

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Carl Jacques, a prisoner at HMP Liverpool, on 10 May 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Jacques was found hanged in his cell at HMP Liverpool on 10 May 2015. Mr Jacques was 38 years old. I offer my condolences to Mr Jacques' family and friends.

Mr Jacques was serving an indeterminate sentence. He had substance misuse problems and had been recalled to prison. The Parole Board had recently rejected his initial application for release after his recall, but his offender supervisor considered that they had agreed a clear and straightforward plan that gave Mr Jacques a very good chance of achieving release at his next parole review. The investigation found that Mr Jacques received good help from specialist staff at the prison, although there was little evidence that this was backed up by support from wing officers.

Mr Jacques' death is a reminder of the uncertainty and stresses that prisoners serving indeterminate sentences face, and which, to a large extent, Mr Jacques seems to have hidden. I consider that there was little to indicate to staff that he was at imminent risk of suicide and it would have been difficult to predict Mr Jacques' actions and prevent his death.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

November 2015

Contents

Summary
The Investigation Process
Background Information
Key Events
Findings.....

Summary

Events

1. Mr Carl Jacques was sentenced to an indeterminate sentence for public protection (IPP) in 2008. He was released on licence in August 2014, but recalled to HMP Liverpool on 13 November 2014. When he arrived at Liverpool, reception staff did not identify any risk of suicide and self-harm.
2. Mr Jacques worked with the prison's Lifeline drugs and alcohol intervention service during his time at Liverpool. On 17 January 2015, he assaulted his cellmate, after his cellmate told an officer that Mr Jacques had smoked 'Spice.' (Spice is a synthetic cannabis or new psychoactive substance that can be considerably stronger than cannabis.) Mr Jacques admitted that he had smoked Spice, but told his offender supervisor that he assaulted his cellmate as he thought this meant that staff would move him to a single cell. A wing manager reassessed his risk but decided he was still suitable to share.
3. On 3 February, Mr Jacques told his offender supervisor that he was finding it difficult to cope with his sentence, his recall to prison and his drug problems. His offender supervisor referred him to the prison's mental health in-reach team and Mr Jacques began weekly meetings with a psychologist.
4. On 9 April, wing staff allocated Mr Jacques a single cell. A sticker next to his name in the wing office indicated that staff had now assessed him as high risk for cell sharing, although there is no evidence that anyone had formally reviewed his risk. On 20 April, the Parole Board told Mr Jacques that they would not authorise his release on licence.
5. On 1 May, Mr Jacques discussed his sentence plan with his offender supervisor, who he had a good relationship with. He cried during the meeting and said that he had to wear a 'mask' in prison to hide his emotions. His offender supervisor told us that they agreed a plan that gave Mr Jacques a realistic chance of release at his next parole hearing.
6. On 10 May, the officer who unlocked Mr Jacques' cell in the morning did not check his welfare, as local and national instructions require. About 50 minutes later, another officer found Mr Jacques had hanged himself. Staff began cardiopulmonary resuscitation, but after further emergency treatment, paramedics confirmed that Mr Jacques had died.
7. The duty manager initially asked HMP Doncaster to send a member of staff to break the news to Mr Jacques' mother, who lived near the prison, but they declined on the basis that, as a private prison, they were not required to. HMP Lindholme then agreed to send a family liaison officer.

Findings

8. Mr Jacques was evidently stressed by his recall to prison, his initial failure to be released and his future prospects for release. Nevertheless, we are satisfied that in the days leading up to his death there was nothing to indicate that he was at increased risk of suicide or self-harm and we consider that it would have been

difficult for staff at Liverpool to have foreseen and prevented his death. Mr Jacques received some good support from specialist staff, but this was not backed up by a personal officer or other officers on his wing. The officer who unlocked Mr Jacques' cell on the morning of his death should have checked his welfare at the time. We are concerned that HMP Doncaster refused to provide a member of staff to inform Mr Jacques' mother of his death.

