Report of Stage 2 of an Investigation

under Article 2 of the European Convention of Human Rights

into the case of JL

Selena Lynch

12 July 2011

ARTICLE 2 INVESTIGATION IN RE JL – STAGE 2

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Executive Summary

Introduction

1. This report is the second and final report of an investigation commissioned by the Secretary of State for Justice into the case of a young man referred to as JL, who hanged himself at HM Young Offenders Institution (HMYOI) Feltham on 19th August 2002. He was rescued but suffered an enduring brain injury.

2. This report can be read alone but is better read in conjunction with that of Professor Cynthia McDougall who conducted the first stage of the investigation. Her report, delivered in May 2010, includes a broader and more detailed examination of the context in which JL hanged himself.

3. I was asked to conduct a public hearing appropriate to the circumstances of the case and to produce a report based upon the evidence and submissions made by JL's representatives and the Secretary of State for Justice, the parties to the investigation.

4. I explored the facts leading to the hanging and considered whether lessons might still be learned from those facts. I looked at the actions of individuals, and the systems and policies for the care and management of prisoners at risk of self-harm and suicide in 2002 and 2011.

5. The passage of time has imposed limitations on what can be achieved, and some allowance must therefore be made to those whose actions or omissions I have criticised.

The facts

6. JL entered the UK as an illegal entrant from Jamaica in March 2002 to join his girlfriend. Their young daughter, who remained in Jamaica with JL's mother, suffered from a serious medical condition. She was often referred to as his wife.

7. JL was remanded in custody to HM Young Offenders Institution on 19th July 2002 having been charged with serious drugs offences. He was identified as being at risk of self-harm and made the subject of an F2052SH, a Self-Harm at Risk Form that could be raised by any member of staff who was concerned about a prisoner.

8. On 31st July 2002 JL claimed that his daughter had died, and a noose was found in his cell. It was soon discovered that his child was alive. He explained to the Assistant Chaplain that he was stressed out and worried about being in prison, about his children's well being and that his child could die. He had become upset after hearing that his girlfriend could not visit, and *"one thing led to another".*

9. On the 8th August 2002, the F2052SH form was closed at a case review with JL and a nurse.

10. In the early hours of 19th August, JL rang the cell bell several times. He told the night duty Operational Support Grade (OSG) that he wanted to see a doctor or nurse but he would not give his name or a reason. The OSG was inexperienced and new to the Unit. He observed that JL had a piece of sheeting around his neck but assumed it was being worn as a scarf of some sort, perhaps because of a sore throat. He telephoned the duty nurse who would not attend the Unit without more information. (It has not been possible to obtain an account from the nurse concerned.)

11. The OSG became aware of the prisoner's name before the end of his shift. He wrote *"constant abuse of cell bell"* in the Observation Book and history sheet. He did not mention the request for the nurse or the sheet around JL's neck.

12. On 19th August 2002, whilst his cellmate was at education, JL hanged himself from his cell bars using a ligature made of sheeting. He was discovered and rescued by an Officer because another prisoner asked to visit him. It may be that the visit was arranged as part of a plan, but it could equally have been a fortunate coincidence.

13. It is not possible to determine whether JL intended to end his life or not. He was far from home and worried about his sick child and the relationship with his girlfriend. He was anxious about the charges against him and found it difficult to understand the legal process. He was often disruptive and demanding, and was not attending regular education or employment. These aspects are seen in many young prisoners but JL stood out, and there were warning signs of his potential for self-harm, whether as a gesture or otherwise.

Conclusions

14. The organisation and management of any custodial institution is complex and involves broad political and societal issues. It can be difficult to identify those who require special measures except with the benefit of hindsight.

15. Many aspects of JL's care were commendable: the decision to place him on an F2052SH; the support offered by the Chaplaincy; the thoughtful and sensitive manner in which some Prison Officers often engaged with him, and the competent efforts to resuscitate him.

16. Nevertheless, based upon the available evidence, there were cumulative and collective failures in the management of JL's care which may have contributed to or failed to prevent his actions on 19th August 2002. The principles and procedures set out in national and local policies for the prevention of suicide and self-harm were not fully applied, and opportunities to rectify errors and omissions were not taken. Poor communication and errors of judgement created the context in which JL came to harm himself.

Failure to appoint a Personal Officer

17. There is no evidence that JL had a Personal Officer. Such an Officer could have given additional support to JL and acted as a point of liaison for those involved in his care. Critically, he or she might have been able to notice and rectify other failures, and to implement the Support Plan created when the nurse closed the F2052SH.

Failures in the management of the F2052SH and the role of Outreach

18. There was a failure to adopt a multidisciplinary approach in managing the F2052SH, in breach of national and local policies. The residential unit and the Chaplaincy, both of whom were closely involved in caring for JL, were not sufficiently involved in reviews or decisions.

19. The management of the F2052SH was largely carried out by the Outreach team; a small group of workers with mental health training (no longer in place at HMYOI Feltham). Their role was to support staff in the management of prisoners deemed to be at risk of deliberate self-harm on ordinary location, but I agree with Professor McDougall's finding that this led to

20. Professor McDougall was of the view that Outreach had concentrated on risk management rather than therapy and I agree with this assessment. They failed to involve JL's family in his care or to investigate the underlying reasons why he lied about his child dying. They failed to implement or manage the Support Plan after closure of the F2052SH or to support the staff in their management of JL.

    The closure of the F2052SH

21. The failure to adopt a multidisciplinary approach was most apparent in the closure of the F2052SH following a meeting between a nurse and JL. There was little continuity of care, because the nurse had not been closely involved with JL. He failed to check the facts, so that his decision was based on false premises. It is difficult to establish the reason why the form was closed in this way because the nurse was not spoken to at the time and cannot now be found. It is possible that he was sceptical about JL's vulnerability and there may have been resourcing issues. It is a matter of record that the Outreach team was understaffed in 2002.

    Failure to implement the Support Plan

22. If proper procedures had been followed, the F2052SH might in any event have been closed on 8th August 2002, and it was open to any member of staff or visiting agency to open another form at any time. However, the lack of consultation and the failure to implement and/or monitor the Support Plan meant that other members of staff were not fully informed of JL's situation, and JL was not given the support he needed.

    Perception of JL as manipulative

23. The failure to appoint a personal officer and to adopt a multidisciplinary approach meant that JL's behaviour was increasingly judged as manipulative. He began to lose the sympathy and objectivity of the staff at a time when he was reaching a crisis and required additional support.

    The night before the hanging; the night-time OSG and the nurse

24. The night time OSG failed to act in accordance with his training and policies when JL asked for the nurse and placed a piece of sheet around his neck. The OSG should have tried to persuade the nurse to attend, particularly once he discovered JL's identity. In the absence of a favourable response he should have opened an F2052SH and passed it directly to the Night Orderly Officer whom he could have telephoned for advice at any time. He failed to write a proper note about the events of the night or to give a full handover to the day staff. His single comment about abuse of the cell bell simply added to the perception of JL as manipulative, rather than raising the sort of concern that would have led to protective measures.

25. I am satisfied that the OSG did in fact speak to a nurse and, although the nurse has not been spoken to, it is accepted by the parties that she should have attended. I would also add that the OSG did not act out of malice, more perhaps as a result of his inexperience and perceived isolation.

Learning the lessons and suggestions for review

26. The failures I have identified were largely individual rather than systemic, but that is not to say that lessons cannot be learned in the organisation and management of custodial institutions, and the selection and training of staff.

27. The prevention of suicide and self-harm is now the subject of Prison Service Order 2700 (Suicide Prevention and Self-Harm Management), and HMYOI Feltham has a local policy which complements the national policy. These provide instructions on identifying and providing care and support for prisoners at risk. The errors and omissions in JL's care are less likely to occur within this new regime.

28. I do not find it necessary or appropriate to make recommendations, due to the facts of the case itself, the passage of time, and the many changes made since 2002. However, there are three areas where I would suggest a review of current guidelines and policies:

    Handovers - the Observation Book

29. Communication failures are frequently seen in the investigation of any adverse incident. Taken with oral handovers, the Observation Book is an important resource in providing staff with what may be vital information about all the prisoners in their care, whether subject to special measures or not. I was told that it is not a formal requirement for staff to read and sign the Observation Book when coming on duty. I have suggested that there should be a review of handover procedures to consider whether further guidance is appropriate.

    Foreign nationals and phone cards

30. I heard that foreign nationals are given phone cards worth £5 each month so that they can make contact with their families. These are only provided if the prisoner is not receiving visits. A member of the Chaplaincy was concerned that this prevented prisoners from having sufficient contact with their families, who might be a valuable source of support. I was told that the system has some flexibility, as was indeed the case for JL, but the policy seems somewhat arbitrary and worthy of review.

    Cell sharing

31. The issue of cell sharing arose in a rather oblique fashion in the investigation, the detail of which can be found in the body of the report. There is scope for including cell sharing as a supportive measure within the present system, but the focus of the Feltham policy is on the risks of sharing rather than the benefits. I would welcome a review of the current policy on this issue.

Selena Lynch
12 July 2011

Glossary

SL A2-43	This report, Annex 2, page 43
CMcD A2-43	Professor McDougall's report, Annex 2, page 43

ACCT	Assessment, Care in Custody and Teamwork Plan. The care planning system used to help to identify and care for prisoners at risk of suicide or self-harm.
Association	Prisoners' recreation and association period
BOV	Board of Visitors, now the Independent Monitoring Board
CARATS	Counselling, Assessment, Referral, Advice and Throughcare Services
CAREMAP	Care and Management Plan, part of the ACCT
Chaplain's Journal	The Chaplaincy kept journals in 2002, separate books for Roman Catholic, non-Catholic and Muslim prisoners. Kept in the Chaplain's office, not accessible to prison or medical staff.
CNA	Certified Normal Accommodation
ECHR	European Convention on Human Rights
F2052A	Record of events for individual prisoners, also referred to as the history sheet or flimsy. Available to all prison staff, now accessed only via a computer.
F2052SH form	Self-Harm at Risk Form accessible to all staff and kept (by staff) with the prisoner at all times unless and until it is closed. The form is no longer in use and has been superseded by the ACCT Plan.
Flimsy	See F2052A
HCC	Health Care Centre
HCO	Health Care Officer
HMYOI	Her Majesty's Young Offenders Institution
History Sheet	See F2052A
Hotel 9	The code for the nurse on duty
IDRC	The International Dispute Resolution Centre (at which the 2011 hearings were conducted)
IEP	Incentives and Earned Privileges (also called the rewards and sanctions scheme)
IMR	Inmate Medical Record contains in particular the Continuous Medical Record, only available to medical staff
Listener	Prisoner volunteers trained by Samaritans to provide confidential support to other prisoners
MDT	Mandatory Drug Test
NOMS	National Offender Management Service

Night Orderly Officer	Night duty Principal Officer responsible for ensuring the prison regime is running correctly and responsible for the management of incidents
OL	Ordinary location
OSG	Operational Support Grade – supports prison officers in carrying out their duties
OSRR	Offender Safety, Rights and Responsibilities Group (within NOMS)
Observation Book	Sometimes referred to as the Occurrences Book. Available to all staff on each residential unit. Entries are made about significant events for all prisoners and general observations. It is still in hard copy form requiring no computer access.
Outreach	Small team of workers with mental health training (usually nurses) working between the HCC and residential units to support staff in managing prisoners on normal location deemed at risk of self-harm or with mental health needs.
P-NOMIS	Prison-NOMIS. HM Prison Service's computerised system
PO	Principal Officer
PSO	Prison Service Order (e.g. PSO 2700)
RUM	Residential Unit Manager
SO	Senior Officer
SOVA	Supporting Others Through Volunteer Action, a registered charity
SPC	Suicide Prevention Coordinator
SSJ	Secretary of State for Justice
YJB	Youth Justice Board
YOT	Youth Offending Team

1. Introduction

1.1 JL was 20 years old when he was remanded in custody to HM Young Offenders Institution (YOI) at Feltham on 19th July 2002. He was identified as being at risk of self-harm and made the subject of an F2052SH, a Self-Harm at Risk Form that could be raised by any member of staff who had concerns that a prisoner may be at risk of suicide or self-harm. The form was closed on 8th August 2002. On 19th August 2002 JL was found hanging in his cell. In spite of effective resuscitation he suffered an enduring brain injury. In order to preserve his privacy, he has been referred to as JL throughout the Inquiry.

