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**Report of an Investigation under Article 2 of the European Convention  
of  
Human Rights into the circumstances surrounding the attempted  
suicide of Mr JL at HMYOI Feltham on 19 August, 2002**

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## **Structure of the Report**

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This report describes an Independent Investigation into the circumstances surrounding the attempted suicide of Mr JL at HMYOI Feltham, to meet the State's investigative obligations under Article 2 of the European Convention of Human Rights (ECHR).

The report has been compiled by the Independent Investigator, Professor Cynthia McDougall, OBE. She has received expert advice and comment from Dr. Ian Cumming on health and mental health issues, and JL's clinical care up to the time of his attempted suicide. Dr. Cumming's assessments and comments have been integrated into the report and he has agreed the final version of the report. Professor McDougall has received comments on an earlier draft report from JL's legal representatives and the Ministry of Justice, and these comments have been taken into account in the final report, dated May, 2010.

### ***Summary***

The report begins with a summary of the full report, how it was conducted, the main findings of the Investigation, and its conclusions and recommendations. Further detail can be obtained in the body of the report.

### ***The Investigation and its Terms of Reference***

The commissioning of the Investigation and its Terms of Reference are outlined in this section.

### ***Methods used in the Independent Investigation, 2008-2010***

This section describes how the Investigation was conducted, which documents were available for examination, information obtained from the documents, further information sought for the current Investigation, and information obtained from follow-up interviews. The section makes it clear how the evidence relating to JL, and events surrounding his attempted suicide, has been obtained.

*INFORMATION OBTAINED FROM DOCUMENTARY EVIDENCE COLLECTED IN 2002 AND 2008–2010*

### ***The context of JL's attempted suicide at HMYOI Feltham, 2002***

Since the Terms of Reference require that events leading up to JL's attempted suicide should be examined in the light of policies and practices in 2002, it is important to describe HMYOI Feltham as it was then and its circumstances at the time of JL's attempted suicide to give a context for events. This context is based on independent evidence at the time, derived from Inspections conducted by HM

Inspector of Prisons, a Report by the Campaign for Racial Equality (CRE), HMYOI Feltham Board of Visitors Annual Report and a report by the Prison Service Standards Audits Unit assessing the establishment's performance in relation to key policies extant at that time.

### ***Background of JL***

We next give information on JL himself and what is known of him prior to his arrival at HMYOI Feltham. Much of this information has been given by JL himself, and is set out in a formal document: 'Background Proof of Evidence'. It is not known who transcribed this document but it was probably a solicitor involved earlier in JL's case. Some of the information is inaccurate and has been corrected by JL in interviews with the Independent Investigator and his current legal representatives.

### ***JL's arrest and chronology of events while on remand at HMYOI Feltham***

A chronology of events following JL's arrival at Feltham is next presented. This gives daily detail, extracted from prison records, regarding JL's management and clinical care at Feltham, information from a report of a Prison Service Internal Investigation conducted in 2002, interview transcripts obtained in the course of the Internal Investigation and the Independent Investigation of 2008-2010. This is followed by a diagrammatic timeline showing the support interventions provided during JL's time at HMYOI Feltham.

### ***The incident of attempted suicide and events of 19 August, 2002***

JL attempted suicide during the afternoon of 19 August, 2002. This section of the report includes information on events leading up to JL's suicide attempt starting with the night of 18/19 August. Information has been obtained from the report of the Prison Service Internal Investigation in 2002, supplementary documents submitted by staff after the incident, prison service records, and information obtained from transcripts of interviews conducted for the Internal Investigation and the Independent Investigation. This section describes the discovery of JL, having attempted suicide, staff efforts to revive JL, the arrival of emergency services, and his transfer to hospital.

### ***Interviews conducted in 2008-2010 with JL, JL's mother, and HMYOI Feltham staff***

Interviews were held in 2008-2010 to explore some of the outstanding issues raised during scrutiny of the prison records and other documentary evidence relating to JL. It was essential to gain the views of JL and JL's mother about events at HMYOI Feltham, and to explore relevant issues. These interviews are described.

Interviews were conducted with available staff who had played a part in JL's experience at HMYOI Feltham. These interviews are described and their contribution to the report highlighted. Some further interviews were conducted in 2010 to explore issues raised by JL's legal representatives and the Ministry of Justice.

#### *Alleged rape of JL at HMYOI Feltham*

During interview JL described an incident of rape that had allegedly occurred at HMYOI Feltham. This and other accounts of this incident are described, and relevant documentary evidence is examined.

#### *CRITICAL APPRAISAL OF JL'S MANAGEMENT AND CARE*

#### ***Prison Service Suicide Prevention Policies in 2002***

The National and Local Suicide Prevention Policies and procedures extant in 2002 are described.

#### ***Application of Suicide Prevention Policies in relation to JL***

Both the National Suicide Prevention Policy and the HMYOI Feltham Local Suicide Prevention Policy are next examined in relation to events surrounding JL's management and care. Each aspect of JL's care is reviewed in terms of the National and Local Policies, and this includes assessment by Dr. Cumming of health care arrangements.

#### ***Comparison with the report of the Internal Investigation, 2002***

There are some similarities and some discrepancies between the report of the Internal Investigation and the findings of the Independent Investigation. These are discussed in terms of the value of contemporaneous reporting and interviews, and the additional findings and issues raised by a more extensive investigation.

#### ***Conclusions and Recommendations***

Conclusions are drawn and recommendations are made on the basis of the above information.

#### ***Glossary of abbreviations and terminology***

This section has been provided to assist reference to documents which are first described in the report in full and later using abbreviations.

#### ***Annexes***

A summary of annexes is provided.

## Summary

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This Independent Investigation report describes the management and clinical care of JL at HMYOI Feltham from his reception on 19 July, 2002, until his attempted suicide on 19 August, 2002. JL was arrested on 18 July, 2002, and remanded in custody to Feltham on 19 July, 2002, for possession of crack cocaine with intent to supply. JL, then aged 20 years old, had arrived illegally into the UK on 15 March, 2002, leaving three children at home in Jamaica in the care of his mother. JL was the father of the youngest of these children and his girlfriend<sup>1</sup> in 2002 was the mother of all three children. JL's girlfriend was already living in the UK, although she had not been granted asylum.

From JL's arrival at Feltham on 19 July, 2002, his anxiety and distress were recognised. He expressed anxiety about his children and his girlfriend, and talked about being in danger in Jamaica where his father and brother had been shot dead. JL himself complained of having a bullet lodged in his foot. On arrival at Feltham he appeared to be disorientated. On 21 July an F2052SH<sup>2</sup> was opened and, as JL's distress continued throughout the day, he was transferred to HMYOI Feltham Health Care Centre (HCC) where he remained over a period of 3 days before being returned to a residential unit. It was, however, recommended that the F2052SH should remain open.

On the residential unit JL's mood swings were observed. Unit staff encouraged JL to involve himself in activities. Requests from JL to change unit, cell or cell-mate were agreed without question in order to facilitate his coping with imprisonment.

While the F2052SH was open (18 days), JL received 23 separate support visits from members of the Chaplaincy, Outreach<sup>3</sup>, CARATS<sup>4</sup>, doctors and nurses, and 4 case reviews were held. Throughout this time he was closely observed and supported by unit staff, and his entry to the F2052SH system was overseen by the Suicide Prevention Coordinator (SPC) who was personally involved at times of crisis. Under the F2052SH system JL was reviewed weekly, which was more

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<sup>1</sup> In the records, reports refer to either JL's girlfriend or wife. It is believed that the terms are used interchangeably to refer to the same person, who was in fact JL's girlfriend.

<sup>2</sup> F2052SH was the self-harm at risk form, then in place in HM Prison Service, which started a process of special supervision and care for those prisoners at risk of self-harm, or following an incident of self-harm.

<sup>3</sup> The Outreach team had some mental health training, and were attached to the HCC with the brief to liaise with residential unit staff in supporting prisoners at risk of self-harm.

<sup>4</sup> CARATS (Counselling, Assessment, Referral, Advice and Throughcare Service) is provided by an external agency supporting prisoners with drug and alcohol issues.

frequently than the national policy required, and in line with 'good practice', as defined additionally in the Local Suicide Prevention Policy<sup>5</sup>.

The health of his youngest child, a daughter, who had a heart problem, was a source of great anxiety to JL. In addition, he became depressed and sometimes angry that he did not receive as many visits from his girlfriend as he would have liked. His girlfriend appears to have visited five times during JL's 31 days at Feltham. On 31 July, 2002, in the early evening JL was very distressed and crying, and told a unit Officer that he had been informed by telephone that his daughter had died. A member of the Chaplaincy and Outreach attended immediately. There was much concern about JL's risk of self-harm at this stage, as it was reported in the subsequent review that a noose had been found in his cell. JL was therefore again transferred to the HCC. The following day it was discovered that JL's daughter had not, in fact, died but that JL had become upset because his girlfriend had told him that she could not come to visit that day. He had used the story about his daughter as an explanation for being so upset. After the facts became known, JL persisted with his version of events for about two hours before finally admitting that it was not true.

JL's case was properly reviewed on 1 August, 2002, in line with national and local policy by a multi-disciplinary team, including a mental health nurse, before he was discharged from the HCC, and the F2052SH remained open. The finding of a noose was recorded in the F2052SH record of his discharge review, although the exact date and time of the finding is not stated.

After a relatively calm week for JL, on the afternoon of 8 August, 2002, the F2052SH was formally closed in the HCC by a member of the Outreach team. Unlike previous reviews, according to the record of the closure, this final review appears not to have been multi-disciplinary, with only JL and an Outreach Registered Mental Health Nurse (RMN) present. This absence of a multi-disciplinary team when the F2052SH was closed was a significant deviation from the National and Local Suicide Prevention Policies, which was judged by the SPC and other HCC staff interviewed to have been exceptional and difficult to understand. Given the amount of multi-disciplinary attention that JL had received while on F2052SH, this reaction is understandable. Although the closure review does not record the presence of a multi-disciplinary team, the Internal Investigation Report in 2002 is clear that 'The Self-harm form was closed on 8 August, 2002,

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<sup>5</sup> National F2052SH policy required review of the prisoner within 72 hours of the F2052SH being opened: thereafter every 2 weeks; before discharge from HCC; and at the time of F2052SH closure. Local policy required review every 2 weeks, but recommended that 'good practice indicates weekly review more effective'.



after a multi-disciplinary case conference' (para 5.7). It is not known whether the Internal Investigator checked this fact at the time of writing the report, or whether this was a mistake in the reporting. It has however not been possible to check this with either the RMN or the Internal Investigator, both of whom have now retired. There was no doubt however that the Chaplaincy did not attend the F2052SH closure review, and they said that they would not have agreed with the closure had they been consulted because of JL's impulsive behaviour.

After the closure of the F2052SH, contacts with the Chaplaincy and CARATS did continue, although much less frequently, and JL was not seen by Outreach. In the 11 days between closure of the F2052SH and JL's attempted suicide he was seen 4 times (by the Chaplaincy, CARATS and the HCC), and was taken to outside hospital at his own request on one occasion because of the pain in his foot. Although there is no doubt that the closure of the F2052SH by one member of staff was against national and local policy, it is assumed that the F2052SH could have been re-opened by any of those seeing JL, or by members of the residential unit staff if JL had shown any recurrence of his earlier distressed behaviour. It is not known whether the suicide attempt would have been prevented if the F2052SH had remained open, although the Assistant Chaplain thought this unlikely. It was her and the Chaplain's view (obtained in interviews in 2008-2009) that JL did not plan to commit suicide, but that his behaviour was more of an attempt to find a way to get out of Feltham.

On the night prior to JL's attempted suicide (18/19 August), it was recorded by an Operational Support Grade<sup>6</sup> (OSG) on night patrol that there was 'constant abuse of the cell bell<sup>7</sup>' in JL's cell, and he recorded this in the unit history sheet. After hearing of the suicide attempt, the OSG went on sick leave. In later correspondence he described events of that night in retrospect. The OSG said that each time he responded to the cell bell, he did not get sensible answers. JL asked to see a doctor, but would not give his name. The OSG contacted the HCC, but they said they would not respond without being given a name. The OSG stated that he checked the cell regularly after these events. In the later correspondence, the OSG stated that at one point JL had appeared to have a 'short wide piece of bed sheet' round his neck. The OSG insisted it appeared more like a 'loosely tied scarf'. He said that it did not look like a noose, and it was only in retrospect that he thought it might have been. JL's cell-mate, who was apparently sleeping during these events, said in interview that he did not know of a noose in their cell on that

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<sup>6</sup> Operational Support Grade is a 'non-contact with prisoners' role.

<sup>7</sup> Means by which prisoners can communicate with staff when locked in a cell.

occasion. There was therefore no other mention of a possible noose, apart from the OSG's statement that he did not think that what he saw was a noose. During the night JL appears to have written two suicide notes, which were found in his in-cell possessions after the suicide attempt.

The following day, 19 August, 2002, JL was called up for a random mandatory drug test (MDT). This MDT screening was later found to be positive for cannabis. JL had at the time of the test been in Feltham for 31 days which would usually indicate that JL had used cannabis while at Feltham. It is not known whether this had any effect on JL's behaviour.

JL was returned to the unit following the MDT at about 14.00 hours. JL asked to be allowed to make a phone call. It is believed this call was to his girlfriend. After the call, he joined a queue of prisoners waiting to be taken to education. He was told that he was not on the list and returned to his cell on his own, as his cell-mate had gone to education.

According to the Internal Investigation report, at about 14.30 hours a prisoner asked if he could be let into JL's cell to talk to him, as he had noticed JL was looking upset. The Officer went to ask for authority from the unit office for this request and the unit office gave approval. When the Officer and the prisoner arrived at JL's cell and opened the cell door, JL was found hanging from the window bars by a ligature. The ligature was made out of a complete bed sheet twisted tightly. JL's knees were bent with his feet touching the ground. The Officer immediately sent the prisoner to get help and called for help himself, while he lifted and supported JL to relieve the pressure on his neck. Officers on the unit, hearing the call, immediately came to assist. There was no chest movement or pulse at that stage. One Officer administered mouth to mouth resuscitation while another administered chest compressions. Officers managed to get a pulse back after about three minutes, but no chest movement or breathing was observed. The HCC staff responded to a Code 1 Alarm<sup>8</sup> at 14.55. They took over resuscitation and successfully managed to get JL breathing again. The ambulance arrived at 15.07 hours, ambulance paramedics took over the resuscitation and JL was transported by ambulance to Charing Cross Hospital. JL returned to HMYOI Feltham on 24 September, 2002, and was located in the HCC with an open F2052SH. Discrepancies in timings in the records of the incident have been closely examined, and no concerns are registered by the Independent Investigator.

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<sup>8</sup> Alarm call for assistance to help with a serious suicide attempt

In terms of Suicide Prevention Policies extant at the time of JL's attempted suicide, it appears that the required processes were in the main properly conducted, with the exception of the closure of the F2052SH, which was not multi-disciplinary. JL received a great deal of support from the Chaplaincy, Outreach and CARATS. JL's health care needs were monitored and medication delivered as required.

The overall impression of JL's management and health care is that this was mainly well-intentioned, without any evidence being found of deliberate harm or neglect. Given the interest the Chaplaincy, Outreach and CARATS had already shown in JL it is my view that, had any serious concerns been raised in the 11 days after the F2052SH closure, this would have been communicated and the F2052SH would have been re-opened.

In an interview with JL for this Investigation, JL could not remember a great deal about his time at Feltham. He could remember his attempted suicide. In his own words 'he was very young, he had no money, didn't get any visits and was alone'. JL said that he had been raped while at Feltham by another prisoner, not a cell-mate, and had not reported it to any member of staff. This incident is described in detail in the report, however there are now three different versions of the incident of rape which make further investigation difficult. JL's mother did not know of any reason why JL had attempted suicide, but was pleased that he was now improving his education and making progress.

I would like to commend residential and the HCC staff for their efforts on 19 August which saved JL's life. Although the after-effects of his attempted suicide should not be minimised, JL and his family are pleased that his life was saved.

JL's attempted suicide was eight years ago, and it is hoped that lessons learned from this case may have already been incorporated into later policies for the assessment and management of suicide risk. Acknowledging this fact, conclusions about JL's case and recommendations arising from his management are included in the report.

## The Investigation

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### 1. Commissioning and Terms of Reference of the Investigation

1.1 This Independent Investigation, to meet the State's investigative obligations under Article 2 of the European Convention of Human Rights (ECHR), was commissioned by the Secretary of State for Justice on 2 October, 2008. The Investigation commenced on 6 October, 2008, and a draft report was submitted to the Ministry of Justice on 17 February, 2009, and to JL's legal representatives on 19 February, 2009.

1.2 At that stage JL's legal representatives had not made a contribution to the Independent Investigation due to an ongoing objection to the 'Independence of the Investigator' and the 'Participation of the Claimant in the Investigation'. There was a restriction on publication of the draft report until a Judicial Review was held on 22-23 July, 2009. Lord Justice Laws gave judgement on 7 October, 2009 dismissing the objections to the independence of the investigator and participation of the claimant. On 15 October, 2009, JL's legal representatives began consultation over the draft report. Comments on the report were received by the Independent Investigator from the Ministry of Justice on 27 October, 2009, and JL's legal representatives on 16 February, 2010. These comments have been taken into consideration and points of accuracy have been noted. Requests that further attention be given to some issues have been followed up, although resisted where there was a risk of impinging on the independence of the Investigation.

1.3. This final draft report is based on the original draft report, with amendments based on issues raised in the consultation.

#### *Terms of Reference*

1.4 The terms of reference for the Independent Investigation were:

- to examine the management of JL by HM Prison Service at HMYOI Feltham from 19 July, 2002, to the date of his life-threatening attempted suicide on 19 August, 2002, and in light of the policies and practices applicable to JL at the relevant time.
- to examine relevant health issues including mental health assessments and JL's clinical care up to the point of his attempted suicide on 19 August, 2002.

- to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations.
- to provide a formal report of findings.

## **2. Methods used in the Independent Investigation, 2008-2010**

2.1 The Investigation was conducted by Professor Cynthia McDougall, OBE, as Lead Investigator, with the support of Howard Davidson, Assistant Investigator. Dr Ian Cumming, Consultant Psychiatrist, Oxleas National Health Service Foundation Trust, was commissioned to provide expert medical opinion to the Independent Investigation, covering the second point in the terms of reference, i.e., to examine the relevant health issues including mental health assessments and JL's clinical care up to the point of his attempted suicide on 19 August, 2002. Dr Cumming also contributed to the conclusions and recommendations.

2.2 Copies of policy and process documents were provided by the Ministry of Justice. Five days were spent at HMYOI Feltham examining documentation, and interviewing staff who had been involved in JL's management from 19 July, 2002, and four members of staff who had been present at the time of the 2002 incident of attempted suicide. Two ex-members of Feltham staff who had transferred to other establishments came to Feltham to be interviewed. The Governor, who had been in charge during JL's time at Feltham, was also interviewed. Howard Davidson visited Feltham for a further two days to follow up on outstanding issues.