Recommendations

- The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which allows officers to get to know prisoners, identify their needs and make regular case history notes.
- The Director of HMP Doncaster should ensure that prison staff inform a prisoner's family of their death, in line with national instructions, when reasonably requested to do so by another prison.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Liverpool informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator visited Liverpool on 13 May 2015. He obtained copies of relevant extracts from Mr Jacques' prison and medical records, viewed closed circuit television (CCTV) footage of the events of 10 May, and spoke to three prisoners who knew Mr Jacques.
11. NHS England commissioned a clinical reviewer to review Mr Jacques' clinical care at the prison. The investigator and clinical reviewer interviewed prison staff on 16 June. Mr Judd interviewed further staff on 1 July.
12. We informed HM Coroner for Liverpool of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Jacques' mother, to explain the investigation. His mother did not have any specific matters she wanted the investigation to consider. Mr Jacques' mother received a copy of the initial report. She did not make any comments.

Background Information

HMP Liverpool

14. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 1,247 men. At the time Mr Jacques was at Liverpool, Lancashire Care NHS Foundation Trust provided primary care services and Mersey Care NHS Trust provided mental health and substance misuse services. Lancashire Care NHS Foundation Trust now provides all healthcare services. The Lifeline team provides additional interventions and services for prisoners with drug and alcohol problems.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Liverpool, in May 2015, has yet to be published. In preliminary inspection feedback, inspectors reported that levels of self-harm and use of suicide and self-harm prevention procedures (ACCT) were lower than in comparable prisons. Drugs and alcohol were easily available and new psychoactive substances presented significant new challenges. Inspectors found that the personal officer scheme was dysfunctional and amounted to no more than naming officers.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for 2014, the IMB reported that a number of improvements had been made to the healthcare service following the removal of the previous provider, Liverpool Community Health, including the development of a more structured mental health referral pathway. The IMB considered that the prison's Safer Custody team operated a positive suicide prevention policy.

Previous deaths at HMP Isle of Wight

17. Mr Jacques was the tenth prisoner to die at Liverpool since January 2014, the fifth self-inflicted death. In our investigation into the death of a prisoner in April 2014, we found a lack of meaningful contact between wing staff and the prisoner. In our investigation into the death of a prisoner in December 2014, the prisoner's welfare was not adequately checked when his cell was unlocked on the morning of his death.

Assessment, Care in Custody and Teamwork (ACCT)

18. Assessment, Care in Custody and Teamwork, known as ACCT, is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in

place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

19. In April 2008, Mr Jacques was convicted of robbery and later sentenced to an indeterminate sentence for public protection (IPP), with a minimum period to serve of three and a half years before he could be considered for release. He had been in prison several times before. Mr Jacques was dependent on drugs and began an opiate reduction programme. Early in his sentence, prison doctors diagnosed and treated Mr Jacques for obsessive-compulsive disorder and anxiety. There is no record that Mr Jacques had previously harmed himself either in prison or in the community. He was released on licence on 21 August 2014.
20. Mr Jacques lived in a residence for former prisoners undergoing drug and alcohol rehabilitation and detoxification programmes. On 4 November, he was given a warning for drinking alcohol. On 9 November, he was found smoking cannabis and was recalled to prison on the recommendation of his offender manager.
21. Mr Jacques arrived at HMP Liverpool on 13 November. At a routine health screen, a nurse noted that he had no history of suicide or self-harm and said he did not feel like harming himself. He said he had used drugs in the past but was not currently drug-dependent. The nurse had no concerns about his physical or mental health.
22. An officer interviewed Mr Jacques and did not identify any risk of suicide or self-harm or any immediate needs. Another officer completed a cell sharing risk assessment (CSRA), which is designed to assess the risk of violence towards a cellmate. He noted that Mr Jacques did not want to share a cell but there was no evidence that he was a risk to other prisoners. He therefore found him suitable to share a cell.
23. On 19 November, an officer completed a triage assessment for the prison's Lifeline drugs and alcohol intervention service. Mr Jacques said he used cannabis and alcohol and the officer concluded that he needed further assessment and intervention for his cannabis use. They completed a recovery plan, which required Mr Jacques to complete the 'Journey to Recovery' drug rehabilitation programme at the prison.
24. On 26 November, Mr Jacques had an introductory meeting with his offender supervisor. They discussed Mr Jacques' recall. The offender supervisor told us that Mr Jacques understood the reasons why he had been recalled but was frustrated about it, as he thought he had been harshly treated. He said that Mr Jacques' funding for residential accommodation in the community was still secure and that if he worked with the Lifeline team there was a good chance that the Parole Board would recommend release at the first hearing, around six months after his recall. He said that Mr Jacques had actively sought help from the Lifeline team to address his cannabis use.
25. On 30 November, a Lifeline worker discussed the Journey to Recovery programme with Mr Jacques who said he would complete an application form for the programme. He agreed to attend the prison's Narcotics Anonymous meetings.