1.2 In 2008 the Secretary of State for Justice (SSJ) initiated a two stage investigation to comply with the State's investigative obligation under Article 2 of the European Convention on Human Rights (ECHR). Professor Cynthia McDougall was commissioned to conduct the first stage in which she examined the management of JL by HM Prison Service and considered what lessons in respect of current policies and procedures could usefully be learned.

1.3 On 19th August 2010 I was commissioned to conduct the second stage of the investigation: to hold public hearings at which JL and the SSJ would be able to participate. *(The terms of reference are dealt with below in para 3.1.)*

1.4 There are two parties in the investigation: the Secretary of State for Justice (SSJ) and JL. The SSJ is represented by Charles Grant from the Treasury Solicitors and Cathryn McGahey of Counsel. JL is represented by Saimo Chahal from Bindmans solicitors, and Jenni Richards QC.

1.5 The reports and Court proceedings thus far have used the word "suicide" in relation to the actions of JL on 19th August 2002. This word bears a special meaning and a high standard of proof. To commit or attempt to commit suicide a person must carry out a deliberate act for the purpose of and with the intention of ending his or her life. Other reasonable possibilities must be ruled out. As I have set out in paragraph 11.8 below, I have not been able to determine whether JL intended to end his life and, for that reason, I will refer to his actions without using the word "suicide". Whilst it may be important to use appropriate language, it does not detract from the principles of care. Self-harming behaviour without suicidal intention is rightly identified by the Prison Service as a risk that requires care and management, because it too can have fatal and near fatal consequences.

2. Background

2.1 Article 2 of the European Convention on Human Rights provides that everyone's right to life shall be protected by law. This includes investigative obligations, and the case of JL was one of several cases in which the Courts were asked to consider the threshold and scope of those obligations when prisoners suffered serious injury or near death. The development of the case law has created challenges in meeting the requirements of promptness and effectiveness in this case.

2.2 In 2002, the Prison Service instructed a retired Prison Governor (Prison Service investigator) to carry out an investigation into the near death of JL. His report was completed in October 2002 but not disclosed to JL's representatives until 2005. They successfully applied to the Administrative Court for a declaration that an independent investigation should be carried out to satisfy the requirements of article 2. *(R(JL) v Secretary of State for the Home Department [2006] EWHC 2558 (Admin)).* The SSJ appealed to the Court of Appeal.

2.3 In 2006, the Court of Appeal heard the case of D v SSJ, about a prisoner who sustained severe brain damage as a result of hanging himself in his cell. (*R(D) v Secretary of State for the Home Department (INQUEST intervening) [2006] EWCA Civ 143).* The Court held that an independent investigation was required to satisfy the requirements of article 2, and declared that the inquiry should be held in public; and that D's representatives were entitled to have access to relevant evidence in advance, to attend the hearing and make representations as to the matters on which the witnesses should be examined, and to be adequately funded. This was later referred to as a "D type investigation".

2.4 In 2007 the Court of Appeal dismissed the SSJ's appeal in the case of JL. *(R(JL) v Secretary of State for the Home Department [2007] EWCA Civ 767).* The Court held that the simple fact of a death or serious injury of a person in custody gave rise to an obligation on the State to conduct an enhanced investigation, and that a D type investigation was required. The SSJ appealed to the House of Lords as to the form the inquiry should take but agreed that a D type investigation into the near death of JL should take place.

2.5 So it was that Professor McDougall began her investigation in 2008, six years after the events occurred. The evidential trail was already cold; some documents were no longer available, significant witnesses could not be found, and others had little recollection of the events of 2002, SL A3-1.

2.6 For the sake of completeness, I should say that the House of Lords dismissed the appeal in JL; the near-suicide of a prisoner in custody that leaves the prisoner with the possibility of a serious long term injury automatically triggers an obligation on the State under article 2 to institute an enhanced investigation. The form of the investigation would vary according to the circumstances. *(R(JL) v Secretary of State for Justice [2008] UKHL 68)*.

3. Terms of reference - purpose and scope of Stage 2

3.1 My terms of reference (as amended) are set out in a letter dated 15th October 2010 from Pat Baskerville, Head of Offender Safety Rights and Responsibilities Group (OSRR) within the National Offender Management Service (NOMS). Put briefly: to conduct a public hearing appropriate to the circumstances of the case; to consider further representations from JL or the SSJ; to consider whether further lines of inquiry should be explored or witnesses interviewed, and to produce a report.

3.2 It is beyond the scope of the investigation to explore and/or pass comment on wider issues, some of which are complex societal and political issues (for example; diversion from custody).

3.3 Consideration of civil or criminal liability falls outside the scope of my investigation, and individuals whose acts or omissions are criticised have been given an opportunity to comment.

3.4 The SSJ agreed to a public hearing in this case at a time when arguments on the appropriate form of investigations continued in the Courts. It is probable that investigations will be carried out in a different way in future as a result of the guidance given by the House of Lords. Whilst the parties were largely agreed on the issues to be explored, I had a sense of uncertainty as to the purpose and aims of the report, but thanks to the cooperative and helpful approach of the parties I have made what I hope is the best use of the material garnered during Stage 2.

3.5 My primary task was to carry out a public hearing appropriate to the circumstances of the case and to allow JL to participate in that process, and to hear submissions from both parties. In my view, the purpose of this report is to explain what has emerged or occurred since Professor McDougall's report, to set out the facts leading to the injury to JL as far as possible in the light of all the evidence, and to see whether lessons can be learned from those facts. This means examining the regime (as it then was) for the care of prisoners at risk of harming themselves, and establishing whether there were relevant errors or omissions in the care of JL by individuals and/or agencies.

3.6 Insofar as errors and omissions may have occurred, I have considered whether they might still occur today. It is not within my remit to examine the current regime in detail, and I have confined myself to matters relevant to JL.

3.7 It is not my role to repeat the work of Professor McDougall or to carry out a detailed evaluation or comparison. Nevertheless, some duplication and repetition is unavoidable in order to make the report comprehensible, and there are areas where further evidence has emerged or where my interpretation differs in some respects. I will not set out small differences in the chronology as that may serve to obscure the central issues.

4. Structure of the report

4.1 This report is best read in conjunction with that of Professor McDougall. For ease of reference, I have attached her report at Annex 3, but have not included the annexes.

4.2 Professor McDougall was unable to obtain some important prison documents (e.g. CARATS and time out of cell records e.g. education), and what remained was somewhat muddled. In order to assist the witnesses I extracted the documents I considered relevant and put them in the order in which I think they would have been in 2002, (SL A1).

4.3 I have elected to eschew footnotes, using instead an abundance of bracketed notes and references.

5. Methodology

5.1 Independent administrative support was arranged by NOMS by the provision of Personal Assistants to the Inquiry. PA1, dealt with correspondence, administration, and the planning and organisation of the public hearings. Her colleague, PA2, provided additional support from time to time.

5.2 A case management meeting was held at the offices of the Treasury Solicitors on 1st October 2011 to discuss the scope of the investigation and the arrangements for the hearing.

5.3 There was some measure of agreement as to the way in which the hearing should be conducted. Oral testimony was only required from witnesses who had not previously been interviewed, or from whom further detail or clarification was required. The passage of time meant that there was little value (or fairness) in calling all the relevant witnesses. Submissions would be made at the hearings and in writing.

5.4 Relevant issues were also identified, to include the operation and management of the F2052SH system, the management of JL particularly during the night before the incident, access to psychiatric assessment and counselling, staffing levels, training, and liaison between medical and residential staff.

5.5 Later it was agreed that certain areas needed no further exploration, namely: the context in which the events occurred, an allegation of rape, issues of race, and issues related to resuscitation. These matters were very fully and adequately dealt with by Professor McDougall in Stage 1. Professor McDougall commended the staff for the way in which they acted promptly and professionally in rescuing and resuscitating JL. I agree with her comments; there can be no doubt that JL would have died but for their efforts.

5.6 Public hearings took place over four days at the International Dispute Resolution Centre (IDRC) in Fleet Street, London on 10th-12th January and 11th March 2011 where I took unsworn evidence from ten witnesses. Seven of them had dealt directly with JL. I heard also from Dr Cumming, a consultant psychiatrist who had acted as independent adviser to Stage 1, the current Governor 1, and DPSM B, a Developing Prison Service Manager, who told me about Feltham today.

5.7 In accordance with the commission the parties were not permitted to ask questions directly of the witness, but had an opportunity to make representations on questions to be put by myself. This was rather awkward at the outset but in the event it served to focus the questions and made the evidence easier to follow and assess. The proceedings were recorded.

5.8 A list of witnesses and other personnel can be found at SL A14. This provides a quick reference to the role of the individual and to the location of interviews and reports. There are no transcripts of evidence for the IDRC

5.9 I have given two individuals an opportunity to comment upon criticisms of their conduct contained in this report, and have taken account of their representations. Unfortunately I was not able to do this in respect of two nurses, who cannot now be found.

5.10 I prepared a file (SL A1) containing the prison documents in what I deemed to be a helpful order, removing duplication and bringing together documents found in the reports of the Prison Service investigator and Professor McDougall. As the originals were mainly unavailable the pagination is rather confusing, so my pagination is contained in a square box at the foot of each page. I have used that system for the annexes where necessary.

6. A note of caution: the limitations of Stage 2

6.1 The requirement of promptness in any investigation is for good reason. The passage of time in the case of JL imposed limits on what could be achieved, creating insurmountable problems in places. The internal prison investigation, though timely, focused primarily on the finding of JL and the efforts to resuscitate him. Important witnesses do not appear to have been seen. By 2008 some documents were unavailable, potential and important witnesses could not be identified or found, and it was clear that most witnesses had little recollection of the events beyond the records made at the time. This makes it difficult to assess the credibility and accuracy of witnesses and to establish a full and accurate account of JL's time at HMYOI Feltham.

6.2 As a consequence, the findings of both stages of this investigation are largely based and reliant upon the written records that can be found. It almost goes without saying that the documents cannot tell the whole story.

6.3 Several key individuals could not be found or had no recollection of the events of 2002. Officer C, an officer who has since left the service, declined to give evidence. She told one of the Personal Assistants that she was concerned about her health and career. In an email to PA1, she said she appreciated that she might have some helpful information as she did remember the incident, but had concerns as to how it could affect her due to her reasons for leaving the service. She made some general comments critical of the Prison Service and agreed that the contents of her message could be disclosed to the parties if she could be granted anonymity. I was unwilling to accede to her request. The parties agreed that the matter would have to rest there as the only way of forcing her attendance would be to convert the investigation to an Inquiry under the Inquiries Act 2005, viewed as disproportionate in all the circumstances.

6.4 It is a matter of regret that I could not persuade Officer C to attend because she seems to have taken an interest in JL throughout his time on Osprey and was apparently on duty on the day of the hanging. Her email is not annexed to this report as it is irrelevant to the case of JL.

7. Further inquiries

7.1 I made some additional inquiries, mostly without a satisfactory outcome:

7.1.1 It was clear from the papers that JL was troubled by the charges against him. I attempted to trace the solicitor representing JL in the criminal proceedings at the time but the records were no longer in existence and he/she could not be identified.

7.1.2 I renewed efforts to find the nurse who closed the F2052SH form. Nurse D was employed as an agency nurse by the West London Mental Health Trust, which was contracted to provide staff to Feltham. It was rumoured that Nurse D had retired or returned to Australia. No note could be found of his details either within the Prison Service or the Trust, and the Nursing and Midwifery Council had no record of his registration.

7.1.3 I recalled an Inquest in 2003, in which the topic of shared cells had been raised in a Rule 43 report to the Prison Service *(Rule 43 of the Coroners Rules 1984 provided for a coroner to make a report to the appropriate authority if he believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which an inquest was held. The Rule has since been amended).* I have discussed this later in Chapter 14.

8. The internal investigation and Stage 1 of the Article 2 investigation

8.1 Internal investigation 2002 – Prison Service investigator

Just over three weeks after the hanging, the Area Manager instructed a retired prison Governor, to carry out an investigation. The terms of reference were wide and perhaps over-ambitious given the time allowed. The Prison Service investigator's team interviewed fellow prisoners, the officer who found and rescued JL, and other officers involved in the resuscitation.