2.3 Following consultation on the draft report, a day was spent at HMYOI Feltham in 2010 conducting interviews with three former Outreach and HCC staff. An appointment with a Prison Officer (now a Senior Officer) who had had involvement with JL's management in 2002 was cancelled due to illness. Further interviews were offered to JL and JL's mother but were not taken up.

2.4 Photocopies of the core Prison Service record (F2050) for JL were available to the investigators, but the core record itself was retained at HMP Pentonville, the last prison where JL was detained as an adult prisoner. The Assistant Investigator went to Pentonville to examine the original file and to confirm that all relevant documents had been made available in the photocopied core record.

2.5 In the course of consultation on the draft report in 2010, it became evident that the poor quality of some of the photocopying and the organisation of the original core record made some events difficult to follow. The core file was therefore obtained from HMP Pentonville, pages that were difficult to read were re-photocopied, and a detailed electronic index was created to assist in locating documents in the bundle of documents relating to the earlier Internal Investigation, and those acquired in the course of the Independent Investigation, 2008–2010.

The Prison Service has confirmed that the original Inmate Medical Record (IMR) could not be located.

2.6 Attempts were made to follow up key people who had left Feltham since JL's attempted suicide in 2002. These were: the prisoner who was at the scene when JL was discovered to have attempted suicide in his cell; JL's cell-mate during the three weeks leading up to JL's attempted suicide; and the CARATS (Counselling, Assessment, Referral, Advice and Throughcare Services) worker who had been in contact with JL during his time at Feltham. To our knowledge, the two prisoners concerned are no longer in the prison system. Assistance in tracing them was sought through Safer Custody and Offender Policy Group (SCOP) and the police liaison officer but no information on their whereabouts was available from prison or police records. CARATS is an externally provided drug counselling service to prisons. Attempts to contact the individual CARATS worker personally, and the organisation with whom he/she worked were unsuccessful. The current CARATS team were unable to provide any information or access to records from 2002.

2.7 The current police liaison officer was contacted to inquire about police involvement following the incident of self-harm. He was able to direct us to police officers who had attended the incident, and who could confirm that a police crime-scene investigation had taken place, and no further action had been required following the incident.

2.8 Attempts were made through SCOP to contact two members of the HCC staff who had in 2002 been seconded from West London Mental Health Trust (WLMHT), including the Registered Mental Health Nurse who had closed the F2052SH. WLMHT searched their records but were unable to find any information about these members of staff, or how they might be located. Three former members of the HCC employed by the Prison Service were however located and interviewed.

2.9 The core prison record on JL was relatively comprehensive, but more general departmental prison records could not always be found. Prison Service Order 9020 (implemented 1 September, 2004 – not in place in 2002) states that, for prisoners serving sentences of 3 months or over, core records should be retained for 6 years after discharge. For any other prisoner received into custody (either after sentence or on remand) core records should be retained for 1 year after discharge. All personal health records should be retained for 10 years after treatment, and, concerning a mental health disorder, for 20 years after treatment.

Although it is accepted that core prisoner records following a death in custody should be retained indefinitely, this had not previously applied to 'near deaths' in custody. There had however been an Internal Investigation at the request of the Area Manager in 2002 into JL's attempted suicide (although at the time this was not mandatory), and therefore the file and many ancillary documents had been retained. Clearly, in the future it will be recommended that core records relating to 'near deaths in custody' should be retained in line with requirements for deaths in custody, i.e., retained indefinitely.

2.10 In practice, therefore, although we had access to the core prisoner record for JL, when we sought information from general prison records going back as far as 2002, success in locating the records was mixed. We were able to access the unit occurrence book, Chaplain's journal, mandatory drug testing records, the control room log and education attendance lists. However records on prisoner visits going back to 2002 were incomplete. No case notes of CARATS interviews were found, although attempts were made by the Independent Investigation team and the current CARATS staff to trace them. Cross-referencing of information in JL's personal file was therefore sometimes not possible from general records, and further information on, for example, who had visited JL was not always available.

#### *Documents reviewed*

2.11 The following documents relevant to the Investigation were examined.

European Convention for the Protection of Human Rights and Fundamental Freedoms. Article 2 – Right to life.

Instruction to Governors, 1/1994. Caring for the Suicidal in Custody. (Policy on Suicide and Self-harm, including F2052SH, in 2002).

HMYOI Feltham Local Suicide Prevention Policy (Guide to policy and procedures for staff). January 2002.

Prison Service Orders (PSOs) in force in July/August 2002

1300 Investigations

1301 Investigations into Deaths in Custody

Follow up to Death in Custody

3630 Counselling, Assessment, Referral, Advice and Throughcare Service  
(CARATS)

9020 Data Protection (Storage of records)

SO13 Standing Order on Healthcare



## Prison and Probation Ombudsman (PPO) Reports

The D Inquiry Final Report.

Report on Reducing Self-harm and Suicide in Prisons: Advice for Prison Staff on using Safer Cells – University College London (2003)

Report of HM Chief Inspector of Prisons Full Announced Inspection of HMYOI Feltham, 14 –23 January, 2002

Final Report of a combined Standards & Security Audit carried out at HMYOI Feltham between 7 and 23 May, 2002

Board of Visitors Annual Report, 2001–2002, HMYOI Feltham

HM Prison Service Report into the serious act of self harm by JL at HMYOI Feltham on 19 August, 2002 (The Internal Investigation).

- Final Report
- Annexes
- Interview transcripts.

HMYOI Feltham Documentation relating to JL:

- SIR (Security Information Record)
- Cell movement record
- Incentives and Earned Privileges compact
- F2052SH, Self-Harm at risk form
- Hospital reception screening
- Multi-cell risk assessment
- Inmate Medical Record (IMR)

General documentation

- Orderly Officer's log
- Unit Occurrence Book
- Control Room log
- Mandatory Drug Testing Records
- Reports of injuries (F213)
- IEP (Incentives and Earned Privileges) Policy
- LIDS (Local Inmate Data System)
- IIS (Inmate Information System)
- Responses to enquiries from solicitors re JL post incident

- Chaplains Journal
- Board of Visitors (now Independent Monitoring Board – IMB) rota diary, minutes of monthly meeting 21 August, 2002, and Annual Report, 2001-2002
- Race Relations incident log, July-August 2002
- Written confirmation from CARATS that no record of contact with JL in 2002 is available
- Report from Medscreen re finding of cannabis in random drug screening test. (Information on concentration of cannabis not presented in the report and not available through Medscreen. Confirmed that details of concentration are not available.)

*Interviews held in 2008-2010*

2.12 Interviews (tape-recorded and signed by interviewees) were obtained from:

- Two Prison Officers – one first on the scene and the other immediately after, and a Principal Officer
- One Prison Officer who responded to Code 1 Call
- An OSG on duty the night prior to JL’s attempted suicide
- The 2002 SPC (Principal Officer)
- HCC Senior Officer in attendance in response to Code 1 call
- Three members of the Chaplaincy team
- One member of the 2002 Outreach team
- Two members of the 2002 HCC nursing staff.

Interviews (not tape-recorded – signed by interviewees) with:

- JL accompanied by Manager of Community Rehabilitation Residence (Note taken by Lead Investigator - Interview notes signed by Manager but not by JL)
- Telephone interview with JL’s mother (Note taken by Lead Investigator)
- The Governor of HMYOI Feltham during JL’s time at Feltham (Note taken by Assistant Investigator)

2.13 Numerous informal interviews were held with staff in Feltham as part of the information gathering process, including a Senior Governor who provided valuable assistance to the Investigation throughout the whole week spent at Feltham; the Chair of the HMYOI Feltham Prison Officers’ Association who was extremely helpful

in identifying staff who had been at Feltham in 2002 and in facilitating and supporting interviews with Officers; telephone interview with a Principal Officer (retired) regarding the OSG interview; the former Chair of the Board of Visitors (2002); members of the Education Department; and staff in the Mandatory Drug Testing Unit.

2.14 Following consultation on the draft report with the Ministry of Justice and JL's legal representatives, further unsuccessful attempts were made to contact two Registered Mental Health Nurses (RMN), seconded in 2002 from WLMHT, one of whom closed JL's F2052SH. Interviews were subsequently arranged with a former member of Outreach, 2 Prison Service HCC Nurses, and one additional Prison Officer (unavailable due to sickness). JL was offered a further interview, and his mother in Jamaica was offered a further telephone conversation, which were not taken up.

### **3. Context of JL's attempted suicide - HMYOI Feltham in 2002**

3.1 The terms of reference require that the management and clinical care of JL is examined in the light of policies and practices applicable at the relevant time in 2002. For this reason it is important to describe the circumstances relating to HMYOI Feltham in 2002, using independent documentary evidence that is available.

3.2 HMYOI Feltham in 2002 was in the shadow of momentous events in their recent past that they were trying to put behind them. Feltham was under close scrutiny and was in the process of taking action to change the environment, culture and regime in the establishment to avoid any serious life-threatening incidents in the future.

3.3 The Zahid Mubarek case had occurred in 2000. In the early hours of 21 March, 2000, the day Zahid Mubarek was due to be released, he had been brutally attacked by the prisoner with whom he was sharing a cell. He died from his injuries a week later. The public inquiry into Zahid Mubarek's murder did not complete its report, until 2006, therefore HMYOI Feltham had not in 2002 been able to benefit fully from the findings from this inquiry. There had however been an internal Prison Service investigation into the case of Zahid Mubarek in the meantime, and an investigation by the CRE had commenced in 2000, so measures to address the failings identified were already being put in place and acted upon.

3.4 Until May 2000, Feltham Young Offenders Institution operated as a single establishment holding remand and sentenced juveniles and young men between the ages of 15 and 21 years. Following the Crime and Disorder Act, 1998, which included introduction of the Detention and Training Order in May, 2000, Feltham separated juveniles (15 to 17 years) and young offenders (18 to 21 years) into two distinct establishments, Feltham A and Feltham B. In January, 2002, there were 375 young adult prisoners held on Feltham B (208 convicted and 167 on remand). Osprey Unit, where JL spent most of his time at Feltham, held 66 young prisoners, comprising a mixture of remands and convicted prisoners. The unit was divided into Osprey A and B and there was no restriction on mixing convicted and unconvicted prisoners. Feltham A (juveniles) and B (young adults) ran independent regimes but shared services such as the gymnasium, the HCC, and the chapel. Generally the two populations were kept apart from each other.

3.5 An inspection by HM Chief Inspector of Prisons conducted in October, 2000 had found that there were serious and continuing failings in the regime for 18 to 21 year olds in Feltham B. So serious were the failings that the Inspector concluded that, if significant improvements had not been made by the end of 2001, Feltham B should be handed over to the private sector.

3.6 An inspection by HM Chief Inspector of Prisons in January, 2002 found major improvements had taken place in Feltham B. The 2002 report stated that it found 'an establishment whose culture, regime and vision were fundamentally changed'. It was thought to be performing similarly to other young offender establishments over many functions, and indeed was performing better in some areas. This inspection did not examine mental health services fully at that time.

3.7 The Inspectorate report (2002) commented favourably on new processes for prevention of suicide and self-harm. Having discussed these processes with prisoners the Inspectorate found that young people consistently said that staff took the issue of self-harm very seriously and there was little doubt among prisoners that most staff would act on their concerns.

3.8 The improvement in self-harm prevention procedures was to a large extent attributable to pilot site initiatives set up at Feltham by the Safer Custody Group<sup>9</sup>. The Inspection report of 2002 noted that a capital investment of £3.88 million was planned to support self-harm prevention initiatives, developing the key areas of reception, first night, induction and detoxification. These had been areas of need identified in the earlier inspection. Two key roles were funded under the Safer Custody agenda to promote the pilot schemes: the appointment of an SPC and a Safer Custody Project Manager. From Prison Service documentation and an interview with the then SPC conducted in December, 2008, as part of the Independent Investigation, the SPC appears to have been very prominent in the ongoing management of the F2052SH process.

3.9 The Inspectorate report (2002) commented positively on a major commitment by the Governor and his senior staff to improving race relations through the introduction of a wide range of initiatives across the whole establishment. Sealed complaints boxes had been placed on each wing to ensure that young people could complain confidentially if necessary. The report comments that, in 2002, approximately 20–25 complaints of racial incidents were received per month, therefore the system was being used. The establishment had also

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<sup>9</sup> A Prison Service Headquarters Policy Group, now known as Safer Custody and Offender Policy (SCOP).

appointed a full-time Imam to the chaplaincy team, which the report states was a rare appointment in prisons at that time.

3.10 Following the introduction of the Race Relations (Amendment) Act in 2000, the first Prison Service Race Equality Scheme was launched across the Prison Service in 2002. A report by the CRE into Race Relations in Prisons published in December 2003, and focusing on Feltham as one of the three prisons under scrutiny, did however see much scope for improvement. Hence a joint Action Plan between CRE and the Prison Service was developed in Autumn 2003 to provide a new framework for change in race relations. It is not known how much these developing policies will have impacted on Feltham in 2002, but Feltham was at that time clearly aware that change was essential, being under continued inspection and public scrutiny since the Zahid Mubarek case in 2000.

3.11 The Prison Service Standards Audit Unit carried out a combined Standards and Security Audit at HMYOI Feltham between 7 and 23 May, 2002, two months prior to JL's attempted suicide. The audit was part of an ongoing national procedure to monitor compliance with the 1999 Agency Framework Document. Its purpose was to provide 'assurance to line managers and the Director General on the performance of both public sector and privately managed establishments and Headquarters Groups'. The rating process used a systematic approach of collecting evidence against a series of baselines, which then led to a mathematical scoring system to produce percentage scores for each standard in the audit. Ratings were categorised as Good, Acceptable, Deficient or Unacceptable. In the Feltham Audit the rating for Race Relations in May 2002 was 'Good' with a compliance score of 99%. The level of staff training on race relations was assessed as being over 98%. For Suicide and Self-Harm Reduction, the rating was also 'Good' with a compliance score of 84%, though insufficiency of staff training in suicide prevention was identified as a weakness.

3.12 The HMYOI Feltham Board of Visitors<sup>10</sup> Annual Report for the year September 2001–August 2002 confirmed the improvements noted above, as did a member of the Independent Monitoring Board in interview for the 2008-2010 Independent Investigation, who had been Chair of the Board of Visitors in August 2002. The 2001-2002 Board of Visitors Annual Report stated that 'this year has seen much positive change within Feltham'. It commented that the establishment had benefited from consistency of senior management and the Board was pleased

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<sup>10</sup> A voluntary lay group who visit prisons to ensure an independent oversight of treatment of prisoners, now called the Independent Monitoring Board (IMB).

this year not to be highlighting the need for stability. It praised the current Governor and management team for moving the establishment forward and making vital changes and improvements that had been long awaited. The Board of Visitors agreed with the conclusions of the Standards Audit, stating that the establishment had achieved a 'good' rating for overall standards, compared with a 'deficient' overall rating two years previously.

3.13 Whilst acknowledging 'immense improvements' the Board of Visitors expressed concern about severe problems of staff recruitment and retention and the high population turnover of prisoners. They commented positively on the first local staff training course which had provided 18 extra 'much-needed' staff. The report commented with sadness and regret on the tragic suicide in September, 2001, of a 16 year-old boy. The Board did however want to stress their view that 'within Feltham there is a high level of care and watchfulness by the staff that are looking after a highly volatile and disturbed population of young men between the ages of 15 to 21'. Additionally they stated that they felt that Feltham's reputation as a centre of self-harm and suicide was undeserved, and that the vigilance of staff had defused a number of potentially difficult situations.

3.14 Throughout the 2008-2010 Independent Investigation, a number of the people interviewed stated that they were proud of the achievements at Feltham in recent years in preventing self-harm, with no suicides having occurred at the establishment since 2001.

#### 4. Background of JL

4.1 JL's 'Background Proof of Evidence', is included in his core prison record. It is believed that JL provided the information, but it is not known who recorded the Proof of Evidence (although it was probably previous solicitors for JL). Some of this information has subsequently been found to be inaccurate.

4.2 The Proof of Evidence states that JL was born in Jamaica on 5 October, 1981. There is no information on his father apart from JL's statement that his father and one brother were shot dead in 2000. In 2002 his mother was living in Jamaica and had in previous years also been shot. JL had said that she was unwell and could not talk properly. JL has an older brother (though with a different surname) who in 2002 was in the UK and had arrived around the same time as JL; his brother was at that time a boxer with a permit to reside in the UK whilst travelling and taking part in competitions.

4.3 It would appear that JL had lived for most of his life in Jamaica. He attended school at Mico Practising School from the age of 5 to 16. This school is noted on the internet to be one of:

'Six special education units which cater to the learning disabled child, the child with a vision or hearing problem, and children in schools who exhibit other learning problems.'

**[<http://www.moeyc.gov.jm/divisions/ed/specialeducation/specialisation.htm>]**

4.4 JL next attended Dunoon Technical High School (a high school in East Kingston) from the age of 16 to 18 where he studied electrical installation. After school he began working for his uncle as a steel rigger (in a later personal summary sheet recorded by the prison he is noted to be a chef and a steel rigger).

4.5 In Jamaica, JL was exposed to violence, and the Proof of Evidence records that he was shot by the opposition to the PNP (People's National Party) who were trying to reduce the number of votes; he was shot in his left leg. He had an interest in playing football and at one time had hoped to become a professional football player and had played for a team in Jamaica.

4.6 JL stated that he had no previous convictions and had never before been involved with the police.



4.7 It is recorded in the Proof of Evidence (with some inaccuracies) that, at the time of his attempted suicide in 2002, JL had been married for 3 years and had three children. His wife was resident in the UK, but his three children, aged 2, 5 and 7, remained in Jamaica with JL's mother. The youngest child, a daughter, was born with a 'hole in her heart' and JL records that she was unwell and in hospital in July, 2002. From interviews with JL in 2009 by the Independent Investigator and his legal representatives, it appears that this information is incorrect. JL has said that he and his girlfriend were not married, and JL was father only to the youngest child, born 3 December, 1999. The three children were looked after by JL's mother, but now JL's ex-girlfriend looks after the two older children, and JL's daughter has remained with his mother in Jamaica. JL said in the Proof of Evidence that he could not afford to bring the children with him, but hoped to be able to bring them to the UK shortly.

4.8 The Proof of Evidence states that JL's wife (now recognised as his girlfriend) had come to the UK before him in 2000 and had applied for and was granted asylum. JL has since confirmed that to his knowledge his girlfriend had not been granted asylum. In 2002 she was working in the UK as a hairdresser, but has now returned to Jamaica, and she and JL are no longer in touch.