26. That day, a prison doctor examined Mr Jacques, who had a problem with his ears. They also discussed his return to prison. She noted that he seemed more introverted than before and Mr Jacques said he would like to discuss his issues with someone. She noted that she would refer Mr Jacques for counselling, but there is no record of this happening.
27. On 16 January 2015, Mr Jacques met his offender supervisor and his offender manager. They discussed the Journey to Recovery programme and funding for residential accommodation if the Parole Board recommended his release. The offender supervisor told us that this was a very positive meeting, after which Mr Jacques was clear about what he had to do to achieve parole.
28. The next day, 17 January, Mr Jacques' cellmate told an officer that Mr Jacques had smoked 'Spice' in their cell. (Spice is a synthetic cannabis or new psychoactive substance that can be considerably stronger than cannabis.) Mr Jacques punched his cellmate while he was speaking to the officer. Prison staff charged Mr Jacques with a disciplinary offence of assault.
29. On 18 January, a custodial manager reviewed Mr Jacques' incentives and earned privileges level (IEP, a scheme designed to encourage and reward good behaviour). The manager reduced Mr Jacques from standard to basic (on a scale of enhanced, standard, basic). This meant he had to move to the first floor landing of J Wing, which is exclusively for prisoners on the basic IEP level. The manager also reviewed Mr Jacques' risk for sharing a cell but decided he was still suitable. On 19 January, at a disciplinary hearing, Mr Jacques was punished with seven days cellular confinement, suspended.
30. On 20 January, Mr Jacques admitted to his offender supervisor that he had smoked Spice and said that he thought prison staff would give him a single cell if he assaulted his cellmate in front of an officer. The offender supervisor told us that Mr Jacques thought that, as a prisoner serving an indeterminate sentence, he should have a single cell. The offender supervisor told him that this behaviour meant he would not be able to support his application for release on licence at his parole hearing in April. The offender supervisor told us that Mr Jacques took this news relatively well.
31. On 3 February, Mr Jacques moved to a double cell on I Wing. Later that day, at a meeting with his offender supervisor, he complained about his recent wing moves and said he thought he was being "messed around". The offender supervisor explained the reasons for the moves and reiterated that Mr Jacques needed to complete the Journey to Recovery programme for his offender manager to support his release. Mr Jacques said he was struggling to cope with his sentence, recall to prison and issues around his drug use. The offender supervisor told us that Mr Jacques felt he was in a cycle from which he would not be able to break free. He referred Mr Jacques to the prison's mental health in-reach team.
32. On 4 February, Mr Jacques saw a member of Lifeline for a review. His application for the Journey to Recovery programme had been postponed for six weeks because prisoners on the basic IEP level cannot participate. Mr Jacques said he was happy to wait but was looking forward to starting the programme, as it was important to his aim of being drug free. Mr Jacques said he had smoked