8.2 The Prison Service investigator considered a letter from Reverend E on behalf of the Chaplaincy, and a report from PO F about his interview of OSG G, who had a significant exchange with JL during the night before the hanging. He also saw a number of people whose interviews were not recorded or summarised: a member of the Board of Visitors (BOV), Probation Officer, Chaplain and Suicide Prevention Liaison Officer.

8.3 The Prison Service investigator completed his investigation in a little over a month and submitted his report on 16 October 2002. He found a number of omissions: some members of staff had not read the suicide prevention policy though it was readily available; posters and notices were not properly displayed, members of staff were not aware of how to find the minutes for Suicide Prevention Management Team meetings; there was a shortage of Listeners, and training figures did not meet the national requirement. (Listeners are Samaritan trained prisoners who can provide confidential support to prisoners.) The Prison Service investigator spoke of extreme staff shortages in 2002 leading to a failure to meet national requirements on training with only 182 staff of all disciplines trained or refreshed.

8.4 I make no criticism of the Prison Service investigator, who conducted a wide-ranging investigation in a short period of time, but it is unfortunate that several significant individuals were not apparently seen in these early days. The Schedule of witnesses and significant personnel at SL A14 may demonstrate the problem.

8.5 Article 2 Investigation, Stage 1 – Professor Cynthia McDougall 2008

8.5.1 Professor McDougall was asked to examine the policies and practices applicable in 2002, and she set out the context in which JL's hanging occurred at paragraph 3 of her report, (CMcD para 3, page 20). In 2002 HMYOI Feltham was an institution undergoing significant changes following the murder of Zahid Mubarek by his cellmate in March 2000. Improvements had been made by 2002 (described by Father H as a "cultural change"), and there is no doubt that further progress has been made in the intervening years.

8.5.2 The Professor set out a detailed account of JL's background and the history of his time in Feltham though, for a variety of reasons, I have not been able to avoid repeating the exercise in my chronology at

8.5.3 Dr Cumming, a Consultant Psychiatrist with extensive experience of prison healthcare acted as Expert Medical Advisor to the independent investigation. He did not prepare a formal report but his notes were made available to the parties, and he gave evidence at the IDRC.

8.5.4 Professor McDougall found that JL's management was mainly well intentioned without any evidence of deliberate harm or neglect, and that Prison Service policies were largely met save in respect of the closure of the F2052SH.

8.5.5 She made some observations about the services provided by Outreach, a small group of workers with mental health training working within the Health Care Centre *(see para 9.3.4 below).* She suggested that they were concentrating more on managing risk than examining underlying issues, and that their remit encouraged a tendency for prison staff to overlook their own role in suicide prevention.

8.5.6 She made six recommendations, (SL A3 para 11, p.78). The SSJ has accepted all the recommendations in principle, and has provided me with a schedule of responses, (SL A13).

9. The care and management of prisoners at risk of self-harm and suicide, nationally and at HMYOI Feltham, 2002

9.1 2002 National policies

These are set out by Professor McDougall and annexed to her report. I set out below some extracts that are relevant to JL for the purpose of this report:

Instruction to Governors 1/1994 (CMcD A2)

Issued 3.2.94, implementation 1.4.94, expiry 31.3.99

"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 and self-harm".

These instructions effectively introduced the Self-Harm at Risk Form F2052SH which could be raised by any member of staff who was concerned about a prisoner being at risk of suicide or self-harm. The aims of the policy included providing activities, enabling prisoners to maintain home and community ties, and working in partnership with families. Closure of an F2052SH form was to be by a "unit manager" when the *"prisoner appears following a case review to be coping satisfactorily".*

Instruction to Governors 79/1994 (CMcD A3)

Issued 24.11.94 for immediate implementation

This provided additional guidance, including guidance on the use of shared/supervised accommodation: *"When a 2052 is raised … it is essential that the decision on the most appropriate location is made on the basis of the individual's need and not simply available accommodation. Every effort will be made to place at risk prisoners in shared and/or supervised accommodation. Where this is the case, a monitoring procedure must be in place to ensure that the at risk prisoner is not left on his/her own e.g. following the transfer or production at court of his/her cell mate".*

Caring for the suicidal in custody. Guide to Policies and Procedures 1997

From the Policy Section Part 1: (relating to prisoners in general, not just those on 2052 forms):

"The residential unit must be supported by a network of other staff who may have a particular contribution to make at various times: health care staff, probation staff, chaplains, psychologists and others. Outside agencies such as the Samaritans and Prison Visitors can also offer support if the prisoner wishes. Regular contact with the family is vital, provided that this relationship has not broken down irretrievably.

… Health care services play a key supporting role. Screening for psychiatric problems is essential on admission and where there are signs of the prisoner developing clinical illness…
The key to the multi disciplinary approach is communication teamwork and support. This requires thorough procedures and systems of documentation … Decisions on the best way to tackle the problem should be based on consultation between those involved. There must be proper feedback to ensure that staff in contact with a prisoner at risk are aware of the situation, and those with responsibility for supervising and supporting the prisoner, including others prisoners – must themselves be supported."

From Part 6: identifying prisoners at risk:

'"Malignant Alienation' – angry uncooperative prisoners may be just as much at risk of suicide as those who are depressed … attitudes of others become critical and judgemental. The individual is perceived as difficult, manipulative or over-dependent, loses the sympathy and support of others and becomes socially isolated. Of course prisoners may sometimes earn criticism of this kind but it is essential to review their behaviour as objectively as possible."

Part 7: Supporting Prisoners at Risk:

"As soon as a prisoner has been identified as potentially 'at risk' a team should be mobilised to assess the underlying problem and come up with a support plan to manage the risk and help the prisoner cope. … It is recommended that one 'keyworker' is assigned to spend time with the prisoner and carry out the initial assessment, consulting other staff and departments as appropriate."

9.2 <u>HMYOI Feltham local suicide prevention policy 2002 (CMcD A5)</u>

Issued January 2002 (strictly speaking the national policy had by now expired but the policy contains a statement of national and local policy which suggests it was to be treated as extant). There is no available record of any policy preceding this one, but the Prison Service investigator referred to it being an update, and there may well have been a policy in place prior to January 2002:

"continuity of care is essential to increasing the prisoner's confidence and ability to cope, involve the same people in the case review wherever possible" (page 10).

Points to consider on developing a support plan include: *"allocate an appropriate personal officer".*

"Look to involve the close family and/or friends. It is our policy to involve families in care of suicidal prisoners…..provide access to a visit or telephone call".

"Liaise with specialist departments to provide support i.e. probation, chaplaincy, psychiatric team, sentence planning, medical officer, CARATS

team, detox nurse, family therapist, psychology, prison visitor, Samaritans, SOVA Education department, counselling services".

"Promote a multidisciplinary approach to the review, involve other departments/agencies (i.e. chaplain probation YOT worker)".

"Closure: the decision to close the F2052SH must be the result of a multi disciplinary review completed by the residential unit SO and will normally happen if there is a unanimous decision".

Included in general guidelines :

"(Obtain) positive reports about coping from the unit staff available".

"Residential Unit SO must complete the case review outlining who attends the case review, summary of the review (including the view of the prisoner concerned), any ongoing support that may assist the prisoner this should be clearly recorded and copied into the usual history sheet in flimsy so it can be referred to after the closure of the F2052SH".

Outreach team (p15)

… ."Role is to support staff in their management of prisoners deemed to be at risk of deliberate self-harm on ordinary location".

"The Outreach worker will continue to see the prisoner on an ongoing basis to provide support in partnership with the unit staff. The level of Outreach follow up will be indicated within the support plan and at least on a twice weekly basis" (page 16).

"Families – our policy is to involve families in the care of suicidal prisoners. Visits and other contact with home and the community may provide an important source of support … Domestic worries may of course be part of the prisoner's problem … If the prisoner has a significant relationship with a relative or friend it is worth involving them in drawing up a support plan, keeping them in the picture, and asking them to report important information to staff"… (page 27).

9.3 Support for all prisoners: Outreach, CARATS, Chaplaincy

9.3.1 All prisoners go through a reception process when arriving at Feltham and new prisoners are given an induction course soon after arrival. There were undoubtedly omissions, at least on the papers, in respect of JL's reception and induction into Feltham in 2002. Important questions about self-harm and mental state were not completed on the reception health screen form (SL A1-43), and the induction documentation has not been completed. These failures could represent underlying problems with compliance, training, staffing and monitoring. In my view, the passage of time and lack of causative connection with JL's hanging make it unnecessary to say more.

9.3.2 Prisoners should be allocated a "Personal Officer" and arrangements are made for another officer to undertake that role in his or her absence. There is no record of JL having a personal officer and, as I explain in my conclusions, this is something I view as relevant to the matrix or environment in which JL came to hang himself on 19th August 2002.

9.3.3 The Chaplaincy is divided into three sections: Roman Catholic, non-Catholic and Muslim. They become involved with prisoners from their arrival at prison and offer as much support as the prisoner requires. Their involvement with JL is of particular importance.

9.3.4 Outreach In 2002 a small team of workers with mental health training (usually nurses) worked between the Health Care Centre (HCC) and residential units to support staff in managing prisoners on normal location who were at risk of self-harm or who had mental health needs. The involvement of Outreach is of central importance to the case of JL and I will return to the subject throughout this report.

9.3.5 CARATS (Counselling, Assessment, Referral, Advice and Throughcare Services). This service is provided by an outside agency for prisoners with drug and/or alcohol problems. A representative called CARATS worker I attended upon JL on several occasions but the notes are not available and it seemed a futile exercise to approach him/her in 2010. Professor McDougall recommended that CARATS workers should record information in unit history sheets and share assessments with staff who are managing prisoners. NOMS accepted the recommendation and explained that a CARATS Practice Manual issued in 2004 makes provision for the sharing of information under the new ACCT system (Assessment, Care in Custody and Teamwork, the successor to the F2052SH system. See paragraph 12 below.)

9.3.6 Listeners Samaritan trained prisoners who can provide confidential support to prisoners. Prisoners can also make calls to the Samaritans directly.

9.4 The F2052SH Self-Harm at Risk Form

9.4.1 The form has now been superseded by the ACCT system, but its introduction in 1994 represented an important development in the prevention of suicide and self-harm in prison. A copy of the form for JL is at SL A1-90 and a blank form is at SL A5.

9.4.2 The form could be raised or opened by any member of staff who was concerned about a prisoner's risk of suicide or self-harm. It would, at all times, accompany the prisoner (with staff) at whatever location he might be within the prison.

9.4.3 The presentation of the form guides staff through the requirements of the system, giving useful guidance about identifying, meeting and reviewing the prisoner's needs and demonstrating the system by way of a flow chart. In summary:

- The member of staff opening the form should pass it to the Residential Unit Manager (RUM) or Orderly Officer (or HCC in emergency).
- The RUM or Orderly Officer should decide on a plan of action either to send the prisoner to HCC or keep him on ordinary location (OL).
- If the prisoner was sent to the HCC he should be assessed by nursing staff, then a doctor within 24 hours. He might then be admitted to the HCC with a nursing plan or discharged to the residential unit.
- On ordinary location a case review would be conducted to decide on a support plan and a Daily Supervision and Support Record would be completed.
- The support plan should be specific about what action should be taken, by whom and when; all available resources in the establishment and the community should be consulted, those with relevant information should be consulted, the plan being drawn up in conjunction with the prisoner/other staff/ departments/agencies/family.
- The form sets out ideas for a support plan e.g. *"allocate personal officer or 'key worker', shared cell, involve family"* and a list of people who can help e.g. *"residential staff, chaplaincy, education, psychology, prisoner's family, other prisoners"…*
- Case reviews should normally be held within 72 hours of the form being raised (unless the prisoner was in the HCC), prior to discharge from the HCC, at least every two weeks whilst the prisoner was being managed on ordinary location, in emergencies, and when deciding to close the form.
- The case review record (at page 3 and 4) states: *"the purpose of a case review is to share information on how the prisoner is coping and reach team decisions on what further action needs to be taken to address underlying needs. Case reviews should normally be unit-based and involve other departments as much as possible"* . The form has separate boxes for *"Staff/Depts attending", "Summary of Review", and "Support Plan" and "Staff/Dept responsible"*. It is to be signed by the review co-ordinator.
- The form could be closed when the prisoner appeared to be coping satisfactorily, to be decided at a case review after discussion with the prisoner. The RUM would sign the form on the front cover. (Once closed, the form would be placed in the core record and so not available to the staff at the prisoner's location.)
- A new form could be opened in the event of further concerns.