4.9 JL stated that he came to the UK in May, 2002, because of being shot in Jamaica. This date is however incorrect. A Detention Order dated 18 July, 2002, completed by the Immigration Service is in the core record, and states that JL had arrived illegally at Gatwick Airport on 15 March, 2002. A dual detention order was imposed at Holborn Police Station on 18 July, 2002, due to JL's immigration status and remand on charges relating to possession of drugs. JL stated that he was not aware that he needed to lodge an application for asylum, so at that time no application for asylum had been made. He had worked as a barber since coming to the UK, but had not been working for a month before his arrest.

## **5. JL's arrest and chronology of events while on remand at HMYOI Feltham**

5.1 This information is drawn from prison records, medical records, the earlier Internal Investigation, and interviews conducted in 2002, 2008, 2009 and 2010.

18 July 2002

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5.2 On 18 July, 2002, JL was arrested by the police for possession of drugs. The police arrest documentation gives the reason for examination by a doctor as 'injuries' and 'detention' (boxes ticked) and text which states 'escaped from police, restrained, officers injured'. Whilst at the police station he was seen in custody by a Forensic Medical Examiner at 14.00 hours at police request, and again at 17.32 hours at JL's request. It has not been possible to decipher the notes from either examination apart from some words relating to a gunshot wound, 'wants to go home to Jamaica' and 'fell on back 1998'.

19 July 2002

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5.3 On the morning of 19 July, JL appeared at Highbury Corner Magistrates Court and was remanded to HMYOI Feltham until 26 July on charges of possession of a Class A controlled drug (19 wraps of crack cocaine) with intent to supply. In the afternoon, prior to arrival at Feltham, Securicor Custodial Services record shows that JL was again examined by a doctor at 15.12 hours, but the reason and treatment were not clearly written and could not be deciphered, but may include 'pain' and 'given'.

5.4 On reception at Feltham on 19 July, JL received a health screen at which a doctor was present. It was noted that JL had 'constant stomach aches'. In terms of his mental health, it was recorded that there was no history of contact with mental health services and no history of self-harm. The space for comment as to whether or not there were any active thoughts of self-harm was not filled in. A question whether JL had seen a doctor in the last three months was ticked 'no'. It was noted that JL smokes cannabis 'once (in) a while'. There is also an entry in JL's IMR which noted: 'states he has problem with hiatus hernia and was kicked in the lower abdomen at the police station by a policeman'. JL consented to receive a course of 3 hepatitis B vaccinations, although in a separate interview he said these were not needed.

5.5 JL was allocated to Kingfisher Unit, a residential induction unit. A first night risk assessment was undertaken which found him to be suitable for multi-cell occupancy from a security point of view, i.e., having no current or previous violent offences. There were no specific health reasons identified which indicated a requirement for either single or multi-cell occupancy. There was a documented handover between the reception staff and the induction unit, which noted that this was JL's first time in prison.

20 July 2002

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5.6 On 20 July, JL was seen by a member of the Chaplaincy team, who wrote in JL's unit sheet that 'he was very anxious and stressed, and seemed vulnerable due to high anxiety'. The Assistant Chaplain who saw JL at that time later provided a detailed retrospective report of her knowledge of JL at the request of the Prison Service Investigation Team (1 October, 2002). In that report the Assistant Chaplain gave a vivid description of her concerns about JL at induction. Although JL was one of a number of prisoners at reception seen that day, he stood out in her mind as being disorientated and shocked. JL told her that he had come to England to join his girlfriend and earn some money, and it did not seem to have crossed his mind that what he was doing (presumably a reference to supplying drugs) could result in his going to prison. JL's main concern was for his children in Jamaica, and who would provide for them financially. JL asked the Assistant Chaplain to help him to write to the Queen to ask her to let him go back to Jamaica to look after his children. The Assistant Chaplain stated that she had been asked this question on a previous occasion by a Jamaican who had newly arrived in England who, like JL, had no concept whatsoever of how his crime was viewed in Britain and how the judicial system worked. The Assistant Chaplain made a comment to the Officer on duty that JL should be watched carefully as he was 'fragile', and that 'he wasn't retaining information he was being given on induction'. However it was her view that JL was so focussed on the well-being of his children that he did not seem to be at risk of self-harm.

5.7 On the same day, 20 July, JL was referred to the CARATS team, which advises and supports prisoners with drug and alcohol related issues. Once more the unit history sheet noted that JL was 'very concerned about his children and mother in Jamaica'.

5.8 JL had his first hepatitis B injection that day.

5.9 On the morning of 21 July a Security Information Report (SIR) was submitted. A prisoner (JL's then cell-mate) had reported that JL had a piece of piping in his cell on Kingfisher Unit, which was described in the SIR as a weapon. When the cell was searched, the piping was found in the cell. JL's cell-mate had reported being scared of JL, who had allegedly taken all of his tobacco. A single cell was advised for JL by medical staff for the protection of others. It was speculated that the piping might in fact have been left in the cell accidentally after cell refurbishment. In any event, no disciplinary action was taken as a consequence of this incident.

5.10 At 11.30 hours on 21 July, an F2052SH was opened by an Officer on the unit as JL was very upset about his family circumstances and was very tearful, although he had not said he was suicidal. The SPC and a member of the Outreach Team held a review at 11.30 hours, and it was agreed and documented that JL would continue to be managed on the unit, but would be moved to a 'Safer Cell'<sup>11</sup>. A member of the Outreach Team would monitor JL daily, and provide support until JL's return to court on 26 July. It was noted that JL had 'nil thoughts of DSH (deliberate self-harm)' but was seen as having unpredictable moods and so the F2052SH should remain open. Unit staff were encouraged to facilitate the support process with a responsive management style. JL was made aware that support was available on request.

5.11 At 13.45 hours on 21 July, JL was seen by the SPC. JL was extremely tearful and distressed. He was given reassurance but this was noted not to have any effect and JL was therefore referred to the HCC where he was re-located for assessment. It was recorded in the unit history sheet that after his arrival JL declined to go into a ward and was instead placed in a single cell.

5.12 At 14.30 hours, a nursing entry on the F2052SH Daily Supervision and Support Record states that JL was 'anxious and crying' on arrival in the HCC, and it was noted that this was his first time in prison, and that support and advice were given.

5.13 At 15.00 hours, the nurse made an entry in the Nursing Section of the Health Care Assessment form, again saying that this was JL's 'first time in prison and (that he was) finding it difficult to cope'. It was added that there were 'No

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<sup>11</sup> Safer cells have been designed with no ligature points and with fittings to limit opportunities for suicide, while retaining an environment that is as normal as possible.

thoughts of self-harm at present'. JL would remain in a single cell, with normal F2052SH observations. JL was to be reviewed by a doctor the following day. It does appear however that JL was seen by a doctor the same day, as this is noted in the IMR, although no time is given.

5.14 It is recorded in the IMR on 21 July that JL was assessed by a doctor after referral for abdominal pain and testicular pain. There were no entries about the reasons why JL had been admitted to the HCC, i.e., distress and anxiety. JL was noted to be 'afebrile' (without fever) but would not allow the doctor to touch his abdomen. No abnormalities were found. It was commented that he talked about an earlier history of being shot in the leg. The final entry is not clear but may say: '? Malingering (rather) than organic'. It was recommended that JL be kept under observation ('K.U.O'). The same doctor appears to have prescribed paracetamol – although this was crossed out on the Prescription Record.

5.15 At 17.00 hours it was recorded that JL joined in association in the HCC and 'seemed to be fine', but later was anxious and banging his cell wall, asking to go back to his unit. He was moved to another cell (Cell 22). JL ate his evening meal but was still anxious. On the evening of 21 July at 19.25 hours, JL was given a single dose of 7.5 mg. zopiclone (a hypnotic) – this was countersigned by a doctor. No reason was given for this prescription, but may have been because of JL's continuing anxiety. JL appears to have slept from around 22.15 hours to 06.45 hours on 22 July 2002.

22 July 2002

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5.16 Early on 22 July, at around 08.45 hours, JL was crying and shouting out that he wanted to return to ordinary location.

5.17 JL was later seen by a doctor who made an entry in the F2052SH. The doctor found JL to be 'happy, making good eye contact and with no suicidal thoughts'. He recommended JL's return to a residential location, with support from staff and the Outreach team, and that JL should be seen by the Outreach team 'before discharge'.

5.18 At 10.15 hours, an F2052SH Health Centre Pre-discharge Review was held, attended by the SPC and a nurse. JL was also present. The review was discussed with the doctor and his comments were included. It was noted that JL had received treatment (presumably referring to the hypnotic and analgesia prescribed the night before), and had slept well. The entry in the F2052SH, summarising the review,

refers to JL being more settled and a comment which is illegible regarding 'acting out behaviour' the previous day. It was also stated that JL appeared to understand that his actions were not appropriate and that he felt more able to cope at that time.

5.19 In the review it was noted that JL had had 'constant panic attacks'; that he had been seen that day by a Medical Officer; and that it was agreed and included in the support plan that he could return to normal location. JL should be placed in a 'safer cell' overnight and reassessed by the Outreach team on 23 July 2002.

5.20 It was decided at the pre-discharge review that, although there were no self-harm issues, the F2052SH should remain open in view of the variation in JL's mood. It was proposed that, on his return to normal location, Outreach would review JL's situation daily, and JL was advised that a Samaritan listener<sup>12</sup> and a free Samaritan phone would be available on request. It was felt that JL should take responsibility for his behaviour and that he should try to work with staff.

5.21 The pre-discharge review held in the HCC, recorded in the F2052SH, was completed by the SPC. An HCC assessment had been conducted and signed by the doctor, and the doctor's discharge report was signed on behalf of (per procuracionem) the doctor. The record of the pre-discharge review summarised the admission, and the support plan recommended the F2052SH should remain open, JL should be relocated in a safer cell overnight, reassessed on 23 July 2002, unit staff to facilitate a safe and responsive regime and management style, Outreach to review daily to support staff and the individual, facilitate a Samaritan listener, telephone to be available on request or when indicated, and for JL to take responsibility for his behaviour and try to work with staff.

5.22 During the day, JL was noted to participate in all activities and mixed well with others, and it was noted that this was in spite of his behaviour the previous day, when he had been saying 'everyone was going to kill him'. It was stated that he was a 'rude young man who appears not to like discipline'.

5.23 At 14.25 an entry in the F2052SH Daily Supervision and Support Record, stated that JL 'was expecting to move to Kingfisher but this has been delayed'. No reason was given, but this appears to relate to the discharge interview by Outreach, required by the doctor to take place before JL's discharge from the HCC, which occurred the following day.

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<sup>12</sup> A prisoner selected, specially trained, and supported by the Samaritans to 'listen' in confidence to concerns of other prisoners at risk of self-harm.

5.24 That evening JL was seen to mix well on association, he cleaned his cell, had a shower, but he was still observed to be anxious, and it was recorded that he needs to be monitored; no feelings of self-harm stated. He was located in a 'safer cell' overnight and was monitored throughout the night at half hourly intervals. JL slept from around 22.15 hours.

23 July 2002

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5.25 On 23 July, JL appeared to have settled. At 09.40 hours he had a social visit (not recorded with whom), and appeared to be in good spirits afterwards. He joined in association, went out onto the exercise yard and went to the gym.

5.26 An entry in the IMR at 14.30 states JL was 'fitted for ordinary location'. 'Seen by Outreach. Discharged to Kingfisher'. The F2052SH Daily Supervision and Support Record notes that JL was 'pleased to be going to Kingfisher Unit'. The cell location history sheet indicates that JL was moved to Kingfisher at 14.52 hours.

5.27 During 23 July, a Security Information Report (SIR) was submitted by a Works OSG that he had seen JL trying to get out of his cell window in the HCC; no time was given. The OSG had spoken to JL and he had got back into the cell. This SIR was difficult for the Security staff to understand as the OSG had stated that JL had most of his body outside of the cell window, however the gap between the bars was no bigger than 4 inches. No action was taken, although it was recommended that care should be taken about the possibility of an attempted escape if JL was taken on escort to an outside hospital.

24 July 2002

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5.28 On 24 July, JL was moved from Kingfisher to Partridge Unit, where he was received at around 10.00 hours. He was seen by an Officer who completed a Personal Officer<sup>13</sup> Contact Sheet which was used to ascertain and record if JL had any immediate problems. The same Officer completed the Prisoner Compact with JL, which was an introduction to the procedures of the unit and a commitment to the Incentives and Earned Privileges Scheme (IEP)<sup>14</sup>. The space for a Personal Officer's name was however left blank, and the Officer signed himself as a Staff Witness. There is no record of JL being allocated a Personal Officer, although at

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<sup>13</sup> The Personal Officer system was introduced so that prisoners would have an identified Prison Officer who would take responsibility for their well-being, and to whom they could talk about any issues relating to their time in prison.

<sup>14</sup> The Incentives and Earned Privileges Scheme offers incentives to good behaviour and privileges dependent on the individual prisoner's response to the Scheme.

one point in the core record it is noted that JL's key worker would help with writing a letter. It is not known who this key worker was.

5.29 During 24 July, JL went to the gym and joined in association. Later when spoken to in his cell JL said that he was fine. JL watched television and slept from around midnight.

25 July 2002

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5.30 From the unit history sheet, at some time during 25 July, JL appears to have been subject to the minor report procedure as part of the IEP on Partridge Unit through being in bed with his bed-pack not made up. 2 x IEP points were noted (presumably deducted).

5.31 JL was seen by Outreach at around 09.00 hours. It was noted on JL's unit history sheet that JL was okay, although it is not clear if this was the view of JL or of Outreach. At 09.30 hours, JL went on a legal visit and returned at around 11.45 hours.

5.32 At 14.45 hours a multi-disciplinary F2052SH review was held. Present at this review was the SPC, a representative from the Probation Service, a member of Outreach and a representative from Sentence Planning; JL was also present. JL denied thoughts of self-harm at this review, but stated he would like to move with his current cell-mate to another unit. No reason was given in the documentation for this request. It was agreed at the review that the F2052SH should remain open, and JL should be allowed to move to another unit, with Outreach support. JL would be issued with an international phonecard so that he could contact his family about his children, and he would be seen by a Probation Officer for advice about seeking asylum. JL would be referred to a doctor for attention to the shotgun injury in his foot (previously referred to as a bullet wound). The next multi-disciplinary team review would be held on 1 August, 2002.

5.33 JL was received on Osprey Unit during the afternoon, although no time is given.

5.34 In the late afternoon, JL went on a visit (not recorded with whom), and later he had his evening meal. That evening at about 21.00 hours JL said he needed to speak to somebody as he was in court the following day. It is noted in the unit occurrence book that an Officer did talk to JL, and that JL's main concerns were again about his daughter in Jamaica who had been taken ill. He denied any thoughts of self-harm.



26 July 2002

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5.35 On 26 July, JL was due at Highbury Magistrates Court. He was examined by the medical officer, and found to be fit for court. At court JL was refused bail and remanded in custody until 23 August. Whilst at court he saw his counsel at around 10.55 hours and later at around 13.25 hours (presumably after his appearance before the court). At 13.45 hours JL began to kick the door and ring the cell bell; it was noted that tea had been poured over the floor. JL was given a light (for a cigarette) and again kicked the door at around 14.15 hours. JL's behaviour was recorded as being disruptive at court, with constant bell-ringing and kicking his cell door.

5.36 JL left court for Feltham at 16.30 hours. JL was returned to Osprey Unit. On reception he said he was worried about his children. Around 19.20 hours on Osprey he said that he was fine. In the evening he watched television and then slept from around 00.45 hours.

27 July 2002

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5.37 On 27 July, JL was again very distressed. At 09.45 hours it was noted that he was in tears. He wanted a phone call, and wanted a change of cell-mate as his current cell-mate was upsetting him. JL was given the opportunity to talk to a Samaritan Listener, which he took up. It was suggested that he might move in with the unit listener, next door to a friend, and he was happy with this proposal. Arrangements were made for a member of Outreach to visit.

5.38 At 10.15 hours the Officer recorded 'I have concerns regarding this lad and Outreach are visiting in the next 10–15 minutes. JL is being observed on association'. At 11.15 hours it is recorded that JL had managed to find some tobacco and was a little easier. He was still asking to move his cell, which Officers were trying to arrange.

5.39 At 11.30 hours JL was seen by Outreach. He was tearful during the interview. The member of Outreach recorded in the IMR that JL was anxious about his court case and wanted bail. He claimed to have had no recent contact with his solicitor (although he had seen counsel the day before at court). JL said that he wanted asylum as his brother and father had been killed in Jamaica. He was worried about his daughters and about his girlfriend. It was noted that JL said his daughter was 'critically unwell in Jamaica with a hole in the heart'. JL was reported to be worried that she would die and that he could not stop thinking about her. JL

said that he would die if she does. JL 'denied current self-harm and no history'. The member of Outreach, a registered mental health nurse (RMN), assessed JL as being in low spirits, but did not assess him as needing treatment for depression. JL talked about his reasons for wanting asylum (father and brother killed). It was proposed that JL be moved to a shared cell with a 'friend from a similar background'. The RMN recorded that JL would be referred to a doctor for his foot injury, and Outreach support was to continue at least twice weekly until JL settled.

5.40 The RMN made a similar entry in JL's F2052SH. It was noted that JL was having increasing negative thoughts though still had plans for the future. It was noted that JL wanted to speak to his mother to find out about his daughter. JL also wanted to speak to his solicitor about his court case. Outreach would attempt to get him a phonecard to facilitate external contact and review JL the following day.

5.41 An Officer looked in on JL on two separate occasions over lunch-time. He thought JL looked a bit depressed.

5.42 At 14.00 hours, JL was relocated to a cell with his friend. He appeared much happier, but the Officer recorded that JL still 'appears to be quite vulnerable'. The cell change seemed to have made a difference to his mood for the rest of the afternoon. It was noted during the afternoon that JL was smiling and joking. Similar entries were noted in the unit history sheet and JL slept from around midnight.

28 July 2002

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5.43 The improvement in JL's mood created by his cell re-location with a friend lasted through 28 July when JL was reported to be much happier, and joined in association and attended the gym. JL did however report 'special sick' due to pains in his foot from his bullet wound and saw a doctor at around 09.00 hours. Although the writing is not clear, JL appears to have declined analgesic medication. No concerns were raised about JL's mental state and he appeared to be getting on well with others.

29 July 2002

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5.44 On 29 July JL declined breakfast; he seemed 'worked up' and was 'refusing to conform to the simplest requests'. At 09.10 hours he was seen by a member of Outreach. The notes in the F2052SH show that JL was still suffering from a painful foot, due to the bullet that was lodged there in 2000 and which had not been

removed when he was in Jamaica (as the family could not afford it). An application was put in to see a doctor with an expectation that JL would be seen sometime that day. JL seemed to be unhappy about a number of things and was requesting an international phone card, and asking for the TV to be switched on. Later JL was seen by a doctor for the bullet injury to his foot, and was listed to be x-rayed. He had his second hepatitis B injection.

