his usual weekly canteen order (an order via the prison shop) for model making equipment, phone credits, toiletries and snacks.
40. At 5:42pm on 13 February, the man made his usual daily telephone call to his mother. The call was relatively brief and was an exchange of news. At one point, the man's mother said that she would be visiting her son in late February and the man confirmed that this was correct. The conversation was concluded with the man telling his mother that he would catch up with her the following day.
41. A fellow prisoner on Jubilee House, told my investigators that the man spent from about 6:45pm to 7:30pm in his cell drinking a cup of tea and

chatting. The fellow prisoner described the man as seeming to be “his normal self”.

42. The night patrol operational support grade (OSG) said that he had worked on nights on Jubilee for about three and a half years. Prior to that, he had been a Senior Officer at Guys Marsh for five years. He arrived at work on the evening of 13 February 2006 at approximately 8.30pm. He said that he had a handover with the officer in charge of Jubilee House and nothing of note was brought to his attention. He then proceeded to check that the cells were locked. He said that this would have involved opening the cell door flap to see if a prisoner was there before moving on. The night patrol OSG said that he could not recall seeing the man that night as he did not know him (or any of the other prisoners) by sight or name, but that the man must have been there as the roll was correct. Asked about the way he usually carried out his duties, the OSG replied, “there’s no reason why I should speak to them at all unless they have a problem during the evening.”. He saw his role as satisfying himself that the house block was secure and the roll correct.
43. The night patrol OSG was asked by my investigators whether he had seen the man the evening before and on the morning of 14 February. He replied that he was unable to remember events on the actual days so he could only say what he would normally do rather than what he actually did. He said he did not normally engage in conversation with prisoners on the unit unless they rang their bell. In practice, a prisoner ringing his bell was “very, very rare”.
44. The night patrol OSG said that during the evening he would have gone around the unit a number of times in order to complete routine patrols using a hand-held pegging device. (This registers on an electronic clock to ensure that regular checks of the wing are being made.) He said that on the morning of 14 February 2006 he checked to ensure all prisoners were present and, although he could not remember seeing the man, he was satisfied he must have seen him and the roll was reported as being correct. However, copies of the pegging reports subsequently obtained by my investigators reveal that there is no evidence of pegging having taken place on the first floor of Jubilee (the two’s landing) where the man was located.
45. The night patrol OSG said that one of the duties of the night patrol on Jubilee would be to change the videotape for the CCTV system covering the corridors. This was done by removing the tape from the machine, placing it in a box and inserting another tape. This would normally be done between 6:30am and 7:00am and the tape would run until the next morning. The OSG said that on the morning of 14 February, at about 6.30am, he noticed that the machine had not been recording during the night so he switched it on at that point.

46. An officer, who was starting his day shift, took over from the night patrol OSG on 14 February. He told my investigators that he did not normally work on Jubilee but had been designated an early start there until the day staff arrived. He arrived at Jubilee House at approximately 7:36am. He was informed by the night patrol OSG that the roll was 40 and, after securing his bag in the office, proceeded to do the count himself. He said that whilst checking the two's landing, on which the man's cell was located, there were a number of cells where he had to tap on the door to get the occupant's attention in order to satisfy himself that they were present. He said he did not notice anything different or suspicious. Having looked in each cell for its occupant and noticing nothing untoward, he returned to the office and phoned the roll number through at approximately 7:44am. He then went to his usual place of work in Cambria House.
47. Another officer who did not usually work on Jubilee house block was assigned to work there for the day. At interview, he said that he arrived on the house block at about 7:37am on the morning of 14 February 2006 and noticed on the CCTV that the other officer who was starting his day shift was carrying out the morning count. The second officer said that he started to carry out daily office checks and that, after a short time, the other officer arrived in the office, signed for the roll and then left. A senior officer (SO) arrived on the unit at about 7:55am and, shortly after this, permission was given for the prisoners to be unlocked. The officer assigned to Jubilee house block that day said he went to unlock the two's landing whilst the SO unlocked the ones landing (the ground floor). The officer assigned to the house block said he unlocked the cell doors by turning the master lock on each, but he did not push them open or look through the observation panels of each door as he was unlocking them. Asked at interview whether it was normal to unlock without seeing the occupant, he replied that it was indeed normal given that the morning number count had already been done. After taking a few minutes to unlock all the cells on the landing, including that of the man who died, he returned to the office.
48. A prisoner on Jubilee, told my investigators that the man was usually one of the first prisoners to be up and about in the morning. Not having seen him that morning, the prisoner went to the man's cell, noting his cell door was slightly ajar, and knocked at the door. As there was no reply, he walked into the cell. The bathroom door which is to the left as one enters the cell was open outwards, so that the prisoner could not see the bed. When he pushed the door back, he saw the man. He touched the man and found him "stone cold". He jumped back and asked another prisoner to tell the officers.
49. The officer assigned to Jubilee house block said that no more than five minutes after he had finished counting the landing, the other prisoner on the two's landing, appeared in the house block office and said that there was someone hanging in a cell upstairs. Both the officer and the SO ran there and saw the prisoner who found the man standing