10. The facts - introduction

10.1 The facts are not very much in dispute, perhaps because the documents often represent the only available evidence. Professor McDougall set out a detailed chronology of JL's time at Feltham, (page 26-43 of her report: SL A3). I had hoped to avoid duplicating her work, but the evidence and submissions received during Stage 2 produced additional material which adds, clarifies or contradicts elements of the chronology. There is little real difference but a critical analysis is not appropriate; instead I have chosen to produce a new chronology, (SL A2). I am grateful to Messrs Bindmans for taking up the challenge of preparing a referenced chronology which provided an invaluable foundation for such a time-consuming exercise.

10.2 Professor McDougall included a timeline in her report (CMcD p43) which is also a useful document (with one small amendment, this is now attached to the chronology, SL A2).

10.3 From this material I have extracted what I consider to be the salient facts about JL's time in Feltham, and from which I have arrived at the conclusions set out in Chapter 11, below.

10.4 <u>Sources of information about prisoners within HMYOI Feltham</u>

10.4.1 There are many documents in an establishment where information about prisoners can be found. Computerised systems are going some way to improve the problems that this can create, but unsurprisingly they create a new set of challenges, to which subject I return later. For the purpose of this report, the primary documents for recording information about JL's care and management by residential and healthcare staff were:

10.4.2 <u>The Record of Events F2052A, often called the "history sheet" or "flimsy"</u>
This will have been available on the residential unit for staff to view and to make entries (including staff and personnel from other departments and agencies e.g. the Chaplaincy). I refer to it as the history sheet throughout. The history sheet still exists, not as a hard copy, but as part of the P-NOMIS computerised system.

10.4.3 <u>Osprey Observations Book</u> (also the Occurrences Book)
Contains entries about all the prisoners on Osprey Unit and can also be accessed by other departments and personnel. It is still used today.

10.4.4 <u>Inmate medical record (IMR)</u>
Kept in the Healthcare Centre (HCC) and can only be accessed by medical personnel. It is still used today.

10.4.5 F2052SH
The Self-Harm at Risk Form referred to in Chapter 9 above (now superseded by the ACCT form discussed in Chapter 12 below). The F2052SH accompanied the prisoner at all times and could be accessed by residential and healthcare staff, and other departments and personnel, such as the Chaplaincy, and CARATS. Once closed, it was returned to the Core Record in the main prison discipline office and would no longer be accessible to staff and others caring for the prisoner.

10.4.6 Chaplain's Journal
The Chaplaincy kept journals in 2002 (they use a case note system now). There were three journals: Roman Catholic, non-Catholic and Muslim. They were not locked away but were kept in the Chaplain's area and would not be accessible to prison staff.

10.4.7 CARATS records. Unfortunately these could not be found.

10.4.8 Education records. Some limited documentation was available.

10.5 The facts – background history

10.5.1 JL was born and brought up in Jamaica. He had a girlfriend, Ms G (sometimes referred to as his wife), who had two children of her own. They had a daughter together, born in 1999. Ms G came to the UK before JL, and the children stayed in Jamaica with JL's mother. JL followed Ms G to the UK, arriving as an illegal entrant on 15th March 2002. It is clear from all the evidence (including a letter found in his cell) that he loved and depended upon Ms G, and worried about her feelings for him and their future together.

10.5.2 There are suggestions that JL may have had some learning difficulties. As a child he was referred to a facility which gives specialist assistance in diagnosing and treating students with learning challenges where he received assistance with his reading. (His writing was of a good standard, as we know from the letters found in his cell.) He later attended High School and studied electrical installation. After school he worked as a steel rigger and part time chef.

10.5.3 He told reception staff at Feltham that he suffered from chronic stomach ache, and he also suffered pain from a bullet wound to his foot, having been shot in Jamaica during political unrest.

10.5.4 JL indicated that he smoked cannabis occasionally, and he was referred to the drug counselling scheme (CARATS) at HMYOI Feltham.

10.5.5 JL had no previous convictions or arrests and had not previously been in prison either here or in Jamaica.

10.6 The facts – events from 18th July 2002 until 19th August 2002

10.6.1 18th July 2002 – Arrest - JL was arrested in London in possession of 19 wraps of crack cocaine. He was charged with possession and possession with intent to supply a Class A drug. A quantity of 19 wraps would be strong prima facie evidence of intent to supply and if convicted he faced a relatively lengthy prison sentence.

10.6.2 He was also detained as an illegal entrant by the UK Immigration Service.

10.6.3 On 19th July he was taken before Highbury Corner Magistrates Court and remanded in custody to HMYOI Feltham for one week.

10.6.4 HMYOI Feltham – reception: JL was seen by a nurse and a doctor as part of the reception process. He complained of constant stomach ache, and a possible hiatus hernia. He was given a phone call to his girlfriend and allocated to Kingfisher Unit, a residential induction unit.

10.6.5 On 20th July 2002 Assistant Chaplain A noted her concerns about JL's vulnerability due to high anxiety. She found JL to be very anxious and stressed, concerned about his family, with no understanding of his legal situation. He wanted to write to the Queen to explain his situation. She made a note in the history sheet that would have been available for any member of staff to read. A second note repeated his concern about his family, and efforts to provide an international phonecard and airmail letters were indicated.

10.6.6 Assistant Chaplain A (and Dr Cumming) told me that JL's desire to write to the Queen represented a naivety on his part rather than an indication of a mental health problem, and their assessment seems both reasonable and accurate.

10.6.7 21st July 2002 – F2052SH opened by Officer J, JL transferred to HCC. The way in which the opening of the form came about is somewhat unclear. It seems that JL had hidden piping in his cell and frightened his cellmate, and yet it is clear that he was assessed as being at risk of harming himself, being described as "very tearful". It was proposed that he should be observed and supported by Outreach until his next Court appearance.

10.6.8 The documentation is in good order and was completed by PO K, the Suicide Prevention Coordinator. He told me that he took on the role of the Residential Unit Manager (the F2052SH requires the Residential Unit Manager or Orderly Officer to carry out certain steps: to speak to the prisoner, to check records, to decide how to proceed in consultation with health care and other staff, and to decide on initial action if the prisoner stays on the residential unit (*see SL A1-91 and 94*)). JL's mood was described as

10.6.9 On the HCC JL became "demanding", was banging the wall and asking to return to the unit, suffering what was described as panic attacks. He was seen by a doctor but the notes do not refer to his mental state; the examination appears to have centred on his complaint of abdominal and testicular pain. The note by the doctor (in the IMR, a document not seen by residential staff), queries whether JL is *"malingering".*

10.6.10 23rd July 2002 – returned to Kingfisher Unit following a healthcare assessment (by doctor and nurse) and a case review conducted by PO K. A support plan was made which included daily review by Outreach. There is no note of residential staff being involved in this pre-discharge review.

10.6.11 Received on Osprey Unit on 25th July 2002 after a short period on Partridge Unit, and a multidisciplinary F2052SH case review. It is not clear whether there was residential input at this review. In other respects the reviews so far were well conducted and documented.

10.6.12 26th July 2002 - JL appeared at Court and was further remanded in custody until 23rd August 2002. His behaviour was disruptive at Court and he continued to express concern about his family.

10.6.13 27th July 2002 Officer C (Osprey) noted concerns about JL: She arranged for JL to see a Listener. An Outreach nurse (Nurse L) attended on him and noted that he denied current self-harm but *"expressed intent should his daughter die".* Nurse L appears to have carried out a full assessment and describes his mood as subjectively low but otherwise *"no symptoms of depressive illness requiring intervention".* The nurse made notes in the IMR and F2052SH, but not in the history sheet.

10.6.14 31st July 2002 - JL was charged with a disciplinary offence after allegedly pressing the fire alarm on dispersing from education. (This may have led to his exclusion from education, although the records are not clear, and JL did subsequently attend education on one occasion.) Later JL had a legal visit, after which he started crying, was upset about his family and requested a phone card.

10.6.15 JL reports the death of his child and a noose is found: Later on 31st July 2002 JL told the staff that he had been informed of the death of his child. This triggered the bereavement process; Father H and an Outreach worker (HCO M) attended and a noose was found in JL's cell.

10.6.16 Return to HCC overnight 31st July/1st August 2002 HCO M made a note in the F2052SH expressing concern that JL may try and self-

10.6.17 1st August 2002 – HCC Discharge Review JL was seen by a doctor and a healthcare discharge review was conducted by an Outreach nurse and staff nurse. Again, there appears to be no input from the residential unit.

10.6.18 The discovery that JL's child had not died After the review, Assistant Chaplain A was tasked with confirming the death. She telephoned JL's girlfriend who told her that the child was alive. She told Assistant Chaplain A that JL had become upset when she was unable to visit. Assistant Chaplain A then spent some time with JL who persisted with his story for some time until he eventually admitted that the story was untrue. He had been upset and *"one thing had led to another".* Assistant Chaplain A made a long note in the F2052SH expressing the view that JL was worried about the possibility of his child dying, and needed a lot of support.

10.6.19 JL agreed to tell the staff that the story was untrue, and told SO N (in charge of Osprey Unit) in front of Assistant Chaplain A, who expressed her admiration at the way in which SO N dealt with the matter – she recalled him saying it did not matter if the story was untrue, JL was obviously distressed and in need of support.

10.6.20 In spite of the fact that JL must still have been in the HCC at this time, there was no further health care review or reconsideration of the discharge once the truth about JL's child was known.

10.6.21 Assistant Chaplain A made a note in the F2052SH and the history sheet to the effect that JL was overwhelmed by anxiety, did not understand the English legal system or culture, and was worried about his children (one being chronically ill), and the future generally.

10.6.22 1st August 2002 - JL returned to Osprey On 2nd August there is reference to the effect that JL was seen by an Outreach Nurse (Nurse L) but the nurse has not made a note. JL later asked to see someone and an officer made a request, but there is no record of a further visit. Officer C reported that he was happy *"now his cellmate has returned from education"*

10.6.23 5th August 2002 Officer C noted that JL appeared a little low, complained of pain and began to cry. A nurse attended on him and Officer C recorded a note in the F2052SH: *"He doesn't appear to*

10.6.24 Outreach visit: Nurse L saw JL at 1930. It is probable that this was the second time JL had seen a nurse that day, although there is no note for the earlier attendance. I assume that the visit was in response to JL complaining about pain in his foot, but the nurse noted: *"still worries about his daughter and wants help to write a letter. Will ask keyworker to facilitate this".* Nurse L made this note in the history sheet (and a similar note in the F2052SH). There is no note of who the keyworker might be or of any letter being written.

10.6.25 7th August 2002 (or 8th) – JL involved in a fight and complained about a prison officer: This evidence comes from a note in the Board of Visitors rota diary. JL was apparently involved in a fight with another prisoner. The fight was quickly and effectively dealt with by staff and JL approached the Visitor to complain about his treatment by a prison officer. There is no record of the name of the officer or the nature of the treatment. The Visitor notes that he/she spoke to the officer concerned and was satisfied that JL's complaints were understood and *"his behaviour being managed".*

It is possible that this note refers to events on the afternoon of 8th August 2002 (see below, para 10.6.31).

10.6.26 8th August 2002 – F2052SH form closed JL had a visit in the morning – it is not clear whether this was a social or legal visit. At 1240 Officer O (not interviewed) made an entry in the F2052SH (not the history sheet) suggesting that JL's behaviour was manipulative. He wrote: *"Rang cell bell asking for a light. I explained this was not possible and a waste of staff resources. This lad cannot seem to comprehend he is in prison and it is my firm belief he is playing on his so called vulnerability. When I looked in his cell 10 mins after he rang the cell bell he was smoking a lit cigarette and laughing and joking with his cell mate."*

10.6.27 At 1440 Nurse D conducted a case review on Waite Unit (for reasons that are not clear). He filled in part of the case review form in the F2052SH (SL A1-98). The box marked "*Staff/Depts attending"* has not been completed. I am satisfied on balance that he carried out the review with JL only. According to the papers he had met JL only once before on 29th July 2002.