5.45 At around 12.15 hours, JL walked away from the servery and said that he did not like the food. He later sat and talked to his cellmate and then in the afternoon went on a visit (not recorded with whom). After the visit he was noted to be in good spirits. JL spent the evening watching television.

30 July 2002

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5.46 JL was visited by a CARATS worker at 09.15 hours. He appeared to have a good day, being seen on the exercise yard, in association, playing pool and chatting to his cell-mate. The F2052SH Daily Supervision and Support records state that JL seemed quite happy. He spent the evening watching television and then slept.

31 July 2002

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5.47 On the morning of 31 July, JL returned from the library with books, and again it was reported that he seemed in good spirits. He spent part of the morning helping with unit cleaning. JL was later charged with pressing the fire alarm on leaving the education department. These two activity reports are hard to reconcile, as the unit records show JL returning to the Unit at 09.05 hours from the library, but the alarm bell incident occurred at 11.50 hours. The Internal Investigation into JL's attempted suicide conducted by the Prison Service in October, 2002, included an interview with JL's cell-mate who mentioned this incident. The cell-mate said it was not JL who rang the alarm bell, but that JL had believed this was an example of racial prejudice. The cell-mate did not say that JL was not in education at the time. The education list for 31 July does not however include JL. Whatever the explanation for these contradictions, as far as can be found, an adjudication for this misdemeanour was not proceeded with.

5.48 In the afternoon of 31 July, at 14.45 hours, the F2052SH records that JL had a legal visit with his solicitor, returning to the unit at 15.40 hours. Later in the afternoon, at 16.15 hours, he was found to be crying as he had not spoken to his children. He requested a phone card. The 'Friends of Feltham' were informed and they issued JL with an international phone card.

5.49 At 17.00 hours on 31 July, JL told one of the unit Officers that he had been told on the phone that his child had died. He was very distressed. The RC Chaplain and Outreach were informed and arrived within 15 minutes to see JL at 17.15 hours. JL did not want to transfer to the HCC, and the Chaplain and Outreach thought he would be better to remain with his friend. However, in view of JL's very distressed state, his statements 'over the last four days that he would kill himself if his daughter died' (recorded in 31 July F2052SH Daily Supervision and Support Record notes), and the information that a noose had been found in JL's cell, it was agreed that JL should be admitted to the HCC.

5.50 The finding of a noose was mentioned twice in documentation relating to JL: once in the case review report, dated 1 August, 2002, the day after JL's claim that his daughter had died, and once in the interview in 2002 with JL's cell-mate, who may have alerted staff to the presence of the noose. There is no record of the date and time of the finding of the noose in the F2052SH Daily Supervision and Support Record, although it is noted in the HCC Discharge Review of 1 August, 2002, as a main reason for JL's transfer to the HCC. The entry ('After being told yesterday that his daughter had died and then finding a noose in his cell.') appears to indicate that the noose may have been found at that time. This review summary appears immediately above the F2052SH revised support plan which is accompanied by names and departments responsible for support plan actions, so there is no doubt that this information was available to staff managing and supporting JL.

5.51 Records show that JL was reluctant to go to the HCC but he was persuaded by staff, including the Chaplain and an Outreach member, that it was in his best interests. At 19.00 hours he was received into the HCC. 'He was placed on level 2 observations (indicated because of 'ideas of suicide following the death of his 2 year old daughter') and placed in a 'safer cell' with strip bedding<sup>15</sup>. He did not settle well and was frequently pressing the call bell. He was given a prescription overnight and regular observation was maintained.

5.52 In the nursing observations (undated but presumed to refer to this time), JL initially talked to staff and then watched television. Later he was seen standing by his door and then sitting on his bed. At around 22.00 hours he was seen reading a book and then standing at the door and watching television before going to sleep at around 22.45 hours.

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<sup>15</sup> Now referred to as anti-ligature cell materials.

1 August 2002

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5.53 The following morning, 1 August, at 09.30 hours an HCC pre-discharge review was held, attended by a Mental Health Team Nurse, an HCC Officer and JL. JL had seen the doctor that morning and was assessed 'fit to return to ordinary location'. JL denied any thoughts of self-harm at the moment, and a special visit with his girlfriend was to be arranged by the Chaplaincy. It was agreed that JL should return to ordinary location but the F2052SH should remain open and be reviewed on 7 August. JL would be returned to Osprey Unit and be seen by Outreach on Friday (the following day).

5.54 At 11.00 hours JL was seen by the Assistant Chaplain who had undertaken to verify the death and arrange a special visit for JL's girlfriend. When the Assistant Chaplain spoke to JL's girlfriend it was discovered that JL's daughter had not in fact died. JL's girlfriend was not aware that anything was wrong apart from informing JL on 31 July that she could not come to visit that day and he had become upset. After this information was received, JL did however persist with his version of events for about two hours, but finally admitted that he had invented the story because he had had a row on the phone with his girlfriend because she was not visiting him as often as he would like. He had been very upset about this, but he had told staff that he was upset because his child had died. A visit did take place with JL's girlfriend in the afternoon and he seemed to be in good spirits following the visit. He spent the evening with his cell-mate watching television and at around 20.52 hours it was noted that JL appeared to be fine. JL remained awake until around 01.50 hours.

2 August 2002

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5.55 On 2 August, it is recorded that JL had a legal visit, and after his return was noted to be smoking and chatting with other prisoners; it was commented that he appeared to be 'mixing a little better'. At 11.45 hours he requested to speak to a member of Outreach, and a visit was arranged for that afternoon. Outreach made an entry in the F2052SH that day that JL 'denies any thoughts of self-harm and states that he has no problems at the moment'.

5.56 JL was noted to be happy after his cell-mate returned from education and was more talkative but it was noted in the unit history sheet that he 'doesn't smile'. In the afternoon he did some cleaning and also went on association. The evening was unremarkable.

3 August 2002

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5.57 3 August seems to have passed quietly without event. Records show that JL joined in association, went on exercise, and watched TV. He said that he was okay when getting his evening meal. Regular observations were recorded.

4 August 2002

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5.58 The 4 August was again without event. JL took all of his meals, went on association and said he was fine or okay when asked at around 16.20 hours and 16.50 hours. Again he watched television and slept.

5 August 2002

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5.59 On 5 August JL went to the gym in the morning and was expecting a visit<sup>16</sup> in the afternoon. It is recorded that in the afternoon he seemed in low spirits. He was in pain and began to cry. A nurse happened to be on the unit and attended JL immediately, giving him pain-killers. JL was noted to calm down and took the pain-killers. He was observed chatting to other lads while waiting for his expected visit. An Officer noted on the F2052SH Daily Supervision and Support Record that 'JL doesn't appear to cope too well when he hasn't the company of his cell-mate, and I would advise close monitoring if this occurs'. Later, at 16.15 hours, he was informed his visitor had not yet arrived. He seemed 'to be all right' following this news, and continued to help with cleaning on the unit. It is recorded in the F2052SH Daily Supervision and Support Record that at 19.30 hours JL was seen by Outreach at his own request. He was again complaining about the pain in his foot and a headache, and was worrying about his family. He was re-referred to the doctor and Primary Care Team. JL wanted help to write to his family, and it was noted that a key worker would do this.

6 August 2002

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5.60 At 08.55 hours, it was noted in the F2052SH that someone on the unit talked to JL about family, immigration and criminal matters (person not identified). JL was allocated employment in the morning of 6 August on a part-time basis in the motor repair store. At some stage during the day he was seen by a member of the CARATS team, although neither the time nor content of the discussion was recorded. In the afternoon JL was on association. At 15.40 hours it was recorded that JL was complaining about the pain in his foot and a headache but was later

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<sup>16</sup> The identity of the visitor was not recorded, nor the nature of the visit.

thought to be in good spirits and said he was fine. There was a Visiting Order in the file for his girlfriend, and it appears that she attended, but there is no note of a visit in the F2052SH Daily Supervision and Support Record.

7 August 2002

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5.61 JL was seen by a member of the Chaplaincy for pastoral care. No time was registered. The F2052SH Daily Supervision and Support Record states that JL remains concerned about his daughter, 'but is more settled than before'.

5.62 At 14.30 hours, the F2052SH Daily Supervision and Support Record notes JL 'gone to education, and returned'. The Education Record did not show an attendance at Education on that day, and it appears that he may have been turned away from Education. There is no indication that JL was upset by this occurrence and for the rest of the day he is recorded as being 'OK' and 'fine'. JL went on association at 15.30 hours, and spent the evening watching TV and talking with his cell-mate. When checked by Officers during the afternoon and evening, he said 'no problems'.

8 August 2002

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5.63 In the morning of 8 August, JL had a visit at 10.15 hours, although it is not recorded who the visitor was, and there is not a visiting order for his girlfriend in the core record. When he came back from the visit at 11.00 hours he asked to see his CARATS worker. He was seen by the CARATS worker that day, but there is no record of the content of the discussion. The record in the unit history sheet is signed by the CARATS worker and states 'Appears OK'.

5.64 At 12.40 hours JL rang his cell bell and asked for a light; he was told that this was not possible and a waste of staff resources. It was noted in the unit history sheet by the Officer concerned that 'he cannot seem to comprehend that he is in prison and it is my firm belief that he is playing on his so called vulnerability'. JL was noted a short while later to be smoking and laughing and joking with his cell-mate. JL was still talking to his cell-mate at around 14.00 hours.

5.65 During 8 August, JL's F2052SH case was reviewed on Waite Unit (HCC). JL was seen by a member of Outreach, a Registered Mental Health Nurse (RMN). He reported that JL established good rapport and eye contact. He was still anxious about his children but JL was now more settled in mood on the unit. He had had a visit from his girlfriend a few days before and she intended to visit again the

following day. JL reported that he was coping well, his cell-mate was very understanding and helpful, he was attending education<sup>17</sup>, he was getting support from staff and Outreach, and denied thoughts of self-harm and suicidal ideation at present and had not 'felt like that for over a week'. He said the incident that led to his admission to the HCC 'was silly'. The F2052SH closure review form was signed by the RMN. The Section of the Review Form 'Staff/Departments Attending' was left blank, and there is no indication that anyone else attended the review other than the RMN and JL. The Internal Investigation Report does however state that the 'self-harm form was closed on 8 August after a multi-disciplinary case conference'.

5.66 At 14.40 hours a record was made in the unit history sheet by the RMN that JL had been seen for review and the F2052SH has been closed. A support plan had been drawn up and was detailed in JL's unit history sheet. The support plan encouraged JL to seek support from staff when not coping well; Outreach support was to be given as appropriate; he should be encouraged to take time out of cell and visit education, association and the gym; family visits (girlfriend visits regularly) should be encouraged; and he should have access to the Chaplaincy, and the Samaritan phone line as appropriate. In the unit history sheet, there is no indication that anyone other than JL and the RMN was present at this review which closed the F2052SH. The Internal Investigation Report, 2002, does however state that 'The self-harm form was closed on 8 August, 2002, after a multi-disciplinary case conference'. It has not been possible to reconcile these two contradictory pieces of evidence.

5.67 The unit occurrence book records that, during the day, 8 August (time not recorded), two prisoners were 'put behind their doors' for causing a disturbance while complaining to staff. One of these prisoners was JL. A member of the Board of Visitors (BoV) was on the unit at the time and observed the disturbance. JL complained to the BoV member about his treatment by a Prison Officer. The member of the BoV talked to JL and to the Officer concerned, and noted in the BOV log that he was satisfied that 'JL's complaints were understood, and his behaviour being managed'<sup>18</sup>. JL was later on association and there seemed to be no problem.

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<sup>17</sup> Reports of JL's attendance at education are ambiguous. Although JL was sometimes on the education list, there is only one confirmation of his attendance.

<sup>18</sup> There is a discrepancy between dates, as the BoV log shows that this incident occurred on 7 August, 2002. This entry had been made in 2002, but was however dated retrospectively by the BoV during the 2009 Investigation. It is assumed that the Occurrence Book date is accurate.



9 August 2002

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5.68 JL was seen by a Chaplain on 9 August. JL was extremely anxious, and talked again about his father and brother who were shot and killed in 2001. The core file includes a visiting order for JL's girlfriend for 9 August, at 15.36 hours, which appears to have taken place.

5.69 The IMR shows that JL complained of abdominal pain on 9 August (time not specified). Following telephone advice from a doctor, he was taken to Ashford Hospital for assessment and that night returned at 03.00 hours having been assessed in Accident and Emergency, and prescribed with pain-killers. It is recorded he was 'feeling much better'. No further outside appointment was arranged.

10 August 2002

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5.70 No events were recorded for JL.

11 August 2002

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5.71 No events were recorded for JL.

12 August 2002

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5.72 On 12 August it was noted that JL attended a workshop. The medical record shows that he refused his third hepatitis B injection that day.

13 August 2002

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5.73 On 13 August JL was visited by his girlfriend early in the morning. JL was listed for education on that day but did not attend.

14 August 2002

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5.74 On 14 August JL attended education.

15 August 2002

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5.75 On 15 August JL was seen by his CARATS worker. It was noted in the unit history sheet that JL was quiet and withdrawn and it was recorded that he was worried about the outcome of his trial and family in Jamaica.

16 August 2002

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5.76 On 16 August it was noted in the unit occurrence book that JL was seeking a lot of staff attention, being 'always on the bell, a drain on staff, crying to get his own way'.

17 August 2002

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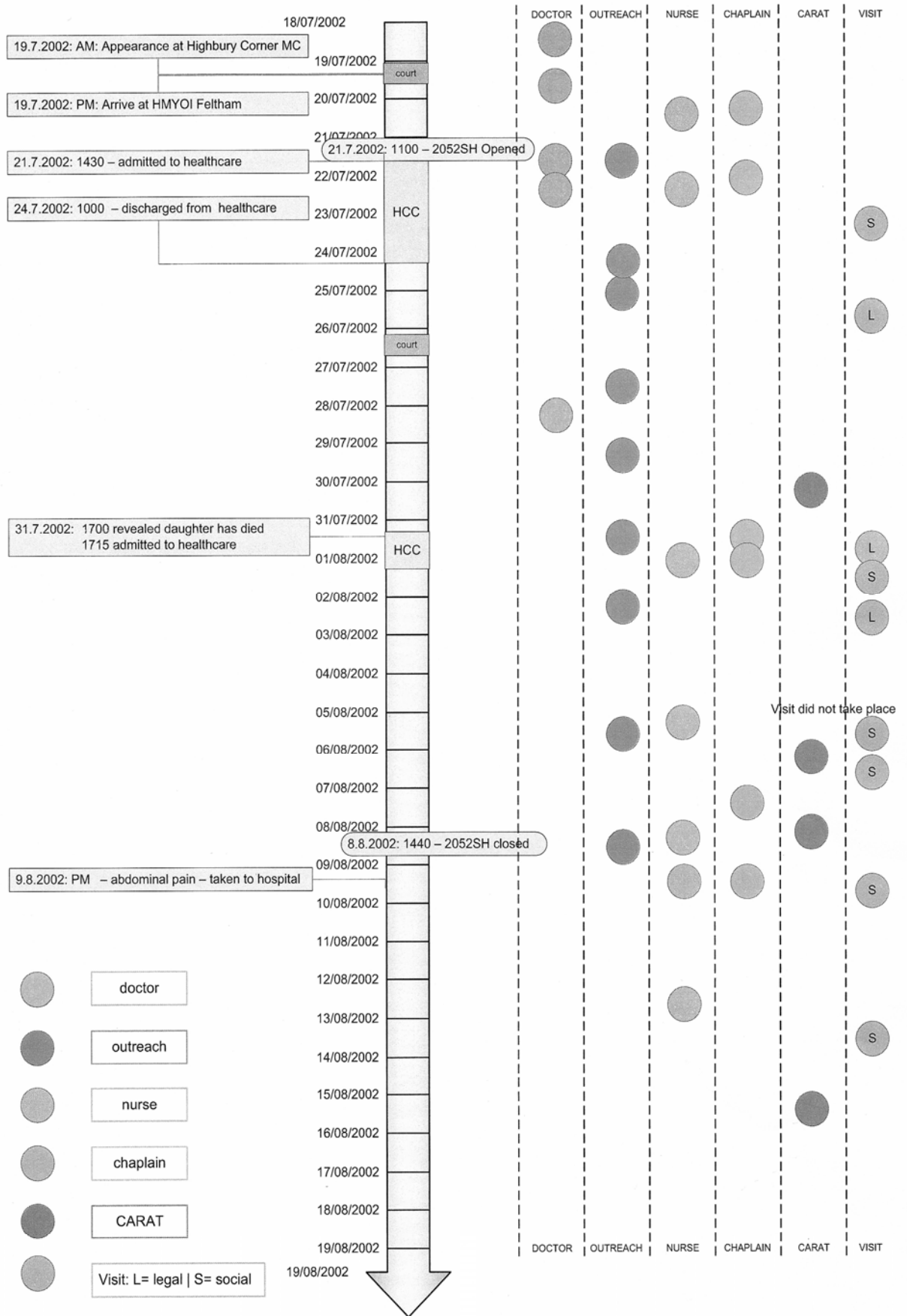
5.77 No events recorded for JL.

18 August 2002

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5.78 No events recorded for JL.

# Timeline of Support Interviews with JL



## **6. The incident of attempted suicide and events of 19 August, 2002**

6.1 During the night of 18/19 August it was noted in the unit history sheet by the OSG who was on duty that night that there was 'constant abuse of the cell bell' in JL's cell. A letter in the Internal Investigation file of October, 2002, shows that the OSG in question went off sick the following night having heard about JL's suicide attempt, and was visited at home the next day by his supervising Officer to find out if he was all right. In the letter it is reported that the OSG was assessing events of the night of 18/19 August retrospectively, having heard of the suicide attempt. He recalled that JL's cell bell had been rung on two occasions in the early hours, and each time when he responded the two prisoners appeared to be asleep. On a third occasion the bell was rung and one of the prisoners asked to see a doctor, but would not say what was troubling him nor give his name. The OSG phoned the HCC Nurse on duty, who said that neither of the prisoners were on medication nor medical instruction and she would not attend unless she was given a name. The prisoner still would not give his name and instead gave a fictitious name. At this time the prisoner appeared to have a 'short wide piece of bed-sheet' round his neck. The OSG insisted it did not look like a noose, more like a 'loosely tied scarf', and he had enquired if the prisoner had a sore throat in view of his earlier request to see a doctor. The OSG checked the cell hourly from then on, during which time the prisoner was writing with the light on until 04.00 hours. The prisoner was later assumed to be JL. Two notes of intended suicide, one dated 18 August, were later found in JL's in-cell property following the incident.