- spice twice since 17 January, but had now stopped and did not intend to use the drug again.
33. On 13 February, a nurse from the mental health in-reach team assessed Mr Jacques, who said he thought he had a “split personality” and post-traumatic stress disorder related to things he had witnessed in prison. He said that he had experienced some suicidal thoughts a few months earlier, but these had gone. She did not ask about these thoughts, but told us that Mr Jacques appeared to be comfortable in prison and he had no concerns for him. She referred Mr Jacques to the prison’s primary care psychological service for further assessment.
 34. On 26 February, the offender supervisor discussed his parole hearing with Mr Jacques and reiterated that he could not support his release at present and that he had recommended to the Parole Board that he should complete the Journey to Recovery programme. Mr Jacques told the offender supervisor that he understood and accepted this. Mr Jacques also said that he wanted to move to a single cell and would like to move to a prison nearer his family.
 35. On 4 March, Mr Jacques was due to move to J Wing to begin the Journey to Recovery programme, but declined the move. He said that he did not want to begin the programme as he had just started a catering course and was waiting to see the mental health in-reach team, who he hoped would recommend he have a single cell. (Prisoners on the Journey to Recovery programme have to share a cell.) He said that he had some “loose ends” to tie up, and was waiting to see a solicitor about his imminent parole hearing. The offender supervisor told us that he thought Mr Jacques had made an impulsive decision, which he was prone to do.
 36. On 12 March, Mr Jacques told a worker from Lifeline that he was enjoying his catering course. He said he felt positive about his parole hearing and might apply for Journey to Recovery again if he did not get parole. His parole hearing went ahead as scheduled on 19 March.
 37. On 24 March, a primary care psychologist assessed Mr Jacques, after the nurse’s referral. Mr Jacques said he felt low because of ongoing stress but had no thoughts of harming himself. She concluded that he had an anxiety disorder and agreed that he should have a programme of low intensity intervention (used to treat patients suffering mild to moderate anxiety or depressive disorders). She no longer works at Liverpool and prison staff did not have her contact details so were unable to speak to her about her contact with Mr Jacques.
 38. On 31 March, Mr Jacques told the psychologist that he found it difficult to get on with his cellmate, which made him feel frustrated and anxious. He said he had occasional thoughts of suicide, but did not plan to act on these and believed things would improve. On 7 April, he refused to provide a sample for a mandatory drugs test and was charged with a disciplinary offence.
 39. The same day, Mr Jacques had another appointment with the psychologist and said that his relationship with his cellmate left him stressed and anxious. He said he had had some thoughts of harming himself, but did not plan to act on these and was focused on moving forward.

40. At a disciplinary hearing on 8 April, Mr Jacques pleaded guilty and said that he had refused the drug test because he had smoked cannabis. Mr Jacques said he liked to smoke cannabis, had problems with his release date and needed a single cell. The adjudicator said that he would arrange a review of Mr Jacques' cell sharing risk assessment. He gave Mr Jacques 14 days stoppage of earnings and loss of association.
41. There is no formal record that anyone reviewed Mr Jacques' risk for cell sharing, but he was given a single cell on 9 April. A sticker stating 'medical single cell' was next to Mr Jacques' name on board in the wing staff office but this was not a healthcare decision and we were told that officers used these for anyone assessed as high risk for cell sharing.
42. Mr Jacques did not attend the Narcotics Anonymous meeting on 13 April, or for the next two weeks. He told a worker from Lifeline that he had got "distracted" on the way to one meeting, but denied that he had missed other meetings.
43. On 16 April, Mr Jacques telephoned a friend. Prisoners' telephone calls are recorded. Prison staff listen to a random sample of telephone calls, but had not listened to Mr Jacques' calls. We listened to the call in which Mr Jacques said that he had decided not to take the Journey to Recovery course because when he finished it he would have had six months "twiddling his thumbs" before he was released. He said he preferred to put the course off for six months and work instead. Mr Jacques said that he had smoked cannabis in prison and asked his friend to arrange for another friend to pay some money into another prisoner's account, as he owed this prisoner money for tobacco.
44. Two days later, on 18 April, Mr Jacques phoned his friend again. He said the debt was for £20 and named a prisoner as the man to pay. This prisoner told us that Mr Jacques had owed him the money for tobacco.
45. On 20 April, the Parole Board informed Mr Jacques that they had not authorised his release on licence. They said that he should complete the Journey to Recovery programme and they would hold his next review by April 2016. None of the I Wing staff we spoke to were aware that Mr Jacques had been refused parole.
46. On 21 April, Mr Jacques told the psychologist that his mood had improved. He said that he still worried about some things, and they discussed ways that he could manage this. She noted that she had not identified any issues that might indicate a risk of suicide or self-harm. Mr Jacques had another appointment with her again on 28 April. He said he had felt settled in the last week, although continued to worry about the future.
47. On 30 April, Mr Jacques phoned his friend again and asked him to pay £20 into the prisoner's account, as the other friend, who he had asked to do this, had not yet done so. Mr Jacques said that the situation was "getting messy" and someone had been onto him to get the money. Mr Jacques phoned back a few minutes later and his friend told him that he had now paid the money. Mr Jacques was relieved and said he had been worrying about this for a few weeks.