10.6.28 The box marked "*Summary of review*" reads: *"Seen on Waite Unit J established good rapport and eye contact. He said that he was still anxious about his kids but was more settled in mood on the Unit. He was visited by his wife a few days ago and she will be visiting again tomorrow. He said that he was coping well on Unit as his cellmate was very understanding and helpful. J attends education, association and gets support from staff and Outreach. He said the*

10.6.29 Support plan Nurse D made a note in the history sheet setting out the support plan, to include: *"Outreach support as appropriate; encourage time out of cell e.g. education association, gym etc, encourage family visits and support wife visits regularly, Chaplaincy and Samaritan phone as necessary".* No reference was made to the staff or departments responsible for these elements of the plan.

10.6.30 Nurse D also made a note in the Osprey Observation Book: *"Reviewed F2052SH. F2052SH closed. See support plan on flimsy".*

10.6.31 JL was *"put behind his door due to arguments with staff"* An entry in the Osprey Observation Book indicates that JL was put in his cell with his cellmate *"due to arguments with staff".* (This may be the incident referred to in the BOV rota diary (see para 10.6.25 above)).

10.6.32 9th August 2002 After a visit from his girlfriend, JL was seen by Dr P, a member of the Chaplaincy. She had seen him before and was seeing him on this day on behalf of her colleague Assistant Chaplain A who was unwell. She noted the history sheet as follows: *"distressed last night. JL continues to worry greatly about his family. He tells me that his father and brother were killed in 2001 and that he has been extremely anxious since then."*

10.6.33 9/10th August 2002 - JL taken to Ashford General Hospital JL complained of abdominal pains and the doctor was contacted over the telephone who advised a visit to Accident and Emergency for a suspected hernia. He was taken at about 0100 and returned at 0300 having been prescribed strong painkillers. There are no notes from the hospital and there was no apparent follow up by the doctor at Feltham.

10.6.34 15th August 2002 After a period of relative stability during which JL received a visit from his girlfriend and attended education (on one occasion), the CARATS worker noted that he was very quiet/withdrawn and worried about the outcome of his trial and his family in Jamaica.

10.6.35 16th August 2002, Officer Q notes that JL is *"always on his cell bell drain on staff crying to get his own way".* In evidence, Officer Q said that JL was becoming more demanding.

10.6.36 18/19th August 2002 Night time – JL requests nurse
OSG G came on duty at about 2015-2030. He was fairly new and inexperienced, and not permanently attached to a particular unit. He did not know JL or his cellmate. OSG G gave an account to a senior

officer on 20th August 2002, but did not see or sign the resulting report. PO F gave his report to the Governor in which he set out the following history:

10.6.37 At about 0010 OSG G responded to the buzzer from JL's cell. Both prisoners appeared to be asleep. 10-15 minutes later the same thing happened again. 10-15 minutes after that, the bell rang again and this time one prisoner asked to see the doctor or nurse. He would not say why or give his name.

(In view of subsequent events, it is clear that the prisoner was JL, and OSG G himself later recorded JL's name in the Observation Book and wrote in JL's history sheet.)

10.6.38 OSG G rang the HCC and spoke to Hotel 9 (the code for the nurse on duty). He probably spoke to Nurse R (who has not been spoken to). OSG G told PO F that the nurse said neither of the prisoners in the cell was on any medication or medical instruction and she would not attend without further information. OSG G observed (at what stage it is not clear) that the prisoner had a short wide piece of bed sheet around his neck and "*mindful of the request for a doctor he asked if he had a sore throat*", considering the cloth to be more like a loosely tied scarf than a noose.

10.6.39 OSG G checked the cell hourly and saw that JL was writing until about 0400 when he appeared to have gone to sleep. The other prisoner seemed asleep throughout.

10.6.40 OSG G made entries in the history sheet and the Osprey Observation Book in the same terms: *"Constant abuse of cell bell".*

10.6.41 <u>19th August 2002, the day of the hanging</u> - Officers Q and C came on duty and signed the Observation Book *"all recent entries read and noted"*. I am satisfied on balance that OSG G did not inform them of the sheet around JL's neck, but it is less clear whether he told them about the request for the doctor or refusal of the nurse to attend.

10.6.42 JL was called up by the Mandatory Drug Test (MDT) Unit for a random drug test. The timings are somewhat contradictory but thankfully not crucial. It seems that JL was at the MDT Unit from about 1100 until after lunch. He made a telephone call, perhaps to his girlfriend, and was turned away from education for some reason. These events may have occurred the other way round. He was then returned to his cell, alone, whilst his cellmate was at education.

10.6.43 After a short period of time, anything from five minutes to half an hour at the outside, a fellow prisoner (Prisoner T) approached Officer Q and asked if he could speak to JL in his cell. He told the officer that he had spoken to JL earlier in the day and that JL was upset. Officer Q told me that there seemed to be no urgency in the

10.6.44 JL was found hanging at about 1430 Officer Q opened the door to find JL hanging from the bars of his cell by a ligature made of sheeting.

10.6.45 The "suicide" notes: Three written items were found in JL's cell and I am satisfied that they were all written by JL. The contents of two might be interpreted as expressing an intention to die by his own hand, one addressed to God and his mother, asking forgiveness, speaking of his love for his family; the other claiming his child was dead and speaking of his distress at hearing about the death of two girls (perhaps a reference to the murder of two children much in the news that year). The third letter, addressed to his girlfriend, is different in style and content. The writing is neater, and the substance has more clarity, albeit written in a lyrical style and expressing his confusion as to whether she loves him. The expert medical adviser to Stage 1 (Dr Cumming) said that it was not possible to come to any conclusion about the state of mind of JL when writing these items.

11. Conclusions

11.1 I have concentrated on setting out my conclusions in relation to matters that were potentially causative of the incident of self-harm on 19th August 2002. This necessarily highlights the negatives, but there were many aspects of JL's management which were admirable in one way or another. Some officers were kindly disposed towards JL and sympathetic to his situation. His frequent requests for phone cards were met without argument, and his transfer to the Health Care Centre and subsequent discharge was appropriate and in accordance with policies and good practice. I have already mentioned the rapid, professional and successful efforts to resuscitate him.

11.2 In each case where I have found a failing of some kind, I have endeavoured to assess whether the failing was individual or systemic, either by the lack of an adequate system or a system that could not for whatever reason be properly operated. Sometimes it can be a little of each. Many adverse incidents have multifactorial causes and JL's hanging is no exception.

11.3 I must reiterate the note of caution about the limitations inherent in such an exercise due to the passage of time and lack of evidence in some areas, and on the dangers of coming to conclusions based upon documents rather than early oral testimony.

11.4 I am in broad agreement with Professor McDougall in that JL's management was mostly well-intentioned without deliberate acts of harm or neglect.

11.5 I am more critical of what I would describe as a cumulative and collective failure to properly manage JL's case. The principles set out in national and local policies were not fully applied. Procedures were not always properly followed and opportunities to rectify the situation were not taken.

11.6 Mostly these failures were minor in themselves, sometimes unavoidable in a busy prison, and easier to identify with the benefit of hindsight. JL's presentation was sadly typical of a sizeable proportion of young men at Feltham, and it requires skill, judgement, experience and adequate resources to identify those who require special measures. I also recognise that the organisation and management of any custodial institution is complex and may involve broader political and societal issues.

11.7 The closure of the F2052SH and the actions of the night-duty OSG on 18th/19th August 2002 cannot be described as trivial, and may well have had a causative connection with the hanging, as I shall explain below.

11.8 <u>JL's intentions</u>

11.8.1 JL was a young man with a background and in a situation that would test anyone. He was just 20 years old; far from home in a strange country and in prison for the first time; his child was gravely and chronically ill; he had fears about the security of his relationship with

11.8.2 He made constant requests for phone cards which may indicate that he was homesick or dependent upon his girlfriend; he had possible learning difficulties and he was not well occupied for much of the time.

11.8.3 He suffered from chronic pain in his stomach which might have indicated a medical condition or emotional upset, and he complained of enduring pain from the bullet wound in his foot.

11.8.4 The "suicide" notes may have been written the night before the hanging, when OSG G saw him writing; this would indicate a level of planning.

11.8.5 JL had used cannabis in Feltham, and on the day of the hanging he underwent a mandatory drug test. He may have known that the results would expose him to a disciplinary process of some kind.

11.8.6 By 19th August he was just four days away from his next Court appearance at which he would probably be committed to the Crown Court for trial. He was rejected from education and he spoke to someone on the telephone who could have unwittingly or otherwise increased the pressure upon him.

11.8.7 It may also be that he was frustrated at the way his behaviour was increasingly categorised as manipulative and demanding. This could have encouraged him to try something more dramatic either as a "cry for help" or as a cynical and manipulative plan.

11.8.8 There lies the problem. All of these triggers and pressures could cause a young man like JL to feel and act in a suicidal manner. They could equally cause him to act in a cynical and manipulative manner, born in some respects out of the immaturity and lack of understanding highlighted by Assistant Chaplain A on his arrival.

11.8.9 The "suicide" notes are of limited help. In my experience as a coroner, such notes are not always what they seem. They can represent an effort to influence others, or even a form of communication for those who have lost or do not have the ability to articulate and convey their feelings.

11.8.10 Officer Q believed that JL made a committed attempt on his life because the ligature was strong and well tied, and that he was unconscious when discovered. Unfortunately this too can be misleading. Many people have little idea how dangerous it can be to place a ligature around the neck. Moderate pressure can cause unconsciousness, and once unconscious the person is unable to remove the pressure.

11.8.11 Assistant Chaplain A was of the view that the whole episode had been arranged with Prisoner T. That could be true, but I was not able to examine Prisoner T, and Officer Q told me that he showed no urgency when asking to see JL. Prisoner T did not admit to such a scheme even when it became obvious that JL's life was in the balance.

11.8.12 Taking account of all these factors, I am unable to come to any decision as to whether JL intended to die when he hanged himself on 19th August 2002. I have therefore avoided the use of the word "suicide" in this report, as explained in paragraph 1.5, above.

11.8.13 Whatever the case, it makes little difference to my findings elsewhere. JL was at risk of harming himself, as Assistant Chaplain A put it, *"simply because he was so prone to acting impulsively when emotional".* This concern applied whether or not his intention was to take his life or to gain attention.

11.9 Personal Officer scheme

11.9.1 There is no record of JL being allocated a personal officer. Officer S partially completed a personal officer contact sheet (CMcD A19-64) but the names of the personal officers have not been completed. The form bears no date but other documents suggest it was written on 24th July 2002 in Partridge Unit where JL stayed for one day.

11.9.2 Officer Q told me that personal officers were allocated on rotation. The officer would become responsible for that prisoner and make entries in their history sheet starting with, for example, *"I have introduced myself as his personal officer".* No such note exists on JL's history sheet. Both Officer Q and PO T said that it was unusual for a prisoner not to have a personal officer, and unusual for it not to be recorded.

11.9.3 HCO M told Professor McDougall that the personal officer scheme was a bit *"hit and miss – some of the officers took it really to heart and did brilliant jobs and others not so good"* (CMcD A21-446(1)).

11.9.4 An inspection of HMYOI Feltham by HM Chief Inspector of Prisons in January 2002 (published in August 2002) found that the personal officer scheme was not operating as it should, and recommended a review, (CMcD A14-107).

11.9.5 Professor McDougall comments that there are references to JL's "keyworker", but this could refer to a variety of people: the unit manager, the Outreach worker and the CARATS worker might all have been referred to by such a title in 2002 (*per* SPC PO K, Officer Q, HCO M). Indeed, HM Chief Inspector's report *(ibid)* uses the words interchangeably. (This potential muddle has been resolved under the new system.)

11.9.6 It has been argued that this might be a "paperwork" problem, and that there was a personal officer. If so, the appointed officer failed to make a note about his/her status or to make any notes about his/her involvement with JL.