outside cell 2-35 in a distressed state. The SO entered the cell and saw the man in a crouching position, under the window with one arm on his bedside locker and a ligature around his neck tied to the window.

50. The SO told my investigators that there was no movement from the man and his skin was a greyish colour. The SO bent towards the man but could not detect any breathing. The officer assigned to the house block that day removed the ligature from the man's neck. He commented at interview that he did not take ligature scissors with him, but the ligature was surprisingly loose and easy to remove. It was not clear what material the ligature was made from but it appeared to be black webbing. The SO noticed afterwards that there was another ligature tied much tighter around the man's neck which appeared to be some sort of wire. Both officers described the man's skin as feeling cold and clammy.
51. At 8:08am, the SO called for emergency assistance on his radio, and asked the prisoners who were milling around to go back to their cells. He did not start Cardio Pulmonary Resuscitation (CPR) as, in his opinion, the man was clearly dead. An ambulance was called at 8:14am.
52. A healthcare officer (HCO) arrived from the Healthcare Centre a few minutes later, having received an emergency call on his radio. He noted that there were no signs of breathing, could not feel a pulse and the man's eyes were fixed and slightly dilated. The HCO moved the locker from under the man's arm, but the arm remained in a fixed position. A staff nurse arrived and together they attempted to open an airway but were hampered by rigor mortis. They applied oxygen and attempted to place the man flat to start CPR, but were unable to do so. An ambulance crew arrived at 8:23am. They could find no signs of life, but applied an ECG in order to detect a trace. No trace was detectable and the man was pronounced dead at 8:30am. They agreed there was nothing further they could do and left the prison at 8:53am.
53. The staff nurse was asked at interview by the clinical reviewer about the attempt to resuscitate the man. He said that the man was clearly beyond help, but as a nurse he was not able to pronounce death and would have been horrified if he missed an opportunity to help the man. In retrospect, however, he felt that their attempts were futile.
54. During Dorset Police's initial enquiries at Guys Marsh, a detective sergeant (DS) explored the possibility of whether access had been gained to the man's cell at any time during the preceding night. Like most other prisons, Guys Marsh operates a system whereby night access can only be gained by a member of staff with the use of a cell key sealed in a key pouch, which in turn has its own security reference number.

55. The DS discovered that on 14 February 2006, the seal number on the key pouch for Jubilee House did not tally with the record held in the security office. However, the police established that, whilst the paper record kept in the Governor's safe had been updated with the new seal number, the record kept in security had not been updated because of staff annual leave and other commitments. The police accepted the explanation. My investigators spoke to an officer who was responsible for carrying out the key audit. His account corroborated the police's conclusions.
56. A closed circuit monitoring system had been installed in Jubilee House, but there were no written protocols for staff to follow in terms of operating the system or auditing its effectiveness. The CCTV recording system on Jubilee had not been switched on the day before the man's death was discovered. It was turned on again in the morning by the night patrol OSG, shortly before he left Jubilee House having finished his shift. Videotapes show the officer starting his day shift looking through the observation panel of each cell, including that of the man who died, and then moving to the next. The police concluded that there had been no third-party involvement in the man's death.
57. A post mortem examination was held on 15 February. It concluded that the cause of death was hanging. No drugs were detected in the man's blood.
58. On behalf of South West Dorset Primary Care Trust (PCT), a clinical reviewer conducted a clinical review of the healthcare the man received whilst in custody. He noted that, although the man's use of anti-depressants had not been reviewed, he did not think that this had contributed towards his death. He commented on the resuscitation attempts on the man. He noted that the PCT should review its resuscitation policy to ensure that staff, "are not placed in the invidious position of having to perform it in inappropriate circumstances." I entirely share that view.
59. My investigators spoke to a number of prisoners and staff at Guys Marsh about the man. Many of the prisoners who had known the man spoke of him as being a kind man who had time for other prisoners. He had good relations with staff on the unit, but was also someone who was known to be a bit grumpy first thing in the mornings. Occasionally he would appear a little down, but then he would crack jokes and it would seem to blow over. One prisoner told my investigators that, when reading an obituary in a newspaper, he would joke that the dead person had "stolen his turn". One of the prisoners told my investigators that the man would say he was going to leave a big surprise in his cell, and he would "sort of laugh and chuckle about it", but no-one expected him to hang himself.
60. Another prisoner described chatting frequently with the man, whom he described as "miserable, but likeable". They would engage in banter.