6.2 JL's cell-mate appears to have slept through all of the events on 18/19 August, 2002. In interview he does however report that, although he did know about the noose found on 31 July, 2002, and indeed appears to have alerted staff to its presence, he was not aware of a noose in the cell on 18/19 August, 2002. Therefore the only information about a noose was from the OSG saying that he did not think that what he saw was a noose.

6.3 It is clear from the reported interview with the OSG on 20 August, 2002, and indeed in the interview for the Independent Investigation, that he was 'extremely concerned' that his performance might have had something to do with JL's suicide attempt. This does not appear to suggest an uncaring man who would not have taken action if he thought that the prisoner was at risk.

6.4 Dr. Cumming's view of this incident is that it was too remote from the suicide attempt to be seen as an immediate trigger to the event. In relation to JL remaining

awake for most of the night, Dr. Cumming comments that sleep issues are not uncommon in prison, and for someone with a history of abusing drugs this could be an alternative explanation. This incident did in fact precede a positive drug screening test on JL the following morning.

6.5 It should be noted that JL's requests for medical attention had always been treated appropriately, including being taken to outside hospital for treatment on the night of 9 August, which was after the closure of the F2052SH. It could be reasonably considered that, had JL given his name when asking to see the doctor on 18/19 August, his request for medical attention would have received a response.

6.6 On the morning of 19 August, the Mandatory Drug Testing (MDT) unit called up JL for a random drug test. He was unable to provide a urine sample immediately so, in line with usual practice, he was retained in the Segregation Unit over lunch-time (11.50-13.50 hours) until he was able to provide a sample. Records show he provided a sample at 13.55 hours and left the MDT suite at 14.00 hours. This sample was sent off on 20 August. The result of the screening test (received on 22 August) was positive, indicating the presence of cannabis. In usual circumstances, this screening test would be followed by a disciplinary adjudication. If the prisoner pleaded guilty then the case would proceed, but if he pleaded not guilty then another test would be carried out. In JL's case, in the light of subsequent events, the result of the MDT screening was not followed up.

6.7 There is no indication in the residential unit records or the Internal Investigation Report of 2002 of JL having either left for, or returned from, the MDT. Interviews for the Internal Investigation in 2002 indicate that at about 14.15 hours JL asked for permission to make a phone call which was granted. It is not known who he telephoned. It appears that he finished his call at the time when other prisoners were being assembled to go to education. JL joined the queue for education, however he was told that his name was not on the list, and this fact is confirmed by the education record. JL then returned to his cell. It should be noted that, although JL had been on the education list on eight occasions, he appears only to have attended once.

6.8 According to the Internal Investigation Report, at about 14.30 hours, a prisoner approached one of the Prison Officers on duty on the unit and asked if he could be let into JL's cell as he said that JL had looked rather upset and he thought he should go and talk to him. The Officer checked with the unit office whether this would be in order, and it was confirmed that if JL was upset it would be a good idea. When the Officer and the prisoner arrived at the cell door and the door was opened,

they saw JL suspended from the window bars with a ligature round his neck. The ligature was made out of a complete bed sheet twisted tightly. JL's knees were bent with his feet touching the ground. The Officer immediately sent the prisoner to seek help from the office, with an instruction to ring the alarm bell (prisoner interview, 2002), and shouted out himself for help, while he lifted and supported JL round the waist to relieve the pressure on his neck. The Principal Officer on duty, a Senior Officer and an Officer returning from escorting prisoners to education heard the calls for help and immediately went to assist. A Code 1 Alert<sup>19</sup> was broadcast at 14.55 hours and was acknowledged by Hotel 9 (HCC Staff) and Oscar 1 (the Orderly Officer). The alarm bell and the Code 1 Alert appear to have occurred in quick succession as both are recorded at 14.55 hours in the control room log, with the record: 'Alarm bell Osprey Unit', then 'not an alarm bell but a Code 1'. Officers first on the scene helped to unfasten the ligature and place JL on the floor. There was no chest movement or pulse at that stage. One Officer administered mouth to mouth resuscitation while another administered chest compressions. Two more Officers arrived in response to the Code 1 Alert and assisted. Officers managed to get a pulse back after about three minutes, but no chest movement or breathing was observed.

6.9 Following the Code 1 Alert, HCC staff responded immediately, and an ambulance was called by the Orderly Officer at 14.58 hours. The HCC Senior Officer and a Nurse arrived on the scene at approximately 15.00 hours.

6.10 When the HCC staff arrived they took over resuscitation using equipment contained in the ambu-bag they had brought with them. It was observed that the pulse had stopped again however the HCC staff managed to get JL breathing again. The ambulance arrived at 15.07 hours.

6.11 After the arrival of the ambulance paramedics took over the resuscitation (15.10 hours). JL was transported by ambulance to Charing Cross Hospital. An air ambulance also arrived but was not used because, according to the Internal Investigation report, it would have taken longer for the air ambulance to reach Charing Cross Hospital because of flight paths at Heathrow Airport. JL was kept initially in the intensive care unit at Charing Cross Hospital where he stabilised.

6.12 The police were informed of the incident, and contacted JL's girlfriend to facilitate a visit to the hospital. JL's girlfriend did not come to the hospital that night. He was visited by the RC Chaplain.

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<sup>19</sup> A Code 1 Alert calls for help to assist with a serious suicide attempt.

6.13 Police conducted a 'crime scene' investigation and, that day, took possession of the uniforms for forensic examination of staff who had been at the scene of the incident. This was apparently usual police procedure, following the earlier Mubarek incident at Feltham.

6.14 Three notes were later found in JL's in-cell property after his attempted suicide. One suicide note undated was addressed to God. The second suicide note appears to be dated 18 August, 2002, but states that his youngest child is dead (which seems to relate back to the incident on 31 July). The third was a fond note, undated, to his girl-friend, which may be unrelated to the suicide attempt.

6.15 JL returned to HMYOI Feltham on 24 September, 2002 and was located in the HCC with an open F2052SH. He was transferred to HMP Pentonville HCC on 14 October, 2002, as an adult. JL was transferred from Pentonville HCC to Camelot Lodge, Chase Farm Hospital, on 27 January, 2003, under the auspices of the Mental Health Act.

6.16 I am aware that there are discrepancies in the timings shown in the records relating to the attempted suicide on 19 August, 2002. The Officer who found JL hanging has recorded this event as occurring at 14.30 hours while all other Officers recorded attending the scene at 14.55 hours, which was the time of the alarm bell and Code 1 Alert. The Internal Investigation, 2002, shows 14.30 hours as the time when the prisoner asked if he might be let into JL's cell. I and the Assistant Investigator spent a great deal of time investigating this time discrepancy both in interviews and in examination of the documentary evidence. The first on the scene Officer appears to have estimated the time of finding JL hanging in his cell, and I can accept his statement that during an incident such as this none of those involved are checking and noting the time precisely. As confirmed by at least one other Officer in interview, after the event was over he checked with the Control Room to find out what the timings were and recorded his arrival as the time of the Code 1 Alert, even though he attended the scene before the Code 1 Alert was raised having heard the Officer calling for help, and was the person who administered mouth-to-mouth resuscitation. It seems likely that the first on the scene Officer did not check the time of the Code 1 Alert but estimated the timing of events.

6.17 It is confirmed in interview transcripts that three officers (a Principal Officer, a Senior Officer and an Officer), arrived in response to the call from the first on the scene Officer and the prisoner. It is not established who made the Code 1 Alert call, but it is to this radioed broadcast at 14.55 hours that more Officers and HCC staff arrived.

6.18 I have investigated these discrepancies as fully as possible given an elapsed eight years since the incident. I am convinced that the only error was of recording or estimating, which was understandable in the circumstances. I also consider it very likely that, had there been any unnecessary delay in going to the aid of JL, it would have been reported in the prisoner's interview, and identified by the police who investigated the incident as a possible crime scene, taking Officers' uniforms that day for forensic examination.

6.19 It is my view that the Prison Officers and HCC staff involved should be commended for their efforts in saving the life of JL. This view is supported by two almost contemporaneous accounts of the incident: one from the Head of Staff Development who attended the scene in response to the Code 1 Alert, reporting on the incident in a letter to the Governor; and secondly the Internal Investigation Report completed soon after the incident.



## **7. Interviews with JL, JL's mother, and staff at HMYOI Feltham**

*Interview with JL on 26 January, 2009, (minuted by Lead Investigator)*

7.1 The interview with JL was assisted by the Manager of the Community Rehabilitation Residence where JL lived at that time, who was present throughout the whole interview. JL was interviewed by Cynthia McDougall and Dr. Ian Cumming. JL was willing to talk to us and, although we anticipated that he might find the interview difficult due to injuries sustained from his attempted suicide, he was able to communicate with us and tried hard to respond to our questions. JL told us about his present situation. He had been in his current residence for two years and was happy there. He attended classes two days a week learning basic English and maths, and was making good progress. Previously JL was located in a Brain Injury Unit for two years. He was at the time of the interview still receiving medication associated with his acquired brain injury. The manager of the residence indicated that JL still required support in looking after his domestic needs and in budgeting.

7.2 JL was in the habit of telephoning weekly to his mother in Jamaica. In interview he said that he has only one daughter, who lives with his mother. When prompted about other children, JL said that they were not his children and they are now with their mother, JL's former girlfriend. She has now returned to Jamaica, and JL implied that he did not now have contact with her or her children. JL's daughter is now well, having had an operation on her heart, and he is no longer worried about her.

7.3 When asked what he could remember about his time at Feltham, at first JL said he could remember very little and that he had put that period of his life behind him. When prompted, he said he could not remember any staff or any prisoners there. He could remember going to the gym, being on association and going to an art class. JL knew that he had attempted suicide, and said that he had had a bad time at Feltham and had wanted to kill himself on two occasions. When asked about his reasons, JL said it was because he was very young, he got no visits, had no money, and he was by himself. He had meant to kill himself and he did not think there was anything anyone could have done to stop him attempting suicide. JL then volunteered that he had been raped by another prisoner; not a cell-mate but by a prisoner who had dragged him into his cell. He said he had not reported this to staff. This incident is discussed in paragraphs 7.12 to 7.18.

7.4 JL said that he wants to stay in the UK, as it is still not safe for him to return to Jamaica; his mother tells him there are still people who hold a grudge against him. JL said that he is looking forward to a life. When asked, he said that he was pleased that staff had saved his life. He is making progress with his education; he wants to work in an office and earn money so that his mother and daughter can visit him. When asked if he wanted us to speak to any member of his family in relation to the Investigation, JL asked if Cynthia McDougall would speak to his mother.

*Interview with JL's mother, 1 February, 2009, (minuted by Lead Investigator)*

7.5 This interview was conducted by telephone by Cynthia McDougall. JL's mother, Mrs. L. said that she was very pleased with JL's progress. She said that she was very appreciative of the help he was being given and said that if he had stayed in Jamaica he would not be alive today. Mrs. L. volunteered that JL had not had a secondary education due to peer influences, but now he was being educated and she could see a difference in him. When asked what she knew about JL's time in Feltham she said she knew nothing about it. She did not know why JL had attempted suicide, although she had been extremely worried. She said that a Chaplain had phoned and said something about a telephone call that might have triggered JL's attempted suicide, but she knew nothing more. She is now very pleased that he is alive and making progress.

*HMYOI Feltham staff interviews*

7.6 Minuted interviews were conducted in 2008-2009 with four members of staff who had been in attendance at the incident of JL's attempted suicide, an OSG on duty the previous night, the then SPC, three members of the Chaplaincy team, and the then Governor of HMYOI Feltham. In 2010 interviews were held with a former member of Outreach, and two 2002 HCC nurses. Supplementary information was provided by the Chair of the Prison Officers Association, a member of the Independent Monitoring Board (Chairman, Board of Visitors, 2002), and members of the education department.

7.7 All people who were asked were willing to be interviewed. Three members of staff came from other prisons, where they are now located, in order to be interviewed. It was clear that they all found it difficult to remember details surrounding JL's attempted suicide without checking with previous notes or looking in the prison files. Four members of staff had been interviewed in 2002 for the Internal Investigation, and it was evident that some were concerned that this issue

had been raised again six years later. As a consequence, some staff who had not on the previous occasion required a 'friend' to attend the interview with them, now did. For some of those who had been in attendance at the incident of attempted suicide, it brought back stressful memories. This had been particularly so for the Officers at the scene who had had their uniforms taken by the police on the evening of the attempted suicide for forensic examination. Police who were involved in the follow-up of JL's suicide attempt confirmed to the Independent Investigation that they had found no cause for further investigation. The RC Chaplain stated in interview that the first on the scene Officer was still shocked by the incident the following day. Although staff aftercare support was made available to all staff who had been present, the traumatic effect of being involved in such an incident should not be ignored, and indeed the need for staff support following an incident is acknowledged in the National and Local Suicide Prevention Policies.

7.8 Interviews for the 2008-2010 Independent Investigation were thought to be necessary to check on issues that had not been explored in the 2002 Internal Investigation. These related to the discovery in the second investigation that JL had been subject to a positive mandatory drug test on the morning of his attempted suicide, his expectation that he should be attending education though he rarely attended, the timing and circumstances of events leading up to his attempted suicide, and his behaviour during the previous night. Members of the Chaplaincy team had, in the Internal Investigation, expressed the view that they had not been sufficiently consulted over the management of JL, and it was thought to be important to give them the opportunity to express their views. The former Governor was able to give an over-view of Feltham as he found it during his tenure, and describe what he was trying to achieve at the time of JL's attempted suicide.

7.9 During consultation on the draft report, concerns were raised, which I shared, about the closure of the F2052SH apparently being conducted by an RMN and JL, without the support of a multi-disciplinary team. Although unsuccessful attempts had been made in 2008-2009 to trace the RMN who closed the F2052SH, further attempts were made in 2010. A formal request was sent via SCOP to the Human Resources Department of West London Mental Health Trust (WLMHT), to seek to make contact with the two RMNs who had been seconded from that organisation in 2002. WLMHT were unable to provide any information about the two members of staff concerned or their current availability. It is believed by prison staff that the RMN who closed the F2052SH has emigrated to Australia. One Prison Service Mental Health Team Nurse (now Head of Health Care in another

prison), a member of Outreach and an HCC nurse, were interviewed to learn more about what was known about JL's care while at Feltham.

7.10 It was unexpected that Mental Health and HCC staff seemed genuinely to recall least about JL, including how he had attempted suicide. This may not be surprising as JL spent more time on Osprey Unit than in the HCC leading up to his suicide attempt, and he had not been assessed as having a mental health problem. In interview the former Mental Health Nurse confirmed that the Mental Health Team (MHT) would not routinely become involved with risk of self-harm cases unless the risk was related to a mental health problem. The Outreach team worked with these cases, and supported the unit staff, in line with the policy that risk of self-harm should not be inappropriately medicalised. It will be clear from the interview transcripts of the HCC staff that, apart from the HCC Senior Officer who responded to the Code 1 alarm, none could add much to our understanding of events surrounding JL's attempted suicide, apart from filling in background information as to how Outreach and the MHT worked.

7.11 All of the interviews were important to confirm the facts found in the records and those obtained from the earlier Internal Investigation. There must be doubt however about the value of interviewing individuals about details of an offender who was in Feltham for little over a month, and an event of attempted suicide, no matter how traumatic, that occurred six to eight years ago, although all attempted to remember details to the best of their ability.

#### *Alleged rape of JL at HMYOI Feltham*

7.12 In the interview held by Professor McDougall and Dr. Cumming with JL in January, 2009, JL spoke of an incident of rape that had occurred during his time at HMYOI Feltham. JL's description of this event is described in paragraph 7.3 of this report, and alleges that a prisoner (not a cell-mate) dragged him into his cell and raped him. JL said he had not reported this to staff at the time. Further investigation of documents relating to the period after JL's attempted suicide uncovered correspondence during February, 2003, between the Governors of HMYOI Feltham and HMP Pentonville included in JL's prison record, and a letter from the Governor of Feltham to the Director of Chase Farm Hospital regarding an allegation of a rape of JL, on this occasion by a Prison Officer (unnamed). The Governor of Feltham had written advising that this allegation was so serious that it should be made to the Police and he encouraged the Director of Chase Farm Hospital to assist JL in making such a complaint. No further correspondence is in the file.

7.13 While at HMP Pentonville, JL was assessed by a chartered clinical psychologist, whose report in November, 2002, and a preceding letter refer to the alleged rape. The psychologist reported 'it is extremely difficult to make sense of JL's claim that he was a victim of rape whilst at Feltham. The lack of information regarding the circumstances of the alleged attack renders it virtually impossible to investigate what may or may not have happened'. The psychologist goes on to say that, in his initial meeting, JL had been extremely preoccupied with reporting that he had been a victim of a sexual assault by an unknown assailant in his cell, but in later meetings JL made no mention of this alleged assault. When the question was posed by the psychologist that the alleged rape might have been in a dream, JL nodded agreement. There is a suggestion in the psychologist's report of the possibility that JL may have been feigning his symptoms and distress.

7.14 Following JL's interview with the Independent Investigator and Dr. Cumming, JL was interviewed by his legal representatives and on this occasion he talked about being raped by a named prisoner. It is suggested on this occasion that the prisoner was aided by a Prison Officer who let the prisoner into his cell and after the rape let the prisoner out again, implying collusion by the Prison Officer and the prisoner in this rape.

7.15 Although it is not in the Terms of Reference for this Investigation to examine the management and care of JL following his attempted suicide, it was thought necessary to investigate whether there was any further information about the incident of alleged rape. There are two references in the records referring to rape. JL was returned to Feltham from hospital on 24 September, 2002, following his attempted suicide and was located in the HCC on an open F2052SH. He was located in Feltham until his transfer to Pentonville on 14 October, 2002. JL's behaviour between 24 September and 14 October, 2002, was recorded as generally unpredictable. There is an entry in the F2052SH Daily Supervision and Support Record on 9 October, 2002, which records that at 07.30 hours JL 'Appears agitated. Convinced he has been raped by a member of staff'. This entry does not appear to have been followed up. Following his transfer to HMP Pentonville there is a record dated 25 October, at 21.50 hours, of JL 'Standing at cell door crying, saying they having sex in my bottom. They're in here with me. I want to go to my yard'.

7.16 It appears that the first recorded allegation of an offence of rape took place while JL was located in Feltham HCC under F2052SH supervision. JL states this was by a Prison Officer, and therefore could not have involved a named prisoner at

Feltham, who was not in any event located in the HCC. There is now additionally an allegation of rape at HMP Pentonville, although in the circumstances described this allegation appears to be unsupported.

7.17 JL's legal representatives have proposed that the incident of rape should be properly investigated with the help of a professional so as to verify the allegation if possible, and in any event ascertain whether JL is suffering any trauma as a consequence which could be ameliorated with treatment.

7.18 In response, Dr. Cumming states that he has no greater ability than anyone else to determine if someone is telling the truth. There are three different accounts of this event, and we cannot determine in this Investigation which is accurate. Issues relating to whether JL is in need of counselling or treatment rest with his current clinical team.