11.9.7 Taking account of all the evidence, I am satisfied that JL did not have a personal officer. There was an opportunity to rectify this by following the *"ideas for a support plan"* suggestion in the F2052SH (to appoint a personal officer), but the opportunity was missed.

11.9.8 It is not possible to say whether the existence or action of a personal officer would have affected the outcome, but it certainly could have done. Indeed, it would be somewhat disingenuous to decide otherwise, since the prevention of self-harm and distress is presumably one of the reasons for having such a scheme. In particular, the implementation of the support plan made on the closure of the form F2052SH could and should have been undertaken by JL's personal officer in the absence of some other nominated individual.

11.10 <u>The management of the F2052SH – a multidisciplinary approach</u>

11.10.1 It is to Officer J's credit that she opened an F2052SH instead of interpreting the hidden piping and fearful cellmate as disciplinary matters. The papers show that JL was then dealt with in a caring and professional manner, and generally in accordance with the national and local policies and guidelines. Reviews were undertaken in a timely fashion and the paperwork is mainly in good order. However, the process did not comply with guidance and policy. The national and local policies in 2002 (CMcD A4, CMcD A5) stress the need for a multidisciplinary approach involving communication, teamwork, consultation and liaison with other departments and agencies. That did not happen for JL.

11.10.2 Members of residential staff are noticeably absent in the F2052SH reviews, although they obviously had access to the form and made entries in daily supervision records. Whether this was causative of the events of 19th August 2002 is debatable, save to the extent that cumulative failures can be indirectly causative. It may also be a symptom of the perception that suicide prevention was seen as a matter for Outreach (para 11.11 below).

11.10.3 I have dealt with the closure of the F2052SH as a separate topic (para 11.14 below).

11.10.4 I have already discussed the personal officer scheme above, and the failure to identify the "keyworker" adds to the impression that no-one took on the responsibility for acting as a point of liaison, vital in a multidisciplinary system.

11.11 Outreach - "ownership of suicide prevention"; compliance with policy

11.11.1 The Outreach team is no longer in place at HMYOI Feltham. Their role (according to the local policy, CMcD A5) was to support staff in the management of prisoners deemed to be at risk of deliberate self-harm on ordinary location.

11.11.2 HM Chief Inspector of Prisons commented in his 2002 report (ibid) that there was a widespread view that suicide prevention was the preserve of the HCC and Outreach, and that this was in contravention of the principle that "suicide is everyone's concern". Professor McDougall concluded that they may have contributed to the perception that "*suicide is Outreach's concern*" (CMcD report SL A3 para. 9.25 p66). I agree with this assessment. I do not share her confidence that Outreach achieved the objectives outlined in the local policy.

11.11.3 In the case of JL, Outreach did not involve residential staff in management decisions, particularly the creation and operation of the support plan on closure of the F2052SH, and this will have reduced the perception or reality of support for them in managing the prisoner. (I have dealt with events following the closure of the form in more detail below.)

11.11.4 Outreach did not involve JL's family in his care, save to refer to a visit from his girlfriend when closing the F2052SH. There seems to have been no contact by Outreach workers with JL's girlfriend or with his mother who had the care of his sick child.

11.11.5 There was a failure to comply with policy by properly investigating or examining the reasons why JL lied about his child dying (see *Caring for the suicidal in custody: Guide to Policies and Procedures 1997* – para 9.1 above). I heard that claims of bereavement are common in prison, and I am sure that this is so, but JL's general presentation made it necessary to explore the reason why he lied. JL was cleared for discharge from the HCC before the lie was exposed, yet there was no review of the discharge or any plan to investigate. Father H described such a lie as a *"huge flag"*; there could be all sorts of reasons for it, from an immature plan to get cigarettes or a plan to escape from a funeral, to something more serious such as extreme distress or mental illness. It should have triggered a multidisciplinary meeting to discuss the alternatives.

11.11.6 Finally, Outreach did not achieve the objective of continued support after the F2052SH was closed. No member of the Outreach team attended upon JL after the closure or, if they did, no note was made.

11.11.7 Professor McDougall found that Outreach's involvement had been one of risk management rather than an examination of underlying issues, and this prevented the development of a therapeutic relationship. I agree with her findings in this regard. HM Chief

11.11.8 The *Instruction to Governors 79/1994* (CMcD A3) referred to the use of shared cells for prisoners at risk, and the need to ensure that prisoners would not be left alone in the absence of their cellmate. Officer C often made notes about her concerns for JL, and on 5th August 2002 she made an important observation in the F2052SH about JL's difficulty in coping without the company of his cellmate (SL A1-126). JL was seen the same day and, in response to Officer C's concerns, by at least one Outreach worker. This represented a missed opportunity to put something in the support plan about JL's need for company, and in my view it should have been considered and noted, at the very least.

11.11.9 It is possible that systemic issues are of relevance here. There is a potential ambiguity in the local policy (CMcD A5). It describes the role of Outreach as supporting staff in the management of prisoners on ordinary location deemed to be at risk of deliberate self-harm. Such prisoners should, of course, be on an open F2052SH. The policy goes on to provide that the Outreach worker would continue to see the prisoner on an ongoing basis – the level being indicated within the support plan and at least twice weekly. This could be interpreted to mean follow up whilst the form was open, or after it was closed. I have discounted any such ambiguity as a reason for the failure to see JL after closure, because the support plan specifically refers to follow up after closure (see below).

11.11.10 The issue of resources is more likely to have played a part. The Chief Inspector of Prisons referred to the service as understaffed. PO K told me that by August 2002 over 500 F2052SH forms had been opened since the beginning of the year. This would have spread the efforts of a team of three or four very thinly, to the point at times where they would not be able to deliver the service required of them.

11.11.11 The Outreach team no longer operates at Feltham. During the hearings at the IDRC there were divided views on the advantages and disadvantages of their role; the dangers of compartmentalisation versus the benefit of clinical skills. These questions are beyond the scope of my remit.

11.12 <u>Referral to psychiatry/psychology</u>

11.12.1 Dr Cumming told me that there was nothing on the papers that would indicate a referral to a psychiatrist. Even with the high anxiety and odd behaviours exhibited by JL, there was not enough to catapult him into a referral. He would expect to see some

11.12.2 I agree that a referral for psychiatric assessment was not necessarily indicated, but I would not go as far as saying that any such referral would probably have been a single assessment with no indication for a further assessment, (CMcD report, SL A3 para 9.27 page 66). We shall never know whether JL was suffering from mental illness. Dr Cumming was clear that he could not make any sort of clinical diagnosis on the papers. JL's presentation was similar in some respects to many young men at Feltham but Officer Q told me that he *"stood out*", and PO T told the Prison Service investigator he found JL to be strange, a *"bit bizarre".*

11.12.3 Dr Cumming explained that this left JL falling between two services. His behaviour did not merit a referral for psychiatric assessment, but Outreach were managing only the risks rather than examining underlying problems, (CMcD para 9.35, page 68 SL A3). In fairness, this shortcoming is often seen in the community. I suspect that there is little time in a busy prison with a relatively high turnover of prisoners to be too ambitious about therapy, but some investigation of underlying causes is necessary in order to deal with risk management. If one treats symptoms without investigating causes, the symptoms are likely to recur.

11.13 Failure to record the finding of the noose on 31st July 2002

11.13.1 It was generally accepted that the finding of the noose in JL's cell was not adequately recorded. A note was made the following day in the F2052SH. Notes should also have been made in the Observation Book, the history sheet, and the Inmate Medical Record. This failing was of individuals rather than systemic.

11.13.2 After the F2052SH was closed on 8th August 2002 this information was no longer available for the staff to see. The effect was not as significant as it could have been because the Chaplaincy was aware of the finding of the noose, as were the officers on duty the day of the hanging. However, the officer on duty the night before JL's hanging was not aware of it. He may have behaved very differently if he had known about it, because he interpreted a piece of sheet around JL's neck as a sign of a sore throat rather than a noose. Although he claimed not to have read the Observation Book, he made an entry in it, and had there been a note about the noose he might well have seen it.

11.14 The closure of the F2052SH on 8th August 2002

11.14.1 I am satisfied that Nurse D closed the F2052SH with JL alone, and I agree with Professor McDougall's conclusion that this was contrary to local and national policies which demand a multidisciplinary process. Even if Nurse D discussed the case with other members of staff, it is certain that he did not involve the Chaplaincy, with whom JL had formed a good relationship. If Assistant Chaplain A had been asked, she would have recommended that the form remain open because of JL's impulsiveness. The nurse would also have learned about Father H's assessment of JL as being a very high suicide risk, albeit before it was discovered that JL was lying about the death of his child.

11.14.2 It is not possible to determine whether this was an isolated incident or a regular occurrence in 2002. Reverend E complained in his letter that the Chaplaincy was often overlooked in reviews, but Father H, Assistant Chaplain A and Dr P all told me that they were regularly involved in reviews and closures.

11.14.3 Nurse D was not in any event the appropriate person to co-ordinate the review. The Outreach team was small and so it is possible that discussions about prisoners were taking place, but the records indicate that Nurse D had not been closely involved in JL's care. He made a note in the history sheet (and not elsewhere) on the 29th July 2002 when JL was complaining of pain in his leg.

11.14.4 This implies a lack of continuity of care, contrary to the principles of national and local policies.

11.14.5 There is a suspicion, and without examining the relevant witnesses it can only remain a suspicion, that Nurse D was sceptical about JL's vulnerability and allowed that scepticism to inform his actions. He may have seen the doctor's note questioning whether JL was *"malingering*". Nurse D's note made on 29th July 2002 gives the impression that he saw JL as over-demanding: *"not happy with a number of things and asking when the TV will be put on".* He was perhaps influenced by Officer O, who made a note in the F2052SH approximately two hours before Nurse D closed it: *"… this lad cannot seem to comprehend he his (*sic*) in prison and it is my firm belief he is playing on his so-called vulnerability…"* (SL A1-130). It may also be that JL lost sympathy and patience once it was found that he had lied about his child's death.

11.14.6 Equally, it may have been that Nurse D was over-worked, over-stretched, and doing his best in difficult circumstances. He obviously spent time talking with JL about a number of issues and he made a substantial note on the form (SL A1-98). He put together a support plan and, although it was not recorded on the F2052SH, he made a note to the effect that it could be found in the history sheet. If time prevented him from writing it in both places, he exercised his judgement well in putting the plan in the history sheet, and applied "belt and braces" by making a further note in the

11.14.7 The failure to consult with others meant that Nurse D's decision was flawed and based on false premises. He wrote that JL had received a visit from his "wife" *(i.e. his girlfriend)* a few days ago, she would be visiting again tomorrow, and that he attended education and had support from Outreach. He took too much on trust, because all of these statements concealed the truth. If he had taken the trouble to check he would have discovered that support from Outreach was relatively limited. Nurse L had last visited JL three days earlier promising him help from his "keyworker" to write a letter, which does not seem to have happened. The visits from his girlfriend (on whom he depended to the extent that he lied about his child's death) were irregular and sometimes cancelled.

11.14.8 Enquiry would have revealed that JL was not attending education. This meant that he would be alone for much of the time, as indeed he was on the day of the hanging. Nurse D noted that JL was coping well as his cellmate was very understanding and helpful, but he failed to see or to consider the significance of Officer C's clear note in the F2052SH on 5th August 2002: *"He 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 …",* (SL A1-126). Had he done so, the support plan might have included such monitoring.

11.14.9 In spite of these criticisms, it is entirely possible that a multidisciplinary approach would have come to the same conclusion to close the F2052SH, notwithstanding any objections from Assistant Chaplain A. (Indeed, Assistant Chaplain A was of the view that an open F2052SH would have made no difference, based upon her belief that the hanging was pre-arranged.) JL had not attempted to harm himself and there had been no repetition of the sort of behaviour that had led to the form being opened or of the dramatic lie about his child dying. Keeping prisoners on open F2052SH forms without good cause is undesirable and unhelpful for staff and prisoner alike. Father H said that prisoners would often ask for the forms to be closed: for some there was a sense of embarrassment and potential source of bullying, and the constant checks were *"wearisome*".

11.14.10 Nonetheless, even if the decision to close the form was correct, the process was flawed, leaving JL without the support he needed, and leaving other members of staff without the support they needed to care for him. This was potentially causative of the incident of hanging.