The man talked to him about his concerns that his victim was pursuing a legal action against him which “would have resulted in the man losing everything he had worked his life for, his house, his land, his freedom, they were even talking about putting a banning order on him, preventing him going back to his home, that was his life!” He said that the man felt helpless being in prison.

61. Prisoners in the cells nearest to the man were asked whether they had heard noise from the cell before he was found. One prisoner, who was in the cell next to the man, said that the night before his death he did not hear the man making matchstick models in his cell as he normally did. Another prisoner, also in an adjacent cell, remarked that, during the early hours of 14 February 2006, he was awoken at about 3:00am by some banging and at about 4:00am he said he definitely woke up after he heard what sounded like someone hitting a bit of wood or a cupboard. A prisoner on the unit also said he was woken at about 4:00am by the night officer putting on his light and slamming his door hatch.
62. A prisoner, who had recently been moved from Jubilee house block, spoke to my investigators about the concerns the man had. Although he had moved to another house block, Jubilee staff were happy to let him visit regularly and chat with the man. He described the man’s mood as up and down and said that the man felt depressed because of the civil proceedings his victim had begun. He said the man was constantly mulling over the issue of his property and what would happen if his house and land were taken away. He described the man as panicking about not being able to return to his home and not seeing his mother. He worried about his mother’s poor health and receiving letters from solicitors. They would chat in the laundry room in Jubilee House and the man would say, “I’m pissed off with, fed up with these letters, this bloke he’s after my house, he wants this, he wants this, my poor mum ...” The prisoner who had been moved from Jubilee house block said he would try to calm the man down. He said the man would feel better once he had spoken to his mother and his sister on the telephone.
63. The man told the prisoner who had recently moved house blocks that he was going to “do myself in”, and the prisoner who had moved said it had got worse after he had been given a visit to see his mother. The prisoner said he would tell the man who died not to be silly and try to distract him by talking about a television programme, playing chess or talk about making matchstick models. The prisoner said that he had seen the man a day or two before his death. The man had asked the prisoner when he would be visiting Jubilee again, and the prisoner had replied that he would probably be over at the weekend. The man had said, “Oh right.” The man had seemed normal to him. The prisoner said that the man had built up good relationships with staff and he could talk to them when he felt down, especially another prisoner friend, the Braille workshop instructor, and another officer. He

described the other officer chatting with the man to keep him occupied and motivated. He felt that, had the officer been on duty the day before the man hanged himself, he might have noticed that the man was not quite his normal self and been able to talk him round. The prisoner who had moved to another house block told my investigators that, if he was particularly concerned about the man, he would mention it to the officers or the man's other friends so they could keep an eye on him. He described the staff at Guys Marsh as "very good and helpful," but he felt that night staff should have made more checks on the man, given his depression.

64. My investigators were unable to talk to one officer as he was on extended sick leave following an operation. However, the other officer described his relationship with the man. He said that staff built up a good rapport with the man, enabling him to talk to them about the things that bothered him. Staff working in the visits area took his mother's age and infirmity into account and used to make sure she was given an appropriate table to one side. Staff had also been supportive of his application for temporary release to see his mother in a nursing home. The man had been relieved when the self harm monitoring form was closed in 2005 as he did not want to leave Jubilee.
65. The officer felt that the man's death had come out of the blue. He was upset that the man had not spoken to him before he went on leave. He said that, if there was something troubling the man, he would have taken the opportunity to help him. He said that several of the officers who worked on Jubilee knew the man well and had wanted to go to his funeral. But none had been asked by senior managers if they wished to attend. When they had made enquiries, the view was expressed that the man's family might not have wanted them there. Nonetheless, the members of staff who had attended the funeral were there because of their position in the prison, not because they knew the man. At the time, this had caused some hurt amongst officers in Jubilee House.