## **8. Prison Service Suicide Prevention Policies**

### *National Prison Service Suicide Prevention Policy*

8.1 The National Prison Service Policy in operation in 2002 had been introduced in 1994 in an Instruction to Governors 1/1994 (Caring for the Suicidal in Custody), followed by an Instruction to Governors 79/1994 (Additional Guidance on Caring for the Suicidal in Custody). These were reinforced in 1997 in a Prison Service publication 'Caring for the suicidal in custody: Guide to Policy and Procedures', introduced by the Director General. The overall aim of the policy was described as follows:

'The Prison Service has a duty of care for all prisoners. We aim particularly to identify and provide special care for prisoners in distress, and so reduce the risk of suicide or self-harm.'

8.2 The key elements of the policy were:

- Primary Care – Creating a safe environment and helping prisoners to cope with custody.
- Special Care – Identifying and supporting prisoners in crisis and treating them with dignity.
- Aftercare – Caring for the needs of those affected by suicide and self-harm.
- A Community Responsibility – Involving the whole prison community in the awareness and care of the suicidal.

8.3 In practice the policy advocated an integrated or 'community' approach, which encouraged supportive relationships, decent conditions and active regimes, care for the individual prisoner at risk, and effective aftercare follow-up. The residential units were to be placed at the heart of the prison's suicide awareness strategy, with a network of support from other staff, i.e., the HCC, Probation, Chaplains, Psychologists and others. Outside agencies such as the Samaritans and Prison Visitors would also give support. Regular contact with the family was considered to be vital, if family relationships had not broken down irretrievably. Communication, teamwork and support were key to the multi-disciplinary team approach.

*HMYOI Feltham Local Suicide Prevention Policy*

8.4 The Local Suicide Prevention Policy had been compiled and issued in January, 2002. Drawing on the principles of the National Policy, it focussed on HMYOI Feltham, listing the expectations for prisoners in general, and in particular for those identified to be 'at risk'. The Local Policy Document described a step-by-step process for opening and closing an F2052SH, and outlined staff responsibilities, including those of the Outreach Team, the SPC, and reception and induction staff. These will be discussed in detail in relation to JL's management in section 9 of this report below.



## **9. Application of the Suicide Prevention Policies in relation to JL**

### *National Policy Statement*

9.1 The National Policy Statement describes the duty of care for all prisoners and the additional support, co-ordinated by the suicide prevention team, that should be provided to care for prisoners who are depressed or suicidal. As required in the policy statement, from the records of the case of JL, he was identified on arrival at HMYOI Feltham as needing special care, a suicide prevention plan (F2052SH) was put in place, a therapeutic approach was adopted, there was co-ordinated counselling to deal with times of crisis, and a range of staff provided observation, support and counselling. Contrary to the policy, according to the records, closure of the F2052SH appears not to have been multi-disciplinary, and the significance of this will be discussed in the following sections. JL was seen by the chaplaincy and CARATS after the F2052SH was closed, although contacts were recorded less frequently after the closure, and there was no recorded contact with Outreach.

### *HMYOI Feltham Local Suicide Prevention Policy*

9.2 Application of the local policy in respect of JL is described below.

### *Expectations for prisoners/trainees identified to be 'At Risk'*

9.3 In principle the expectations listed in the Local Suicide Prevention Policy for prisoners at risk of self-harm were met.

- JL was provided with help to cope with custody
- He was encouraged to engage in purposeful activity
- A risk assessment was carried out
- JL was identified as at risk from his second day at Feltham
- An F2052SH was opened
- He was observed in line with F2052SH policies
- JL was encouraged to keep in touch with family by provision of telephone cards, and with visiting orders for his girlfriend
- His girlfriend was contacted at times of crisis
- JL received continuity of care from teams of staff – see timeline (page 43)
- Although not directly expressing suicidal thoughts, his anxiety was taken seriously

- All of the required reception and induction screening procedures took place
- Access to Samaritans, Outreach and the Chaplaincy were facilitated
- Information on risk was shared.

*Reception and induction*

9.4 On reception at HMYOI Feltham, a number of issues specific to JL were identified and noted:

- It was JL's first time in prison
- He was an illegal immigrant
- He had complained of physical symptoms from injuries sustained in Jamaica, and during his arrest by the police for his current offence
- There were family concerns about his girlfriend in the UK and his children in Jamaica
- He was very distressed and disorientated
- He was not considered at immediate risk of self-harm but it was advised that he should be watched carefully
- He had been charged with a drug offence.

9.5 The following issues were acknowledged in the core record and addressed within the first two days at Feltham, as follows:

- A 'first night cell occupancy risk assessment' form (local) was completed
- JL was assessed by an HCC worker
- He was examined by a doctor
- He was offered hepatitis B injections
- JL was interviewed by a Chaplain for pastoral care
- He was referred to the CARATS team who advise and counsel on drug related issues
- JL was reviewed by the SPC and a member of the HCC Outreach team (for mental health assessment)
- An F2052SH was opened to provide special care against 'risk of self-harm'

- JL was located in a 'safer cell'<sup>20</sup> as a precaution against possible self-injury
- JL was later relocated to the HCC due to additional concerns about his extreme distress.

9.6 It appears that JL was carefully assessed during his first two days in Feltham, and a great deal of care was taken to address his concerns and ensure his safe custody. The Local Suicide Prevention Policy in place at that time appears to have been followed during the reception/induction period, although it is not possible to check every aspect of this process six to eight years after the event. A comprehensive support plan was drawn up incorporating ongoing support for JL by Outreach, the SPC, CARATS, and the Chaplaincy, and help was offered through the Samaritan Listener scheme. A Security Information Report (SIR), submitted on the second day following JL's arrival, that stated that JL had scared his cell-mate, and taken his tobacco, was not formally pursued and JL was moved to another cell. This episode appears to have been handled with sensitivity.

#### *Risk of self-harm*

9.7 JL was identified within the first two days of arrival at Feltham as being at risk of self-harm, and on the second day an F2052SH was opened. The SPC, recognising that JL was extremely distressed, recommended his transfer to the HCC for special observation and assessment. A support plan was drawn up pre-discharge from the HCC in line with the Local Suicide Prevention Policy.

9.8 The F2052SH was in operation from 21 July until 8 August 2002 (18 days). During this time, the F2052SH was reviewed four times, on 22 July, 25 July, 1 August and 8 August. As required by the National Suicide Prevention Policy, JL was reviewed within 72 hours of the F2052SH being opened, and weekly thereafter rather than two-weekly as required by the national policy document. Local HMYOI Feltham policy had the same requirement of two-weekly review, but additionally noted that 'good practice indicates weekly review is more effective'. JL's reviews were therefore in line with national suicide prevention policy, and in line with 'good practice' as defined by local policy. For all of the reviews except that of 8 August, a multi-disciplinary team was recorded as present, together with JL. JL's views were taken into account in all cases, and detailed support plans were drawn up. Unit staff were encouraged in JL's first support plan to provide a 'safe and responsive

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<sup>20</sup> Cell with anti-ligature fittings.

regime and management style' which they seem to have followed. From the entries in the F2052SH Daily Supervision and Support Record, JL's periods of distress were quickly responded to, and requests by JL to change unit, to change cells and to change cell-mates were agreed without challenge. Behaviour that might have attracted disciplinary action was handled sensitively. Requests to see a Chaplain, a member of Outreach or the CARATS team, from records, were promptly dealt with, and the requested visits generally occurred on the same day. Ongoing problems with a previously acquired physical injury resulted in appointments in the HCC, including an emergency visit to Ashford Hospital during the night of 8/9 August 2002, and provision of pain-killers, although no curative treatment is noted to have been provided. JL's concerns regarding contact with his family in Jamaica were supported and recommendations for provision of international phone cards and advice on seeking asylum were acknowledged and recorded. From records, it appears that both means of support appear to have been provided on at least one occasion.

9.9 In consultation JL's legal representatives questioned whether the 'continuity of care' principle, emphasised in the Local Suicide Prevention Policy, was achieved. The timeline of consultations (page 43) shows that during the period when the F2052SH was open, JL received a considerable amount of attention from Outreach, the Chaplaincy, CARATS, and the HCC (seen 23 times in 18 days). This is in addition to four reviews (3 of which were multi-disciplinary), ongoing attention by members of unit staff, a visit to discuss immigration issues (presumably by Probation) and 3 legal visits. Over the 31 days from his arrival at Feltham until his attempted suicide, JL was seen on 30 occasions by Outreach, CARATS, an HCC doctor and nurses, and a probation officer. When such a large amount of attention is being given, it is difficult to achieve individual attention on all occasions. What is evident is that JL received strong team support. In case reviews, where the policy advocates continuity of attendance where possible, there was a member of the Outreach team present on all four occasions.

9.10 Key moments of distress were dealt with promptly and, where risk of self-injury seemed to be elevated, transfer to the HCC occurred rapidly. These included JL's distress on first arriving at Feltham, and later when he claimed that his daughter had died. Although the National Suicide Prevention Policy extant in 2002 questioned whether a move to the HCC was always appropriate at times of severe distress, and the Local Suicide Prevention Policy refers to '*possible* in-patient admission' to the HCC, a decision was taken on two occasions to move JL there. In the second case, when JL was reluctant to go to the HCC, careful consideration

was given to risk. JL had said that 'he would die if his daughter died' and it is recorded in the F2052SH case review that a noose had been found in JL's cell. No record of the date and time when the noose was found appears in the F2052SH Daily Supervision and Support Record, however its presence in the case review record ensures that it was read in conjunction with the updated support plan, and designated staff and departmental responsibilities. The move to the HCC was conducted with the assistance of those involved in JL's pastoral and health care, i.e., with the assistance of the Chaplaincy and a member of the Outreach team.

9.11 As required in the Local Suicide Prevention Policy, JL was regularly monitored wherever he was located during the period of the F2052SH. The daily entries met the requirements of the policy, i.e., early after roll check, during the morning, afternoon and evening. It was evident from the entries that staff made an effort to have discussion with JL about his support plan most days. At night the requirement of half hourly monitoring at irregular intervals appears to have been generally observed.

9.12 The Local Suicide Prevention Policy instructs that the F2052SH file should follow the offender to every location, and this did occur when JL moved between residential units and on two occasions to the HCC. The policy does however suggest that the file should follow the prisoner to visits, the gym and education, when necessary. It appears that the F2052SH file did not follow JL on these short duration visits, and from interview transcripts where a POA representative attended, it appears that this process was not always followed as it led to identification of those on F2052SH by fellow prisoners, which was considered undesirable. Interviews by Chaplains and CARATS would usually occur on the unit and so would be recorded in the F2052SH Daily Supervision and Support Record.

9.13 The major discrepancy between the Local Suicide Prevention Policy and practice was the closure of JL's F2052SH on 8 August, 2002. The case review is signed by the member of Outreach, (a registered mental health nurse - RMN), although the Policy requires that closure of an F2052SH is completed by the Residential Unit Senior Officer in the presence of a multi-disciplinary team; JL attended the review. The Outreach team had been involved throughout the F2052SH process with JL, and may have felt that they knew him well, however closure by one individual did not conform to the policy. There is however some ambiguity here, as the Internal Investigation report, 2002, states that a multi-disciplinary case review was held. It is not known whether the Internal Investigator clarified these events when writing his report in 2002 or whether he made an error.

As it has not been possible to trace the RMN involved, we were unable to conduct an interview with him about the procedure. Other HCC staff who were questioned about the closure of the F2052SH and whether it would have been closed by an individual member of Outreach found it hard to believe that this had occurred. The then SPC who was responsible for maintaining the F2052SH process in line with policy was shocked that Outreach had deviated from the policy in the F2052SH closure process for which he was responsible in 2002. Multi-disciplinary meetings at that time appear to have been the norm (cf Internal Investigation Report, para. 10.2.2. They were usually held in Waite Unit (HCC), and it was in Waite Unit that the closure of the F2052SH was recorded to have taken place. It was the SPC's view that it was more likely an omission in the paper-work rather than the process that only the member of Outreach was present with JL, as the section of the review form relating to staff/departments attending was unusually left blank. There is however no other evidence to support this view apart from the Internal Investigation report, and one must assume that the F2052SH was closed by a single member of Outreach. In any event it is known that members of the Chaplaincy were not consulted about the closure of the F2052SH, although they had been closely involved in supporting JL and would have resisted closure.

#### *Chaplaincy support*

9.14 Members of the Chaplaincy, both in 2002 and in 2008-10, have expressed their disappointment at not being consulted about the closure of the F2052SH on JL. A report from the Chaplaincy was submitted to the Internal Investigation in 2002 which clearly summarises their views. The Chaplain wrote: 'Chaplaincy had a large input into JL's life here and I believe we should have been consulted about his care, but we are generally bypassed when decisions of this nature are made'. The Assistant Chaplain who was heavily involved with JL is quoted as saying that 'if she had been invited to a case review she would have recommended that it (the F2052SH) be kept open for the foreseeable future'. Despite this, she said it was not her view that it was JL's intention to commit suicide. In the Chaplaincy report contained in the core record at the time of the Internal Investigation, and in interview for the 2008-2010 Independent Investigation, the Assistant Chaplain expressed the view that JL had been very concerned with making provision for his children, and indeed JL had told her that he would not kill himself as that would make things worse for his children. Nevertheless the Assistant Chaplain thought that JL was so prone to mood swings that he was at risk of acting on impulse, and might see it as a way of getting out of prison. In her view, JL's suicidal actions on

19 August, 2002, were more likely enacted to show how desperate he was rather than as part of a suicide plan. These views were supported by the Chaplain in interview in 2008-2009, who similarly did not think that JL intended to commit suicide, but thought that JL's actions were more likely intended to manipulate the system in order to get out of Feltham. The Assistant Chaplain referred to rumours that JL had asked a fellow prisoner to alert a Prison Officer to open the door of his cell as he planned to appear to attempt suicide, possibly as a means of getting out of prison. She could not be certain that this rumour applied to JL but she did think that the attempted suicide would have happened whether JL was on an F2052SH or not.

9.15 A further 11 days passed following the closure of the F2052SH before JL's incident of attempted suicide occurred, and there is no evidence of any recommendations that a further F2052SH should be opened, which was an option open to anyone working at Feltham. In that time JL was seen once by the Chaplaincy and twice by the CARATS worker, as well as by unit staff. His overnight outside hospital visit also occurred after the F2052SH was closed. It is presumed that a new F2052SH could have been re-opened if serious concern about possible self-harm had re-emerged.

#### *Suicide Prevention Co-ordinator (SPC)*

9.16 It is evident from the files that the F2052SH system was closely managed by the then SPC, and it is clear from the core record that the SPC was personally involved in the crisis management of JL's case. In his interview for the 2008-2010 Independent Investigation, the former SPC demonstrated a thorough knowledge of the suicide prevention policies and processes that were in existence in 2002 and how they were applied in HMYOI Feltham. It had been his responsibility to ensure that the policies were carried out in practice. He expressed shock that the F2052SH appeared to have been closed with only a member of Outreach and JL present and thought that this was more likely an error in paperwork.

#### *JL's physical and mental health care*

9.17 The following sections of the report about JL's physical and mental health care have been completed in consultation with the expert medical advisor to the Independent Investigation, Dr. Cumming. These sections cover: health care arrangements at Feltham in 2002; services by the Outreach Team; input from medical staff; and the role of the HCC in JL's management.

### *Health care arrangements*

9.18 At the time when JL was held at Feltham, the HCC itself was seen by HM Chief Inspector of Prisons (2002) as inadequate. A purpose-built HCC was planned, but during the refurbishment the HCC was located within a wing of one of the residential units with 29 in-patient beds. In-patient care was provided by two staff grade doctors, seconded National Health Service staff, Prison Service Nurses and HCC Officers, of which there were 7, and a Principal Officer.

9.19 In 2002, health care at HMYOI Feltham was managed via a partnership between a local mental health service and a private company, Forensic Medical Services (FMS). The latter provided medical input to primary care and the former provided mental health care via a service level agreement with West London Mental Health NHS Trust. From interview with a mental health nurse in 2010, it appears that the mental health team worked within the HCC and did not routinely provide support to prisoners at risk of self-harm, unless possible self-harm was associated with a mental health problem. It appears that they worked independently of the Outreach team. The Report by HM Chief Inspector of Prisons (2002) noted that, since the last inspection, health care services had gone through an enormous amount of change as a consequence of new partnership arrangements and it was hoped that this had brought about positive change.

### *Service by the Outreach Team*

9.20 The Outreach team had been present since 1998. Members of Outreach involved with JL, as shown in his F2052SH reviews and Daily Supervision and Support Record, were a Principal Officer, who was the SPC in charge of Outreach, a team of two registered mental health nurses (RMN), and an HCC Officer. The inspection report of HM Chief Inspector of Prisons in 2002 did not provide a review of mental health services. The Chief Inspector did however express the opinion that the Outreach team was understaffed, and there were concerns about whether it could meet the needs of the population. To put this statement in context, JL's F2052SH was numbered 513/02, indicating that 513 F2052SHs had been opened and managed in the first seven months of 2002. The Inspection Report of 2002 complimented Outreach on its involvement with 'self-harm and risk management' in the F2052SH process and the team at Feltham was identified as an example of best practice. At the time of JL's imprisonment the prison was piloting a new reception screen (which was later adopted across the estate). One consequence of this was that fewer prisoners were seen in reception by the doctor and more were



referred to the Outreach team as a result. Outreach had a policy to see referrals within 24 hours, and was seen as the first point of contact in the prevention of suicide and self-harm. The 2002 Inspection Report commented that there was a prevailing view that self-harm and suicide prevention was a medical problem that required young prisoners to be cared for in the HCC, with Outreach to support them in the main prison. This was in contravention of the principal that 'suicide is everyone's concern'. The Inspection Report suggested that the Outreach team was seen as being responsible for ensuring that the F2052SH process operated effectively and for leading the F2052SH reviews.

9.21 In contrast with the findings of the 2002 Inspection Report and the new reception screening process, JL was seen on reception by a doctor. Although this would have no bearing on later developments, issues of current risk of self-harm were not recorded in detail in the modified first reception health screen, JL having responded that he had had no previous mental health problems nor history of self-harm.

9.22 Outreach was first involved after the F2052SH form was opened on JL rather than as a response to other needs, thus it appears that in keeping with the findings of the Chief Inspectors Report, 2002, it was a service that centred on self-harm and suicide prevention rather than more general mental health issues. It is recorded that Outreach saw JL within 24 hours of the F2052SH being opened. This is in keeping with recommended policy. There is however little information on the Outreach assessment beyond the actual procedure and initial view that JL could be managed at that time in the main prison. A more in-depth interview (or at least one that was recorded) did not take place until several days later on 27 July, 2002. This seemed to be a good assessment with the intention to clarify the suicide risk and also to ascertain whether a mental illness was present. The assessment clarified the issues well and helped to guide the management of JL at that time, which was essentially one of locating him with a prisoner that he wanted to be with.