11.15 <u>Failure to implement the support plan; events from closure to the hanging:</u>

11.15.1 Once the F2052SH was filed away, a wealth of information about JL was no longer available, but he remained on Osprey Unit where the staff knew him quite well, especially Officers C and Q, both of whom were on duty on the day of the hanging.

11.15.2 While JL was under the protection of the F2052SH the staff made and recorded observations over twenty times in a day. After the closure there are just four notes in his history sheet, and four notes in the Observation Book, for a period of eleven days. Half these entries deal with disciplinary matters. Whether this represents a failure to engage with and support JL during this time is difficult to gauge.

11.15.3 I am sure that the staff spent as much time as they could engaging with prisoners and providing for their needs. One can see an example of that in Assistant Chaplain A's comments about the supportive way in which SO N dealt with JL when the lie about his child was exposed. Officer Q told me that he had put himself out for JL over a period of time, and I have no reason to doubt this or to interpret it as a complaint. On the 19th August 2002 he had a discussion with JL about his girlfriend's visit, and was involved in arrangements to get him a phone card, to get his hair plaited, and to allow a fellow prisoner to go and speak to him. These aspects of daily life in a prison do not always appear in written records.

11.15.4 It is also clear from the records and from Dr P's evidence that JL was seen by the Chaplaincy and CARATS after the F2052SH was closed and they raised no apparent concerns or sought to open another.

11.15.5 Nevertheless, it is my view that the support plan put together by Nurse D, both in content and delivery, left others without support and information. He went to the trouble of making several notes about the closure and the plan, but the plan itself lacks clarity, and I do not believe that any individual was tasked with implementing or monitoring the arrangements. In light of the prevailing view that suicide prevention was an Outreach responsibility (see above), it is likely that the residential staff, the Chaplaincy, and CARATS assumed that someone else was responsible.

11.15.6 It cannot be argued that any failure to implement or monitor the support plan was not potentially causative. I reiterate the point I made about personal officers (above). The objective of the support plan is to prevent self-harm and suicide, and if it is deficient in some way, the likelihood of self-harm is increased, and the opportunity created.

11.15.7 The plan provided for JL to seek support when not coping well. That much may have happened. It next provided for *"Outreach support as appropriate".* What is meant by *"appropriate"* is not explained, and no support was in fact given. There is a sense that once the

11.15.8 The plan appropriately provides for activities: *"encourage time out of cell e.g. education, association, gym etc.".* It does not specify who should be responsible for doing this, although one assumes it means residential staff. Encouragement to attend education was wholly unsuccessful because it seems that JL only attended on one occasion, the 14th August 2002. If attending education was seen as a supportive measure, it was not being delivered (see note in chronology SL A2-15).

11.16 Perception of JL as manipulative:

11.16.1 The national publication *Caring for the Suicidal in Custody: Guide to Policies and Procedures 1997* (CMcD A4) refers to the concept of *"malignant alienation"* whereby angry uncooperative prisoners can be perceived as manipulative or over-dependent, so losing the sympathy and support of others. Staff are reminded that although such criticism might be entirely justified, the prisoner's behaviour must be reviewed as objectively as possible.

11.16.2 I have already surmised that Nurse D was sceptical about JL's vulnerability, and there is a sense of rising antipathy towards JL throughout the documents up until 19th August 2002. Claims of bereavement and the preparation of nooses were sadly commonplace at Feltham, JL had made no actual efforts at self-harm, and his behaviour was often disruptive and difficult so taking up a disproportionate amount of time and effort.

11.16.3 The perception of JL as possibly manipulative can be seen from the outset. On 21st July 2002, the doctor apparently questioned whether JL was malingering and the following day JL was described as a *"rude young man who appears not to like discipline"* (SL A1-104). On 8th August 2002 (the day the F2052SH was closed) Officer O noted that JL was playing on his *"so-called vulnerability".* On 7th (or 9th) August 2002 JL made a complaint to a Visitor about an officer, something that is likely to have been viewed with irritation at the very least.

11.16.4 On 16th August 2002 Officer Q made a note in the Observation Book: *"always on his cell bell drain on staff crying to get his own way".* The Officer explained that by the 16th August 2002, JL was becoming more demanding. He told me that he found JL to be manipulative; … *"he knew how to play, he knew how to get things … he would only tell half the story, one minute crying wolf, very low, threatening self-harm. If he did not get his own way he would make threats … there was a build up of his behaviour, it got to the stage there were so many lies, it was kind of "what's he done now?"* The subsequent note by the night time OSG is likely to have reinforced

11.16.5 I was told that JL's behaviour was not untypical of many prisoners at Feltham, and, as Officer Q told me, it is necessary to make difficult judgements as to whether a prisoner has a genuine problem or is being a nuisance and requires firm discipline. Sadly it seems to me that by the 19th August 2002 JL had lost the sympathy and objectivity of the staff who were, perhaps understandably, getting tired of his rather needy behaviour. This attitude contributed to the context in which JL was able to hang himself on 19th August 2002.

11.17 <u>The night before the hanging; the night-time OSG and the nurse</u>

11.17.1 OSG G was relatively new and inexperienced and was not permanently based on Osprey Unit, though had been on the unit before. He came on duty on the evening of 18th August 2002 without any knowledge of JL or his history and there is no suggestion that he was told of any concerns about him during handover. I accept that it would not be possible or even necessary to look at the history sheets for all prisoners at the start of a shift, and that there was no formal requirement for him to look at the Observation Book, although some members of staff would read and sign the book by endorsing *"all entries read and noted".*

11.17.2 OSG G did not recall looking at the Observation Book. If he had done so, he would have seen the recent entry from Officer Q on 16th August 2002: *"always on his cell bell drain on staff crying to get his own way".* If he had gone a little further back in the book he would have seen that JL had been taken to hospital with chronic stomach pains on 9th August 2002, that he had been the subject of an F2052SH which was closed on 8th August 2002, and that his daughter had died (this was never corrected in the Observation Book).

11.17.3 Once JL made a request for the nurse, OSG G could have read the Observation Book. He could have gone directly to the history sheets for both prisoners, because the names of both prisoners were written on a board outside the cell. That would have been of limited assistance, because photographs were not kept with the history sheets (as they are now). Nevertheless, he would have discovered that one of the prisoners had a significant history. The history sheet for JL revealed that he had been admitted to the healthcare centre due to concerns of suicide following the death of his daughter, and his continuing anxiety once the lie was discovered. He would have been able to see the support plan made by Nurse D on 8th August 2002, and the most recent entry on 15th August 2002 by CARATS worker I, the CARATS worker, who wrote that JL was very *"quiet/withdrawn, worried about the outcome of his trial and family in Jamaica".*

11.17.4 OSG G would not have had access to information about the finding

11.17.5 All this ignores the fact that OSG G did at some stage look at the Observation Book and JL's history sheet. He told Professor McDougall that he still did not know if the man he spoke to was the man who hanged himself, but that cannot be right. Before OSG G went off duty on 19th August 2002 he knew very well that the prisoner who had asked to see the nurse was in fact JL, because he made entries to that effect in the Osprey Observation Book (SL A1-66) *and* JL's personal history sheet (SL A1-34).

11.17.6 I am reluctant to make adverse findings in respect of OSG G because he was not given an opportunity to speak to the Prison Service investigator back in 2002, or even it seems to check the account given on his behalf by PO F. I am all the more reluctant to do so knowing that PO F reassured OSG G that he had done a good job. Regrettably I cannot avoid coming to the conclusion that OSG G failed to act in accordance with his training, and with the policies and guidelines for the prevention of suicide and self-harm. He should have done more as a result of JL's request to see the nurse and the placing of a sheet around his neck. Indeed, OSG G himself accepted that he could have argued with the nurse or opened an F2052SH (and given a fuller handover, as I mention below).

11.17.7 I am satisfied that OSG G had received training in suicide prevention policies. He may not have received training on the local policy during his induction which pre-dated the coming into force of the January 2002 local policy, but I am satisfied that it was available on the unit and that he will have been familiar with the F2052SH system.

11.17.8 I have no doubt that OSG G gave what he thought was an honest and accurate account. He was obviously shocked and taken aback by what happened to JL. In particular, I have no doubt that he did contact the nurse at one stage, probably before he learned or decided that the prisoner was in fact JL.

11.17.9 OSG G told me that prisoners often ring the bell and hide; that some can be a drain, pressing bells all night. He said *"it's a game to them, they're bored. If someone had really been playing up or unusual activities I would write in the flimsy which I did in this case".* That,

11.17.10 Nurse R was never spoken to, and so it would be unfair and unsafe to make any findings or criticisms of her. It may not have been her that OSG G actually spoke to, and it may be that her recollection of the conversation was very different. If OSG G's account is correct, there is no doubt that she should have attended or asked for more information about both prisoners in order to make an informed decision about the appropriate action. Any doubt should have been resolved in favour of going to the Unit.

11.18 Handover to the day staff 19th August 2002

11.18.1 Officers coming on duty on the day of the hanging received a verbal handover from OSG G, and access to the Observation Book. Both Officer Q and Officer C signed the Observation Book in the same way by writing *"all recent entries read and noted"*. They will have seen OSG G's entry: *"constant abuse of cell bell"*. This alone could have reinforced Officer Q's perception that JL was becoming more demanding.

11.18.2 OSG G thought that he might have told the day staff about the nurse's refusal to visit, but he could not recall. Officer Q could not recall being told anything about it, and it is difficult to make any finding about this except to say that I am satisfied that OSG G failed to give a full and proper handover about the events of the night, particularly the observation of JL with a piece of sheet around his neck.

11.18.3 I have considered whether JL was in fact just "playing up" by asking to the see the nurse and putting a sheet around his neck, and whether, in any event, his behaviour was connected to the hanging itself. On balance, whilst his behaviour could be categorised as "playing up", it should have provoked concern and investigation. It is likely that if more had been done during the night and/or a full handover given to the day staff, JL may not have been in a position to hang himself, whether as a gesture or in a committed attempt to end his life. An F2052SH might have been opened, or at the very least he would have been given a little more time and attention. Officer C had previously shown that she was sensitive to his needs and well-being. The crisis could have been averted.

11.19 19th August 2002, the day of the hanging

11.19.1 I am satisfied that the day staff were not fully informed of the events of the night, particularly regarding the sheeting that JL had placed around his neck.

11.19.2 Officer Q told me that knowing about the sheet was important; he said: *"those of us who knew him would have said 'this is a concern'",* and I agree. That piece of information alone may have turned back the tide of antipathy and prevented the hanging. An F2052SH might have been opened, or more time spent talking to him, more involvement in his rejection from education, more interest in the phone call that JL made, and more thought given to him being alone in his cell. On 5th August 2002 Officer C had written the note about JL not coping well in the absence of his cellmate, and suggested close monitoring on such occasions. If she had known about the events of the night, it may have triggered alarm bells.

11.19.3 Any one of these measures might have made a difference unless it is the case that JL was cynically manipulating the system to help his case in the Courts. As I have said, it is difficult to come to a firm conclusion about whether JL intended to end his life or not, but even if he was attempting to manipulate the system, I do not think that it was a cynical and calculated effort. The notes indicate a degree of distress that would be difficult for him to fabricate.

12. The care and management of prisoners at risk of self-harm and suicide nationally and at HMYOI Feltham in 2011

12.1 It is something of an understatement to say that the landscape has changed dramatically since 2002. Suicide Prevention and Self-Harm Management is now the subject of PSO 2700. It provides instructions on identifying prisoners at risk of suicide and self-harm, on providing subsequent care and support for such prisoners and for the staff who care for them. During the hearings at IDRC we looked in particular at Chapter 8: *Planning and Providing Care for Prisoners at Risk of Suicide/Self-Harm*, and at Annex 8G: *ACCT (Assessment, Care in Custody and Teamwork) Procedures.*

12.2 PSO 2700 is a large document with a facility to navigate to links; it is best viewed on line at www.hmprisonservice.gov.uk/resourcecentre. I have annexed the first eight pages of the main document. These pages list the contents; fifteen chapters and almost a hundred annexes, as well as Annex 8G explaining the ACCT system (SL A11).