ISSUES

66. Although the man was largely cheerful, telling jokes and making light of his situation, it is also clear that he could quickly become depressed and feel low. My investigators' interviews with prisoners who were close to the man reveal a person who was preoccupied by fears about his mother's ill health, and what the future held for him if he was prevented from returning to his home area. To the man his home was much more than just a place where he lived. His identity was bound up there with deep family ties. He had never lived anywhere else. His letter to *Inside Time* showed the issues he was wrestling with, and that he was unable to see a way forward. Yet the stark reality was that his victim was also his neighbour. The dispute between them which culminated in the man's imprisonment had not only remained unresolved, it was very much at the forefront of his mind.
67. The man suffered from ill health. He was taking a number of prescribed drugs for depression, diabetes, coronary and respiratory problems, and alluded to staff on several occasions about the possibility of dying in prison. His medical record contained comments that his prognosis was poor. His depression, which pre-dated his imprisonment, may have made him more susceptible when he was feeling low.
68. Jubilee House provided the man with positive and supportive relationships with prisoners and staff who provided acceptance and a listening ear. I have been impressed by the consistently positive comments prisoners made about Jubilee House staff: on their approachability, their willingness to listen and to help them deal with problems or issues as they arose, and the way they treat prisoners as individuals. My investigators noted the open and relaxed atmosphere of the house blocks they visited, and that staff/prisoner relationships appeared excellent. It was commendable that the prisoner with whom the man was friends, and had been moved to another house block, was allowed to visit the man even though they were in different house blocks. This showed a caring attitude towards the man and a recognition that friendships between prisoners are important. This I consider to have been good practice.
69. I am concerned that few of the prisoners my investigators spoke to knew the night staff by sight. Indeed the night patrol OSG, who was on duty the night before the man's body was discovered, said at interview that he rarely had verbal contact with the prisoners on Jubilee House. He did not feel he needed to know their names or speak to them unless there was a problem. He could not recognise any of the prisoners by sight including the man. This was despite the fact that the man had been there for over a year, turnover was low, the unit only held 40 prisoners, and the night patrol OSG worked there regularly. It may well be that the residents of Jubilee House pose few problems or risks but, as the man's death has shown, even the most 'compliant' prisoner can

be a troubled individual. The task of building an effective rapport between staff and prisoners is not solely for those who work in the day time.

70. On the morning that the man died, it was realised that the video machine linked to the CCTV system in Jubilee House had not been switched on, and there was no visible evidence of night checks being carried out. The electronic records from the pegging clock showed no trace of the pegging point on the first floor being activated. However, a couple of prisoners recalled being woken up after having their cell light turned on by the night officer. Nevertheless, in light of the apparent failure of the system, it would be sensible for the Governor to arrange a maintenance check of all the pegging equipment.
71. My investigators learned that the CCTV system was self managed on Jubilee. The security department within the prison did not have an overview of its use. I am pleased that, since the man's death, written procedures have been developed concerning its operation.
72. Those who saw the man after he had died confirmed that his arm had been resting on his locker and he appeared to be crouching. Although the officer who found the man could not specifically remember seeing him, he was certain that there was nothing in the man's cell that had attracted his attention as out of the ordinary. CCTV footage of the officer checking the cells does not reveal anything untoward. It may be that the officer saw part of the man's arm resting on his locker and took this as sufficient confirmation that he was present and awake. The purpose of counting the unit at that time of the morning was to ascertain that all prisoners were accounted for, so that the prison could be unlocked for the day's activities. I would only have expected the officer to seek oral confirmation of the man's presence if he had been out of sight, for example in the toilet.
73. After the alarm was raised, staff acted quickly and efficiently to handle the aftermath. The SO, the first member of staff to be present, decided that it was futile to attempt resuscitation as the man was clearly dead. However, healthcare staff attempted to administer oxygen and start cardio pulmonary resuscitation even though rigor mortis was evident. The clinical reviewer established that nursing staff felt obliged to pursue resuscitation. The clinical reviewer has made a recommendation on this matter which I endorse.
74. **The PCT should review its resuscitation policy, to ensure that their staff are not in the invidious position of having to perform it in inappropriate circumstances.**
75. Guys Marsh's Family Liaison Officer was fully trained to carry out her role and I understand that she provided an effective link between the man's family and the prison. It is unfortunate however, that staff from Jubilee House were not offered the opportunity to pay their respects by

attending the man's funeral if they wished, subject to the wishes of his family. My investigators discussed this with the Governor who expressed his regret and accepted that the issue could have been handled more sensitively.

76. In sum, I do not think that the man's death could reasonably have been predicted. However, his death is a reminder that even prisons like Guys Marsh must be alert to the dangers of suicide and self-harm. Sadly, even the good staff-prisoner relationships which I have been pleased to record and acknowledge in this report are no guarantee that a prisoner will not try to end his life.

RECOMMENDATIONS

The PCT should review its resuscitation policy, to ensure that their staff are not in the invidious position of having to perform it in inappropriate circumstances.