9.23 There is little information beyond the first assessment and this indicates that Outreach involvement with JL became one of managing risk within the F2052SH process. This can be seen in subsequent assessments and interventions which tended to have a risk emphasis rather than examining underlying issues. In some instances there is no record of the nature of the contact. Most of the entries are rather brief which may indicate that the interactions were also brief and imposed limitations in developing a therapeutic relationship with JL. It would have been

useful for instance to have clarified why JL made the bogus claim about his daughter having died.

9.24 It can be seen from the core file that Outreach's involvement was very much within the period that the F2052SH form was open. Indeed although the recorded contacts by Outreach appear to have been brief, there were a considerable number of times that Outreach either met or had some intervention into the management of JL, with the obvious point that their involvement stopped after the F2052SH form was closed. Outreach appeared to take responsibility for closing the F2052SH without consulting more widely. However, the interview in 2010 with the former member of Outreach suggests that they did appear to take a caring interest in the young offenders.

9.25 It is concluded that Outreach easily achieved the objectives outlined in their part of the Local Suicide Prevention Policy, although they may have contributed to a perception that 'suicide is Outreach's concern'.

#### *Input from medical staff*

9.26 As the input from Outreach was largely a risk management process, this did not generate a reason to see a psychiatrist. The admission to the HCC on the first occasion was not a reason for such a referral on its own and this is in keeping with the Local Suicide Prevention Policy. The Expert Medical Advisor to the Independent Investigation, Dr. Cumming, was not of the view that seeing a psychiatrist would have added anything to JL's management. It is his view that there seemed to be no indication that it was necessary for JL to see a psychiatrist and the only benefit might have been that this would have provided a more in-depth assessment. However Dr Cumming concluded from reading the documentation and interview transcripts that the outcome of any assessment would have depended upon when the assessment took place, and more than likely it would have been a single assessment with no indication for a further assessment, as there was already considerable support for JL.

9.27 In the draft report consultation process, JL's legal representatives requested further comment from Dr. Cumming on JL's mental health, posing questions relating to suicidal thoughts, anxiety about his father and brother who had been killed, whether JL could have been suffering from post traumatic stress disorder (PTSD), or paranoia, and whether he would have benefited from seeing a psychiatrist or a psychologist.

9.28 In answer to specific questions raised by JL's legal representatives, Dr. Cumming makes the point that it is possible to speculate that a prisoner may be concealing suicidal thoughts, but diagnosis has to be based on what the prisoner is saying at the time of assessment, rather than making a subjective interpretation of his thoughts. Dr. Cumming comments that, although JL was continually anxious, it is not the same as saying that he suffers from PTSD. Far more clinical symptoms and signs are needed to make such a diagnosis. Dr. Cumming's view is that there could be many explanations for the variation in JL's behaviour and perception, particularly in someone with a history of abusing drugs, and it would be wrong to make a clinical diagnosis of paranoia based on the current information. No clinical diagnosis was made by medical staff during JL's time at Feltham and, in Dr. Cumming's view, there is insufficient evidence to make any further clinical diagnosis now.

9.29 JL's legal representatives asked whether JL would have benefited from a psychological referral. Professor McDougall points out that imprisonment is a very stressful experience, and it is not uncommon for prisoners to suffer extreme anxiety about their partners, their families and their court cases. In circumstances where prisoners appear unable to cope with these stresses they are given extra support through processes such as the F2052SH. This distress is an understandable reaction to their situation, requiring social support, and is not necessarily related to a psychological problem. Referral to a psychologist frequently is dependent on availability, but did not appear to be warranted in JL's case.

9.30 As there was no indication of the need for JL to see a psychiatrist or psychologist, the involvement of medical staff fell into three roles: prescribing, attending to physical health needs, and what might now be considered primary mental health. Dr. Cumming noted that, although the reason for JL's first admission to the HCC was to manage risk after the F2052SH had been opened, this was not the basis of the consultation with the doctor that took place subsequently, which was related to physical health.

9.31 In terms of physical health issues, there were two identified complaints that surfaced and resurfaced during the time that JL was at HMYOI Feltham. Firstly JL complained about abdominal pains, and secondly repeatedly reported a bullet still lodged in his foot which caused pain. JL complained of these on several occasions and in general these were managed by the use of analgesia. On 29 July, 2002 there is an entry which refers to a proposed x-ray for JL's foot but this does not appear to have taken place by the time of the later attempted suicide. It is Dr.

Cumming's view that, as the problem did not seem to impede JL beyond occasional complaints of pain and had been present for some time, it is unlikely that this medical condition should have been seen as a priority.

9.32 Dr Cumming commented on the second issue of the abdominal pains which JL suffered from time to time. On 9 August, 2002, the pains were of a nature and degree that JL was required to be transferred to the local hospital. Dr Cumming stated that, although it might be tempting to conclude that this was a serious complaint, this might also reflect that the event occurred out of hours, and presumably when a doctor was not in the prison (the time of the complaint was not recorded). There is no clarity from the records about what was responsible for this pain and JL seems not to have complained about it later, nor was he offered another appointment to attend outside hospital.

9.33 Dr. Cumming concluded that, although either medical condition on its own was unlikely to be the causal factor that prompted JL to try to take his own life or prompt the sense of despair evinced in his suicide note, they might have contributed to how he felt about being in prison.

9.34 Dr Cumming commented that the medical entries on JL were remarkably brief, and seemed to be more statements of fact rather than opinion and diagnosis. He would however accept that this is not uncommon in prison medical records elsewhere.

9.35 It was Dr. Cumming's view that JL's case seemed to rest between two services. JL's problems were not of a nature or degree that required the involvement of a psychiatrist or psychologist, but also did not go beyond the intervention and management by Outreach whose focus was one of risk management. A doctor was involved with the HCC discharge plans after JL's first admission but it is not clear as to the doctor's involvement in the second admission which was signed pp (per procuracionem or on behalf of the writer). The doctor seemed to have been involved in facilitating discharge from the HCC (as a doctor's signature was needed for discharge to take place) rather than an inherent and integral part of the medical service provided.

#### *The role of the Health Care Centre (HCC)*

9.36 The 2002 HM Chief Inspector's Report indicates that it was usual for there to be a large number of prisoners within the HCC on an F2052SH form. It is conjectured that these would largely fall into two categories: the first because of an

underlying problem (such as mental illness) which heightened the risk, and the second group, there because the F2052SH had been opened and the risk of self-harm needed to be clarified and managed in the short term until they were ready, and of a low enough risk, to be returned to the main prison.

9.37 As has already been noted, admission to the HCC was largely based on a need to manage risk rather than to understand any underlying issues. JL was taken to the HCC for precisely those reasons on two occasions, 21 July, 2002 (after the initial F2052SH was opened and he was found to be distressed) and on 31 July, 2002 after he had claimed that his daughter had died. Dr. Cumming felt that the admissions, on the basis of the information available at those times, were both warranted. Equally he felt that the discharges were indicated, although the information and detail about the process is rather scant.

9.38 An interview was held in 2010 with the Mental Health Nurse who attended the pre-discharge review following the 31 July admission to the HCC. Although she could not remember JL, it was her view that she would be there to assess whether there was a need for further MHT intervention. It appears that such intervention was not thought to be necessary, as no further involvement of the MHT took place.

9.39 In terms of the Local Suicide Prevention Policy, JL was seen within 24 hours of the opening of the F2052SH by a doctor in the first instance although it is not clear as to the second occasion when he was seen. The in-patient management team also fulfilled their role in terms of the initial review and did not hurriedly acquiesce to JL's earlier demands to return to the main prison. Dr. Cumming felt that they also showed good practice in involving Outreach before discharge from the HCC.

9.40 Dr. Cumming noted that the entries in the F2052SH form stopped during the second admission to the HCC in deference to entries in the Hospital Care Plan and Level 2 observations. Although this makes practical sense it does not allow for others who later might be caring for JL under the F2052SH form to benefit from their input. In general, Dr. Cumming was of the view that the HCC worked in line with the National and Local Suicide Prevention Policies for health care, and there were no significant deviations that would have a later bearing upon the incident of attempted suicide on 19 August, 2002.

*Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS)*

9.41 It has not been possible to investigate the contribution to JL's management and care at Feltham by the CARATS team. Although it is clear that CARATS, and one worker in particular, were involved with JL from his arrival at Feltham, there are no case notes available on the interaction with JL. There is an occasional brief comment entered in the unit history sheet about JL's concerns, but by and large the content of JL's discussions with CARATS remains unknown. Efforts by the Assistant Investigator in 2008-2010 to seek out this information have not succeeded; the CARATS contracts have been placed with different organisations over the last few years, and the current CARATS team was unable to enlighten us as to the activities of their predecessors. What is clear from JL's unit history sheets and the F2052SH is that the CARATS representative was seen 4 times in 21 days, twice at JL's request, between his first referral interview and the incident of self-harm. The CARATS worker responded quickly when an application for an interview was made by JL. Since JL made requests to see the CARATS representative, it appears that he found these discussions helpful and agreeable. It is disappointing not to have information from CARATS, as JL's positive screening for cannabis at the time of his attempted suicide suggests that he may have been continuing to use cannabis at Feltham. However it is not possible to assess the degree of problem he was having, nor how his drug intake was impacting on his behaviour.

9.42 Although records of CARATS involvement are virtually non-existent, in an interview in 2010 with the former member of Outreach, it was suggested that CARATS had been very co-operative with unit staff. Therefore, although written communication was sparse, it appears that there may have been a good level of informal communication. It is possible that confidentiality issues were prominent with external counselling agencies at that time, but it is hoped that, in serious situations such as potential self-harm, there is now multi-disciplinary sharing of information.

9.43 Dr. Cumming commented that the lack of records regarding CARATS involvement with JL has imposed limitations on our understanding of JL's involvement with cannabis. It does not appear that at any time CARATS had raised concerns about JL either within the F2052SH process or outside of it. They did not appear to have been included within the Local Suicide Prevention Policy. On 15 August, 2002, after JL's F2052SH had been closed, the CARATS worker noted that JL was quiet and withdrawn and commented that he was worried about his forthcoming trial and his family in Jamaica. These worries appear not to have been

of a sufficient degree to prompt CARATS to open another F2052SH form or to bring the issue to the attention of anyone else.

### *Regime activities*

9.44 The Local Suicide Prevention Policy recommends that the unit Senior Officer should try to keep the prisoner occupied by offering opportunities for work, association, and/or other activities. From the regular reporting in the unit history sheet, it appears that there were periods when JL was in very low spirits and tearful and remained in his cell, and others when he involved himself in association, going to the gym, the library, and the exercise yard, and helping with the wing cleaning. He was offered opportunities for education. It therefore appears that efforts were made to encourage JL in activities when he was on Osprey Unit. There is however a discrepancy between JL's comment to the RMN at the review when his F2052SH was closed that he was attending education, and the Education Department records which show JL's infrequent attendance at education. Also JL's expectation that he was likely to be included on the education list on 19 August was surprising. From the education records, it appears that JL was listed to attend education or a workshop on eight occasions during his time in Feltham, but he is only marked as having attended education on one of these occasions and attending a workshop on another. The Education Department has no record of a requirement for JL to attend education after 14 August, which is the last date when he was on the education list. It therefore appears that either JL did not take advantage of a number of the occasions when he would have been able to go to education. Comments from JL's cell-mate in the 2002 Internal Investigation suggest that JL was barred from education after ringing the alarm bell, although prison records of JL's involvement in this incident are ambiguous.

### *Racial issues*

9.45 There is rarely any mention in the records relating to JL of racial issues raised or addressed during JL's time in Feltham. There is no record in JL's file of any racial complaints made by him. The only reference by JL to racism at Feltham is in his suicide note which states '...some of the Goves (Officers?) don't like me and are racist'. The main other reference to racial issues is recorded in the interview with JL's cell-mate conducted for the Internal Investigation, 2002. JL's cell-mate said that JL thought the staff were racist, and when anything went wrong, such as being blamed for the alarm bell being rung when they were leaving education, JL said he was accused because of his race. When JL was asked about

racism at Feltham in the interview for the Independent Investigation (2008-2010), he said he could not remember any racism. However JL could remember very little about Feltham and events there, and this should not be taken as a contradiction of earlier statements.

9.46 The Governing Governor in 2002, in interview for this Investigation, said that race relations were not particularly good when he arrived at HMYOI Feltham towards the end of 2000, but he did not believe they were much different from other prisons at that time. He said that Feltham had a lower than average representation, for London, of black and Asian Prison Officers at that time. He had tried hard to reduce racism at Feltham, and had sacked a number of white Officers for racism during his tenure there.

9.47 The investigation by the CRE, commenced in 2000, expressed dissatisfaction with the state of race relations at Feltham at that time, although the Standards Audit conducted in 2002 gave a rating of 'good' for race relations at Feltham, and a 98% level of compliance with policies. Both the Chief Inspector's Report, 2002, and the Board of Visitors Annual Report, 2001-2002, commented on the improvement in race relations due to the strong efforts being made at that time by the management team. The Independent Investigation did not find any evidence in the records of direct racism against JL or any complaint from him, apart from the comments in a prisoner's interview report (2002) that JL thought staff were racist, and JL's comments in a suicide note.

#### *Staff training*

9.48 According to the Standards and Security Audit conducted in 2002 and from the Board of Visitors Annual Report 2001-2002, there had been a high concentration on race relations training at Feltham at that time. The Audit Report stated that the level of staff training was at over 98%, which they concluded was as high as could practically be achieved with such a large number of staff and a relatively rapid turnover. The Audit team had found that staff across the establishment were aware of the race relations policy and provided a fair interpretation of the action to be taken should they witness any form of racist incident or behaviour. These comments and conclusions were supported by the Board of Visitors in their Annual Report.

9.49 Although the Standards and Security Audit, 2002, rated Suicide & Self-harm Reduction standards as 'good', the level of compliance was lower than for race



relations, at 84%. The Audit team commented that efforts had continued, since an earlier audit, to increase the rate at which training was delivered on suicide and self-harm prevention, but they highlighted staff training as an area of weakness. The Internal Investigation (2002) recorded that the training figures on suicide and self-harm reduction available to them did not reflect the national requirements, and it was recommended that the Governor give priority to refreshers in Suicide Awareness Training.

9.50 Staff who attended the incident of attempted suicide by JL were questioned about staff training when they were interviewed for the Internal Investigation in 2002. Two of the Officers were relatively new in post and had gained their knowledge from basic Prison Officer training. More experienced Officers did not always recall refresher training having taken place. They did however appear to be knowledgeable about practical requirements of the Local Suicide Prevention Policy; they were all familiar with the F2052SH process, availability of Samaritans and Listeners, and of the Outreach team. They also acted appropriately in practice when confronted with JL's attempted suicide. It may therefore be concluded that information on suicide prevention had been conveyed to staff, possibly through staff briefings, which Officers may not have regarded as formal training. The unit Principal Officer who attended the attempted suicide scene was familiar with the documentation and where it was located, although more junior Officers could not always describe where to find the relevant documentation.

9.51 This finding links with comments by the CRE in their report in 2003 on race relations policies, which could be said of policies more generally, including those relating to suicide prevention. The CRE commented that in their view undue emphasis was placed by the Prison Service on the development of elaborate formal policies with the assumption that once the policy had been adopted at the top of the Service it was then being followed at the bottom. The CRE thought that this assumption was mistaken. In conducting this 2008-2010 Independent Investigation, I do recognise the point that is being made about the complexity of formal top-down policies, but I would not necessarily agree that the policies are not being followed at ground level. From the current Investigation, it is clear that the policies were being followed, and this was also the conclusion of the Audit report. I do however consider that it is unrealistic for Officers to be expected to keep up to date with numerous complicated and detailed policy documents and to be able to quote their standing order numbers and where policy documents are located. Detailed policies are of course needed, but there also needs to be some translation into more accessible descriptions and illustrations of the necessary working

practices. Skills-based training would be much more effective and be much more likely to be remembered.

#### *Record-keeping and monitoring*

9.52 Standards of record-keeping and monitoring were variable. F2052SH review documents were generally well completed with clear action plans and designated persons accountable for the actions. Some of the unit history sheet records were quite detailed and informative. Some however were very brief, e.g. 'Seen by CARATS'. Doctor's records were generally brief, and most often undecipherable; this applied both to those kept by the HCC and the external Securicor Medical Records.

9.53 There was not always good agreement between entries which appeared in different files. For example, when JL went for his mandatory drug test it is recorded at 11.00 hours in the MDT log, but not shown in JL's unit history sheet. The MDT log and the Segregation Unit Occurrence book do agree that JL arrived in the Segregation Unit at 11.50 hours. According to the MDT log, JL returned at 13.50 hours and produced a urine sample between 13.55 and 14.00 hours. JL was then returned to the residential unit, however the Segregation Occurrence book does not record JL as having left the Segregation Unit until 14.40 hours.

9.54 There were discrepancies between timings relating to the incident of attempted suicide itself. On 19 August, 2002, it is recorded that JL was found hanging and was held round the waist and supported by an Officer at 14.30 hours, while all the other Officers report coming to his aid at 14.55 hours, which is the time when the Code 1 Alert was broadcast. An alarm bell had been rung (this is assumed to be by the prisoner who had asked to see JL, and who was instructed by the Officer to seek help and ring the alarm bell). The alarm and the Code 1 Alert are recorded in the same entry in the Control Log at 14.55 hours: 'not an alarm but a Code 1', suggesting that they occurred in quick succession. This discrepancy in timings was investigated in interviews, and it was pointed out by the Officer who found JL that he had estimated the time, and one could not be aware of the exact time when an event occurred and how much time elapsed in the course of the incident. All of the Officers who came to assist in lowering JL and resuscitating him reported 14.55 hours as the time they responded, i.e., when the Code 1 Alert was recorded in the control room, although some staff had clearly responded earlier to the calls for help from the Officer who found JL hanging and the prisoner who accompanied him. Having interviewed those involved in the incident and

scrutinised the records, we had no doubts that there was an error in the paper records, and that events were described as accurately as was possible under the circumstances. We concluded that all of those involved had acted with alacrity to save JL's life.

9.55 Some of the problems with records were related to conducting the Investigation six to eight years after the event. JL's unit history sheets often only recorded that JL 'went on a visit'. No further detail was recorded about who had visited, and indeed the residential unit Officers may not have known. Prison visits records had not been retained for 2002, so we were unable to confirm who had visited. In two instances a visiting order had a line through it. We assumed that the visit had taken place, as a specific time was given.