48. On 1 May, Mr Jacques met his offender supervisor to discuss the coming year before his next parole hearing. The offender manager joined the meeting by telephone. They discussed a transfer to a prison closer to Mr Jacques' home, but decided that he should stay in Liverpool to complete the Journey to Recovery programme, as this would allow him to meet the Parole Board's requirements quicker. They also agreed that Mr Jacques would work in the kitchens for a few months before starting the programme. (He had got a job in the kitchens after his catering course and was waiting for a start date.) This was a long meeting and Mr Jacques had cried during it. He told his offender supervisor that he had to "wear a mask" in prison and he could let the mask slip during the meeting because he was in a comfortable environment. The offender supervisor told us that he did not open an ACCT plan because, while Mr Jacques was emotional in the meeting, his mood was not low and he was laughing and joking at the same time as crying. He said that this was a constructive meeting, in which they agreed a plan for Mr Jacques to achieve release on parole at his next hearing.
49. On 5 May, Mr Jacques met the psychologist for his weekly appointment. He said he was a little frustrated that he was still waiting to start work in the kitchens, but otherwise had no concerns. They discussed how he could cope with feelings of frustration and boredom. She again did not consider he was at risk of suicide or self-harm.
50. On 7 May, Mr Jacques wrote a poem for Inside Time, a newspaper for prisoners. The tone of the poem was mainly forward looking and Mr Jacques wrote about the need to keep his faculties intact until he was released and that he would not give up his life for anybody. He referred to his past and questioned how he had begun on the path that led him to prison.
51. A prisoner on I Wing said that he and Mr Jacques had coffee together most mornings and he saw him on 9 May. He told us that Mr Jacques had felt he could not see any light at the end of the tunnel after being refused parole, and felt that he was losing his support network outside prison. Mr Jacques told him that he had "built up a wall" in prison to hide his emotions.
52. On the night of 9 May, Mr Jacques spoke to a prisoner in the next cell through his cell window. This prisoner told us it was a normal conversation and he passed Mr Jacques some food through the window.
53. An operational support grade was the night patrol officer on 9 May. He said that Mr Jacques did not press his cell bell to call him to the cell at any time during the night. He completed a morning roll check to establish that all prisoners were present in their cells at around 5.15am. He said that Mr Jacques was asleep in his cell at the time.
54. At around 9.05am on 10 May, Officer A unlocked the cells on Mr Jacques' landing. CCTV footage shows that he unlocked the doors but did not check prisoners. The officer told us that he wanted to unlock the cells as quickly as possible so the prisoners could come out. He was not aware of any instructions to check prisoners' wellbeing when unlocking their cells.
55. The CCTV shows that no one went into or out of Mr Jacques' cell in the next 50 minutes. At around 9.55am, Officer B began locking prisoners back into their

cells. When he arrived at Mr Jacques' cell, he found him hanged by a bed sheet around his neck, tied to the bed frame. He shouted for assistance and an officer immediately went into the cell, followed around ten seconds later by another. When he heard Officer B's shout, a Supervising Officer (SO) radioed the control room to ask for staff assistance.

56. Officer B cut the sheet from around Mr Jacques' neck, laid him on the floor of the cell and began cardiopulmonary resuscitation. The SO tried to radio a code blue medical emergency (indicating a life threatening situation) when he arrived at the cell, but could not do so immediately as the control room were broadcasting the earlier call for staff assistance. Another SO arrived at the cell shortly afterwards and successfully made the call. The prison's control room recorded this at 9.56am and an operator telephoned for an ambulance immediately.
57. A nurse arrived and took over cardiopulmonary resuscitation, helped by other nurses. The nurses attached a defibrillator, which found no shockable heart rhythm so they continued with resuscitation. Paramedics arrived at the cell at around 10.10am and took over emergency treatment. At around 10.15am, they pronounced Mr Jacques had died.

Contact with Mr Jacques' family

58. The duty manager that day searched prison records for Mr Jacques' next of kin details but said this took a while to verify as two different people had been listed as Mr Jacques' mother. He established that Mr Jacques' mother lived near Doncaster and at 11.30am, he phoned the duty manager at HMP Doncaster to ask for someone from the prison to inform Mr Jacques' mother of his death. The duty manager said he could not do this. He told us that this is not something that a privately operated prison would normally do, and that a member of staff from Doncaster would not know the full details of what happened.
59. The duty manager then telephoned the duty manager at HMP Lindholme, who agreed to send a family liaison officer to visit Mr Jacques' mother. The duty manager briefed the family liaison officer on the circumstances of Mr Jacques' death and she visited Mr Jacques' mother at around 2.10pm, but no one answered the door. She waited for 45 minutes and tried again before returning to Lindholme. She went back at around 4.05pm and informed Mr Jacques' mother that her son had died.
60. On 11 May, the Governor of Liverpool and a prison's family liaison officer visited Mr Jacques' mother to offer condolences and support. Mr Jacques' funeral took place on 1 June. In line with Prison Service guidance, the prison contributed to the costs of the funeral.