12.3 Locally, HMYOI Feltham has a policy which has recently been updated: *HMYOI Feltham Suicide Prevention and Self-Harm Management, May 2011* (SL A7).

12.4 The current Governor of HMYOI Feltham kindly came to the IDRC to give some evidence about the current regime, as did DPSM B, a Developing Prison Service Manager/Principal Officer and Suicide Prevention Coordinator at Feltham since June 2010.

12.5 I was also provided with some relevant documents: A blank ACCT form and Post Closure Review form, a Pocket Guide for Staff on Caring for People at Risk in Prison, ACCT Guidance Notes, and a sample “Alerts” page from the new computer system Prison NOMIS (P-NOMIS).

12.6 The ACCT process has replaced the F2052SH system. It is more flexible with an emphasis on care. It introduced trained assessors to help identify prisoners at risk, and case managers to ensure action plans are delivered. Like the F2052SH, the ACCT form contains a flowchart and guidance notes to take the user through the requirements. A Care and Management Plan (CAREMAP) is drawn up at the first case review conducted within 24 hours of concern being raised, and the form is not closed until the requirements of the CAREMAP have been met.

12.7 It is unnecessary to provide further information about the new regime, except insofar as it is relevant to some of the factors identified in the case of JL as contributing or potentially contributing to his hanging.

13. Learning the lessons

13.1 Many of the problems I have identified in JL's care were caused by individual failings of one kind or another, and in most cases they were avoidable even within the less sophisticated and somewhat inflexible policies of the time. In some cases, they were possibly the result of a range of contributory and systemic factors. The passage of time makes it impossible to make any fair determination about those factors, but perennial and sometimes unavoidable problems of staffing, training, management and communication failures are likely culprits.

13.2 No system can offer a universal panacea, but the new regime should provide an environment where the failures apparent in JL's care are less likely to occur.

13.2.1 Personal officers, case managers

13.2.1.1 I am told that the personal officer scheme now operates well and was the subject of positive comments in the most recent inspection.

13.2.1.2 The ACCT plan provides for the Unit Manager to chair the first Case Review and to appoint a Case Manager, so removing the muddle about key workers and case managers inherent in the F2052SH system. The Case Manager must ensure the CAREMAP actions are carried out in a timely manner, ensure that any referrals to specialist staff are made, and organise the next case review.

13.2.2 Multidisciplinary approach

13.2.2.1 The F2052SH system provided for a multidisciplinary approach, and the ACCT system builds on that requirement. The first case review must be attended by the Unit Manager, the Case Manager and, where possible, the Assessor. Thereafter, the Case Manager must ensure that any specialist staff who have been asked to provide care to the at-risk prisoner are invited to contribute to the next case review, and suggestions are made as to others who should be involved, including the Chaplaincy.

13.2.3 Closure of the ACCT Plan

13.2.3.1 The ACCT Plan can only be closed once all the CAREMAP actions have been completed and the Case Review Team judges that it is safe to do so. The Case Manager must enter in the record of the final Case Review why the Case Review Team feels it is safe to

13.2.3.2 Closure must be recorded in the F2052A (history sheet).

13.2.3.3 A post closure review must take place within seven days of the closure. The ACCT form (SL A8) contains guidance on keeping the prisoner safe after closure, requiring a gradual reduction of support, with one or possibly more follow-up interviews. (HMYOI has produced a local Post Closure Review form (SL A9)).

13.2.3.4 The closed ACCT Plan remains on the wing until completion of the post closure interview(s). Once it is confirmed there are to be no further post closure interviews the closed ACCT Plan is stored in the F2052 record, but there is a facility for leaving it on the wing in the case of those who present a chronic risk of suicide (PSO 2700 Annex 8EE).

13.2.4 Family involvement

13.2.4.1 The ACCT documentation contains several references to the support that families can provide, where appropriate, e.g. in the CAREMAP guidance. There are two aspects to this: first to involve the family directly, and second in ensuring that the prisoner maintains contact with his family. Problems in maintaining relationships, for whatever reason, can be dealt with in the triggers and warning signs identified by the ACCT team (see below).

13.2.5 Failure to investigate underlying reason why JL claimed that his child had died

13.2.5.1 This was primarily an individual failing in the case of JL, but it occurred within a system that focused more on risk management than therapy. The structure and content of the ACCT system focuses more on care. For example, the assessment interview notes specifically draw the Assessor's attention to problems that may be overlooked such as relationship and practical problems outside and inside prison.

13.2.6 Failure to deliver support plan

13.2.6.1 The CAREMAP documentation requires a record of the issues to be addressed, the action required, and the identity of the person or department responsible for implementing the plan.

13.2.6.2 The ACCT form has a prominent section in which triggers and warning signs are shown. This could include, for

13.2.7 Perception of prisoners as manipulative

13.2.7.1 Chapter 9 of PSO 2700 contains guidance on the management of prisoners whose behaviour is particularly challenging, and it is likely that the use of trained Assessors will increase the chance of identifying prisoners who are genuinely manipulative and those for whom it is a sign of distress and/or represents a risk of self-harm, whether suicidal or otherwise.

13.2.8 Activities

13.2.8.1 ACCT guidance (and presumably prison guidance generally) focuses on the need for activities. Unit managers are required to ensure that in-cell activities are provided when activities are cancelled or reduced for at-risk prisoners. ACCT guidance points out that activities which distract from painful thoughts and worries are a particularly important part of the care of a prisoner who uses self-harm as a coping strategy.

13.2.9 Multiple recording systems/P-NOMIS

13.2.9.1 The multiplicity of records within a prison presents an obvious risk of communication failures. In some areas, multiple records are necessary and desirable, but clear guidelines and good monitoring and auditing must take place to reduce the risks. PO K and DPSM B both told me about the measures now in place (see DPSM B's statement SL A12, para 7 p2).

13.2.9.2 Annex 8G of PSO 2700 (SL A6) requires entries to be made in the Observation Book and the history sheet as well as the ACCT documentation; and the opening of an ACCT form must also be noted in the clinical record. The Observation Book is of particular importance and I have dealt with this below in relation to handovers (14.2.1).

13.2.9.3 The new computerised system known as P-NOMIS was established after 2002. It should prevent over-reliance on paper records and facilitate good communication. Witnesses spoke of difficulties due to the shortage of terminals and the speed of the system. DPSM B did not wholly accept the criticisms, because desk officers can collate information when required, and the Governor told me that improvements are being made.

14. Suggestions for review

14.1 Professor McDougall made a number of recommendations in her report (SL A3-83). Her recommendations were accepted in principle, and the SSJ has provided a schedule showing the response (SL A13). In summary, the recommendations are largely dealt with by the new ACCT system.

14.2 As a result of the evidence given at the IDRC, there are a few areas where I would suggest a review. I must emphasise that it is a review I recommend, and not a recommendation to take any particular action. That is because my remit has been relatively and suitably narrow, and dwelt on unique, albeit not uncommon, events relating to JL. Action that may seem appropriate to prevent one outcome can have undesirable and unexpected effects elsewhere.

14.2.1 Handovers - the Observation Book

14.2.1.1 The Observation Book is a very important resource for staff coming on duty, because it is impossible for them to read the history sheets for each prisoner (whether on a computer or not). It does not take more than a minute or two to read a whole week's worth of entries. Witnesses spoke of the value of an oral handover, but a written handover is equally important. If, for example, a member of staff new to a particular unit read the book for the past week or so, they might pick up the fact that certain prisoners were previously on ACCT forms.

14.2.1.2 In 2002 staff were regularly making a note in the Observation Book to the effect that they had read and noted the contents. I was told that all staff now do so, but when I asked if it was a specific requirement, I had the impression that it might not be. OSG G told me that although he now makes a note, he was not sure whether it was obligatory, and Governor 1 spoke of it being a matter of outcome rather than process.

14.2.1.3 In all the circumstances, I would recommend a review of handover procedures to consider whether further guidance is appropriate. This applies to all prisoners, not just those on ACCT forms, for whom there are specific guidelines about handovers (e.g. HMYOI Feltham local policy SL A7-22).

14.2.2 Foreign nationals and phone cards

14.2.2.1 Father H expressed the view that foreign nationals were not able to make sufficient contact with their families both in 2002 and now. Foreign nationals are given phone

14.2.3 Cell sharing

14.2.3.1 JL hanged himself while his cellmate was absent at education. Officer C had previously noted that he did not cope well without the company of his cellmate and advised close monitoring in such situations. Whatever JL's intentions, the opportunity and the desire to hang himself might have been avoided if he had been placed on an F2052SH which included provision for monitoring in the event of him being alone in the cell.

14.2.3.2 I recalled a case from 2003 in which a man had hanged himself at HMP Belmarsh whilst on an open F2052SH and in the absence of his cellmate. A local Governor's Order 16/02 (dated 31 May 2002) reminded staff that prisoners on open F2052SHs should not be left alone in such circumstances. (I have not annexed these documents to my report but they have been disclosed to the parties.)

14.2.3.3 Counsel for the SSJ expressed surprise that such an order had existed, because it would be impossible to put into practice. I heard also that the Youth Justice Board (YJB) does not favour the use of shared cells, and the killing of Zahid Mubarek by his racist and violent cellmate graphically demonstrates why great care is needed.

14.2.3.4 However, the Belmarsh Order was itself a reflection of national guidance in place in 2002. The *Instruction to Governors 79/1994* (CMcD A3) also referred to shared accommodation as a supportive measure: *"Every effort will be made to place at risk prisoners in shared and/or supervised accommodation. Where this is the case, a monitoring procedure must be in place to ensure that the at risk prisoner is not left on his/her own e.g. following the transfer or production at court of his/her cell mate."*

14.2.3.5 Current policy also refers to the use of shared cells as a supportive measure, particularly PSO 2700 Annex 8D - *Ideas for developing use of shared cells*, which contains

- *Create a doorway between two cells to allow prisoners to share each other's company but retain privacy when they prefer.*

- *Create a "two room suite" without reducing CNA: two beds in one cell, furniture in neighbouring cell for daytime association.*

- *Maintain a register of prisoners who are willing to act as "supportive cellmates" and are considered suitable.*

And this from Annex 8GG on Cell Sharing:

"ACCT Plans must make clear whether provision needs to be made for when an at-risk prisoner in shared accommodation is alone in the cell (e.g. if the cellmate is at education, on a visit or at court, or - in establishments with locked spurs and night sanitation arrangements - likely to leave the cell at night). If such provision is decided as necessary, it must be included in the CAREMAP."

14.2.3.6 DPSM B made the point that prisoners should not be responsible for keeping other prisoners safe, but he agreed that an at-risk prisoner might be doubled with a cellmate in order to reduce feelings of loneliness and as a means of support. It has also been correctly pointed out that these provisions apply to prisoners on open F2052SH and ACCT forms, and JL was not on an open form at the time of the hanging.

14.2.3.7 There is obvious scope for including cell sharing as a supportive measure within the present system, but the focus of the Feltham policy seems to be firmly fixed on the risks of sharing rather than the benefits. All prison establishments are different, whether by location or category, and I can see that the use of shared cells for young persons and young adults may create a greater risk of harm than in the adult population. It is also worth noting that HMYOI Feltham appears to manage the prevention of harm very well. Governor 1 told me that there have been no deaths or near deaths at the establishment since 2002.

14.2.3.8 Nonetheless, I wonder whether the pendulum has swung too far in the direction of avoiding risk at the cost of providing support and I would welcome a review of the current policies on this issue.

15. Final note/acknowledgements

15.1 I am very much indebted to the parties and their representatives. The case of JL has had a stormy history in the Courts, but I received nothing but intelligent and co-operative assistance at all times from counsel, solicitors and their clients. Representatives from OSRR provided resources and support without interference or delay.

15.2 I am grateful to the personal assistant in this case for her patient and skilful administrative support, as well as another personal assistant who was always ready and able to step in when needed. Errors of substance, form or punctuation are mine alone.

15.3 The last word should belong to JL. There can be no doubt that the events of August 2002 altered his life forever. It is good to know that he continues to make progress, and I was especially pleased to see him at a part of the hearings at the IDRC in January 2011. I wish him well for a long, healthy and happy future.

Selena Lynch
12 July 2011