9.56 The D Inquiry Report, by the Prison and Probation Ombudsman, 2008, made reference to the failure of the Prison Service to retain records under the instructions of PSO 9020. In the case of JL, his core records were mainly available, although supporting departmental records were sometimes difficult to locate six years after the event. Archived records could have been more carefully indexed to make them easier to locate, and this should now happen to facilitate future investigations.

9.57 A major difficulty was the poor quality of photocopying of records and the occasional disorganisation of contents. We have deliberately not re-arranged these records as they are numbered and have been used in previous judicial hearings. We have however re-photocopied them where information was rendered ambiguous due to missing dates and times, and produced a detailed electronic index so that items can be more easily found. We hope that this will make background documentation more accessible.

## **10. Comparison with the report of the Internal Investigation, 2002**

10.1 It should be noted that there was no formal requirement in 2002 for an investigation into an attempted suicide to be conducted. The Area Manager did however commission an Internal Investigation following JL's attempted suicide. The time-scale of the Investigation was short, and it was interrupted as the investigating Officer was required elsewhere (1 month, which extended to 35 days). However the Investigation started within a month of the date of the attempted suicide, so would have benefited from more recent memories of events. The core file was available, and other supporting records of events would have been more easily accessible at that time.

10.2 The report gave a good outline of events, but the current Independent Investigation did not rely on the detail of the Internal Investigation, 2002, when it was discovered that there were a small number of discrepancies between the internal report dates and those found in the core record and appendices. There were also events which needed further exploration.

10.3 The Internal Investigation had concluded that the closure of the F2052SH had been multi-disciplinary, which we found to be unsubstantiated. The Internal Investigation Report did however point out the absence of a Chaplaincy contribution to the decision on closure. The Report recommended that attendance by the Chaplaincy on all case reviews should be considered, both as a local and national requirement. No reference is made in the Internal Investigation, 2002, to the Mandatory Drug Test (MDT) which was conducted on JL on the morning of the attempted suicide and which the screening later found to be positive for cannabis. There was no record in the core file that JL had gone for an MDT test, although the result was included in supporting information that we traced for this Investigation. There was no reference to a noose having been found in JL's cell at or before the incident when JL reported that his child had died.

10.4 There was little or no reference to the events of the night of 18/19 August, although the letter from the Principal Officer reporting his interview with the OSG who had been on duty that night was included with the supporting appendices. These events required some discussion.

10.5 The current Investigation had difficulty in checking on social and legal visits. The unit history sheets often recorded that JL had gone for a visit, but it was not known who had visited. The Internal Investigation, 2002, had access to current

visitor records which the 2008-2010 Investigation did not, so we have referred to the internal report for visits information.

10.6 The Independent Investigation (2008-2010) found no indication of bias on the part of the Internal Investigation (2002). The time spent on that report was however short (just over one month) compared to the current Investigation which has taken approximately eight months (actual investigation time). The scale of an investigation, involving the management of a huge amount of documentation which needs to be checked and cross-referenced, should not be underestimated. Errors and omissions in the Internal Investigation may therefore be attributed to the length of time allocated to the Investigation rather than any intention to misreport events.

## 11. Conclusions and Recommendations

11.1 In summary, it would appear that JL's management during his time at HMYOI Feltham was largely in line with National and Local Suicide Prevention Policy, with the exception of the closure of the F2052SH on JL which appears to have been without the support of a multi-disciplinary team. This did not conform to National or Local Suicide Prevention Policy. JL's management was however mostly well-intentioned, and there is no evidence of any deliberate acts of harm or neglect in his case. The records give the impression of a range of staff trying hard to support a young man in line with the F2052SH policies in existence at that time.

11.2 There were short-comings in the recording and processes, and these may, understandably but not excusably, occur in a busy prison with, to quote the Board of Visitors Annual Report of 2001-2002, 'a highly volatile and disturbed population'. It has been noted that JL's F2052SH form was numbered 513/02 which indicates that 513 Self Harm At Risk Forms (F2052SH) had been opened and managed at Feltham in the first seven months of 2002.

11.3 JL was, in his own words, 'very young, he had no visits, he had no money, and he was by himself'. Although JL was not formally tested or examined, the background information indicates that JL had special schooling and may therefore have been of borderline intelligence<sup>21</sup>, which might explain the rather naïve view he had of the criminal justice system when he first came to Feltham, and the actions he might take to achieve his release.

11.4 Dr. Cumming was not of the view that JL's behaviour on arrival or during his imprisonment indicated mental illness. In terms of intellectual limitations, Dr. Cumming did not consider that these would be easily apparent and JL's intellectual ability had not been raised as an issue in any of the documentation. Dr. Cumming pointed out that this range of intelligence would be a regular feature and finding with many prisoners in any prison in England and Wales.

11.5 The main process omission in JL's management was that, contrary to National and Local Policy, the closure of the F2052SH was not multi-disciplinary, but appears to have been closed by one individual in interview with JL. The Internal Investigation 2002, however, states that the closure followed a multi-disciplinary case conference. From the reaction of staff interviewed, and the other reviews conducted on JL, it would appear to have been exceptional for one person to have

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<sup>21</sup> The minimal IQ required for someone to function normally and independently in the world (without some form of institutional assistance).

closed the F2052SH. In the interview with the SPC for the current Investigation, he seemed genuinely shocked that this breach of policy could have happened in a system he had been monitoring so closely, and he checked our F2052SH documentation in detail to confirm this.

11.6 A major consequence of this was that the Chaplaincy were not consulted. It is clear that, had they been consulted, the Chaplaincy would have disagreed with the closure, although the Assistant Chaplain who worked closely with JL did not think that retaining an open F2052SH would have made any difference to the outcome. It should be noted that 11 days elapsed following the F2052SH closure before JL's attempted suicide, during which he was seen by unit staff, the Chaplaincy, the HCC staff and CARATS, any of whom could have expressed concern or re-opened the F2052SH if it had been thought necessary.

11.7 Despite the lack of a multi-disciplinary team and consultation with the Chaplaincy, all other requirements of the closure process had been followed. The Outreach RMN who closed the F2052SH discussed with JL aspects of his risk, recorded JL's positive answers, and prepared a support plan for the unit staff to follow. It is not possible to know whether, had the F2052SH remained open, JL's attempted suicide could have been avoided.

11.8 A positive feature of the F2052SH process at Feltham was that JL was present at all the reviews, including the closure interview. Attendance at the multi-disciplinary reviews varied, but could include the SPC, a member of Outreach, a member of Probation, a Sentence Planning Officer, and members of the hospital team. It appears not to have been usual for members of the Chaplaincy, Education or CARATS to attend. In JL's case these were all key to JL's risk management. It is recognised that it may not always be possible for representatives of these departments to be present at every review, however where a member of one of these professional groups is very involved, as in the case of JL, it is important that they should be invited to attend. Certainly in JL's case the Chaplaincy and CARATS were closely involved, and should have been consulted in the reviews. In addition, no member of unit staff appeared to attend reviews. Ideally a prisoner's Personal Officer should attend, although that may not always be practical.

**Recommendation: It is noted that the Internal Investigation, 2002, recommended attendance by the Chaplaincy at F2052SH (now ACCT – Assessment, Care in Custody and Teamwork) reviews both locally and nationally, and this recommendation is supported. In cases where drug**

**abuse is involved a CARATS representative should also attend, and Education staff should be invited to attend or make a contribution to the review, where prisoners are attending education classes.**

11.9 Particularly relevant to JL's case was the involvement of CARATS. In view of JL's positive test for cannabis, their view on his management and state of mind were crucial. Nowhere is there any record of their interaction with JL, their knowledge of JL's attitudes or concerns about taking drugs nor the impact of drug availability or non-availability on JL's moods while at Feltham. Dr. Cumming commented that cannabinoids (derivatives of cannabis present in the urine) can remain in the urine for a long period; the accepted period and upper limit is 30 days. Considering that JL had been in custody for 31 days at the time of his drug screening, it seems likely that he had used cannabis within prison at some point.

11.10 In the 2009 interview with JL at the Community Rehabilitation residence where he then lived, JL admitted to still smoking cannabis on occasion and confessed that cannabis made him confrontational and even violent. He was however adamant he had not smoked cannabis at Feltham. From the interviews with staff in 2002 and 2008-2010, and prison records, it is evident that JL suffered from mood swings. The CARATS team view would have been invaluable in understanding JL's moods and behaviour. It is recommended that CARATS should contribute to reviews on risk of self-harm and share their understanding of the prisoners' problems relating to drug abuse.

**Recommendation: The CARATS teams should record information about their interviews with prisoners in unit history sheets, and share assessments with staff who are managing prisoners, particularly when an ACCT (formerly F2052SH) process has been opened. These records should be available when required for any future investigations.**

11.11 The Outreach team played a significant part in JL's risk management as required by the Suicide Prevention Policy. Dr. Cumming was of the view that Outreach drifted towards 'ownership' of the F2052SH process rather than supporting unit staff in their management of JL's risk. He thought that their role had become one of risk management rather than taking responsibility for wider mental health issues, which was confirmed by the Mental Health Nurse who clarified that a separate team was responsible for mental health. This had also been noted in the



Chief Inspector's Report, 2002. What seems evident from interviews with staff conducted for both JL investigations is that staff valued the Outreach support.

11.12 I do however agree with Dr. Cumming that there appeared to be a gap in the service provision. JL did not appear to need to see a psychiatrist nor a psychologist and his risk was being managed, but no service existed to deal with the problems underlying his sometimes erratic behaviour. JL appeared to require support with social relationships rather than mental health intervention, as his crises were mainly triggered by concerns about his family and the relationship with his girlfriend. A great deal of social support was provided by the Chaplaincy, but JL might have also benefited from Probation Service support or counselling in resolving the family relationship problems.

**Recommendation: A specialist service should be available to address the underlying social problems associated with risk of self-harm, where needed, for prisoners identified under ACCT (formerly F2052SH).**

11.13 Dr. Cumming noted that there was a strong element of dependency which JL appeared to use to help him cope. It can be seen that he responded well to support and input from staff that were involved with him. He also responded well to the support and presence of other prisoners and specifically requested a particular person to share a cell with him (who it is thought was of a similar cultural background). Incidents of crisis seemed to occur when he was not receiving support, particularly from his girlfriend, as mentioned above. Although JL continued to receive support after the closure of the F2052SH, frequency of contact was much reduced, and may have had a negative impact on JL who depended so much on a high level of attention. Although there has been much improvement in aftercare arrangements applied following closure of an ACCT process, this has usually been related to prisoners being discharged from prison or transferring to other prisons. The policy does not appear to cover the closure of the ACCT documentation within an ongoing prison situation and how prisoners such as JL, who have become dependent on the support, can be encouraged to become more independent. Thought should be given to introducing a more gradual withdrawal of ACCT support services, where appropriate, at a pace that is not disturbing to the prisoner.

**Recommendation: Where prisoners can be shown through review to have become dependent on the added support the ACCT process provides,**

**consideration should be given to withdrawing the process more gradually as part of the closure plan.**

11.14 Suicide Prevention Policies are highly detailed and it is necessary that they are specific and unambiguous in the instructions they give. These detailed top-down formal policy documents are not however easily referred to by a Prison Officer working on a busy residential unit. In conducting the current Independent Investigation it was evident that Officers did do the right thing when faced with a near-death in custody, and their prompt and proper actions saved the life of JL. Most of the Officers interviewed in 2002 were however unable to quote the number and location of the policy document in question and few admitted to reading it, although they were able to act responsibly when required. Suicide Prevention Policy is one of many policies with which they are required to be familiar. It is not the function of this Investigation to make suggestions for change to the current Prison Service system of policy development, but it is suggested that attention should be drawn to simplifying the instructions and policy dissemination to Prison Officers, drawing on skills-based training.

**Recommendation: Methods of translating Formal Policy Documents into accessible and simplified instructions for Prison Officers using skills-based training methods should be developed.**

11.15 Although core records had been retained following the Internal Investigation, 2002, a great deal of time was spent in searching for more general prison records, such as occurrence books, control room logs and records of visits. It is recommended that these should be more systematically archived and locations recorded to assist future reference.

**Recommendation: Archived records in accordance with PSO 9020 should be more clearly indexed to facilitate future investigations.**

11.16 I would finally like to commend the residential unit Officers and the HCC staff who attended the attempted suicide scene for all their efforts in supporting, removing the ligature and resuscitating JL. It is evident that, if not for their efforts, JL would not be alive today. Although the after-effects of JL's attempted suicide should not be minimised, in a recent interview with JL and his mother as part of this Investigation, both said that they were very pleased that JL had been saved, and that JL is now trying to re-build his life.

## Recommendations

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- 1. It is noted that the Internal Investigation, 2002, recommended attendance by the Chaplaincy at F2052SH (now ACCT – Assessment, Care in Custody and Teamwork) reviews both locally and nationally, and this recommendation is supported. In cases where drug abuse is involved a CARATS representative should also attend, and Education staff should be invited to attend or make a contribution to the review, where prisoners are attending education classes.**
- 2. The CARATS teams should record information about their interviews with prisoners in unit history sheets, and share assessments with staff who are managing prisoners, particularly when an ACCT (formerly F2052SH) process has been opened. These records should be available when required for any future investigations.**
- 3. A specialist service should be available to address the underlying social problems associated with risk of self-harm, where needed, for prisoners identified under ACCT (formerly F2052SH).**
- 4. Where prisoners can be shown through review to have become dependent on the added support the ACCT process provides, consideration should be given to withdrawing the process more gradually as part of the closure plan.**
- 5. Methods of translating Formal Policy Documents into accessible and simplified instructions for Prison Officers using skills-based training methods should be developed.**
- 6. Archived records in accordance with PSO 9020 should be more clearly indexed to facilitate future investigations.**

## 12. Glossary of Abbreviations and Terminology

F2050	Main Core Prison Record
F2050A	Information of Special Importance
F2052A	Unit History Sheet for individual prisoners
F2052SH	Self-harm at risk form (part of the process of special supervision and care for those prisoners who are at risk of self-harm, or following an incident of self-harm)
ACCT F2052SH)	Assessment Care in Custody and Team Work (Successor to
CARATS	Counselling, Assessment, Referral, Advice and Throughcare Services (External agency assessing and advising prisoners who have drug or alcohol problems)
Code 1	Alarm call for assistance to help with a serious suicide attempt
FME	Forensic Medical Examination
HCC	Health Care Centre
HMYOI	Her Majesty's Young Offenders Institute
IEPS	Incentives and Earned Privileges Scheme (A reward system that links access to enhanced facilities with the willingness of offenders to address their offending behaviour)
IIS	Inmate Information System
IMR	Inmate Medical Record
LIDS	Local Inmate Database
Listener	Samaritan trained prisoners who provide confidential emotional support to prisoners who are at risk of self-harm
MDT	Mandatory Drug Test
Officer	Prison Officer
OSG	Operational Support Grade
Outreach	Keyworkers, with mental health training, appointed to work between the Health Care Centre and residential units to support staff in managing prisoners on normal location, who are at risk of self-harm, or who have mental health needs
PO	Principal Prison Officer
RMN	Registered Mental Health Nurse
Safe cell	Modified prison cell designed with fittings to reduce the opportunities for suicide, while retaining an environment that is as normal as possible
SCOP	A Prison Service Headquarters Policy Group i.e., Safer Custody and Offender Policy Group
SIR	Security Information Report
SO	Senior Prison Officer
SPC	Suicide Prevention Coordinator, with primary role to implement, co-ordinate and evaluate the Establishments Suicide Prevention Policy

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We would like to thank all of those with whom we came into contact in conducting this Investigation; without exception they were extremely helpful and co-operative. We appreciated the efforts of staff at Feltham who went out of their way to facilitate our Investigation and answer our questions. Special thanks go to Mick Cowan who acted as our point of contact at Feltham and ensured that any requests were attended to, and Russell Cole, the Chairman of the Feltham Branch of the Prison Officers Association, who advised us about staff from 2002 who were still at Feltham, and how we could make contact with Officers who had retired or transferred to other establishments. We very much appreciated the support we received from Health Care Centre Staff who provided us with office accommodation, working facilities, and escorted us when necessary to different parts of the prison. Thanks are also due to JL himself, his mother, Mrs. L., and the Manager of the Community Rehabilitation residence, who added an important dimension to the Investigation. Their balanced view of events and their positive outlook do them credit.

## Annexes

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1. European Convention for the Protection of Human Rights and Fundamental Freedoms. Article 2 – Right to life
2. Instruction to Governors, 1/1994, Caring for the Suicidal in Custody. (Policy on Suicide and Self-Harm, including F2052SH, in 2002)
3. Instruction to Governors, 79/1994 – Additional guidance on Caring for the Suicidal in Custody
4. Caring for the Suicidal in Custody – Guide to policy and procedures. Booklet, with introduction by HM Prison Service Director General, 1997
5. HMYOI Feltham Local Suicide Prevention Policy (Guide to procedures for staff). January 2002
6. Health Care Standing Order 13
7. ACCT Policy. PSI 18/2005 and PSO 2700 Suicide Prevention and self-harm management
8. Prison and Probation Ombudsman Guidance on Completion of Investigations
9. Prison Service Order 3630. Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS). 2002
10. Reducing Self-harm and Suicide in Prisons: Advice for Prison Staff on Using Safer Cells. Jill Dando Institute of Crime Science, University College London. (Extract, undated)
11. Report of the D Inquiry. Prison and Probation Ombudsman, 2008
12. The Zahid Mubarek Inquiry. Summary Report, 2006
13. Commission for Racial Equality submission to Phase II of the Zahid Mubarek Inquiry
14. Report of a Full Announced Inspection of HMYOI Feltham, by HM Chief Inspector of Prisons, January 2002
15. HMYOI Feltham Board of Visitors Annual Report, 2001-2002
16. Final Report of a Combined Standards & Security Audit carried out at HMYOI Feltham between 7 and 23 May, 2002
17. Court of Appeal Judgement. C1/2006/2464. Respondent JL. Appellant Secretary of State for the Home Department
18. High Court of Justice, Queen's Bench Division. Approved Judgement. C0/2328/2009 before Lord Justice Laws. JL v SSJ [2009] EWHC Admin 2416. Hearing date 22 and 23 July 2009.

### **Restricted disclosure**

19. Prison Service Investigation Report and annexes, ISS REF. 600/02, completed 16 October, 2002
20. Transcripts of interviews for Prison Service Investigation, 2002
21. Transcripts of interviews for the Independent Investigation, 2008-2010
22. Extracts from HMYOI documents:
  - SIR (Security Information Record)
  - Cell movement record
  - Unit Occurrence book
  - Control Room log
  - Mandatory Drug Testing Records
  - Report from Medscreen re random mandatory drug test
  - Chaplain's Journal
  - Orderly Officer Log
  - Board of Visitors (now Independent Monitoring Board) rota diary, minute of monthly meeting, 21 August, 2002.
  - Education report
23. Clinical Psychologist's letter, 11 November, 2002  
Clinical Psychologist's report, 9 January, 2003