Support for prisoners and staff

61. After Mr Jacques' death, the duty manager debriefed the staff involved in the emergency response to allow them the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.
62. The prison posted notices informing prisoners of Mr Jacques' death, setting out the help available if they needed support. Staff reviewed all prisoners subject to

suicide and self-harm prevention procedures in case they had been adversely affected by Mr Jacques' death.

Post-mortem report

63. A post-mortem examination established the cause of death as asphyxiation due to hanging. Toxicology tests found no evidence of illegal or unprescribed drugs in Mr Jacques' death.

Information received after Mr Jacques' death

64. After Mr Jacques died, a friend of his, who had known him in the community, wrote an article for Inside Time about him. His friend said that Mr Jacques had been increasingly worried about the effects of long-term imprisonment. When his application for parole was refused, Mr Jacques had told his friend that he almost did not want to be released as prison felt like home and he was scared to get out. Another friend wrote to the Morning Star and said that Mr Jacques' IPP sentence meant he did not know if or when he would be released.

Findings

Identifying risk of suicide and self-harm

65. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Liverpool should have recognised Mr Jacques as at risk and opened an ACCT.
66. Recall to prison, serving an indeterminate sentence and a parole refusal are all factors that increase the risk of suicide. Mr Jacques had cried during his last meeting with his offender supervisor and said he usually masked his true feelings. He told his friend that he could not see any light at the end of the tunnel after the Parole Board had refused his application for release on licence. A friend of Mr Jacques' thought that his IPP sentence caused him stress as he did not know when, or if, he would be released. However, the offender supervisor told us that he had agreed a clear plan with Mr Jacques that gave him a realistic chance of achieving release at his next parole hearing and at the end of the meeting, Mr Jacques had appeared positive. A prison psychologist reviewed Mr Jacques frequently and did not identify him as at raised risk of suicide.
67. Mr Jacques had longstanding substance misuse problems, which had led to his recall to prison in November 2014. In January 2015, Mr Jacques admitted that he had smoked 'Spice', a new psychoactive substance. One of his friends told us that Mr Jacques used heroin on I Wing, and he admitted that he had smoked cannabis in prison. Substance misuse can be a trigger for suicide and self-harm and there are concerns that the use of new psychoactive substances in particular, can produce a range of reactions and might increase the risk of suicide and self-harm. However, staff from the prison's Lifeline drugs and alcohol intervention service reviewed Mr Jacques frequently and none of them had any concerns about his risk. The toxicology report found no trace of illegal drugs but did not test for new psychoactive substances. There is no evidence that Mr Jacques had used a new psychoactive substance shortly before his death. We therefore cannot know whether this influenced his actions.
68. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. None of the staff we spoke to said they had ever considered Mr Jacques at risk of suicide or self-harm. His friends agreed that they had never thought that Mr Jacques would harm himself. Mr Jacques had no recorded history of self-harm, either in prison or in the community.
69. We are satisfied that while Mr Jacques was at Liverpool, including in the days leading up to his death, there was little to indicate to staff that his risk had heightened or that he was at imminent risk of suicide. We do not consider that staff could reasonably have been expected to predict his actions and prevent his death.

Personal officer scheme

70. Mr Jacques' assigned personal officer said that he was unaware of this, as the allocation of cells had changed without him realising. In any event, he said that staff do not have time to carry out personal officer duties.
71. From when he moved to I Wing in February 2015, there were no personal officer entries in Mr Jacques' case notes and no entries from any officers about his welfare. We acknowledge the difficulties of running a successful personal officer scheme in a large local prison such as Liverpool but it is a concern that Mr Jacques' personal officer was unaware of this responsibility. We also note that the recent inspection of Liverpool found that the personal officer scheme was not operating effectively. None of the officers we spoke to during the course of the investigation really knew Mr Jacques and none, including his personal officer, knew that he had recently been refused release on licence. We are not therefore satisfied that Mr Jacques received meaningful support on I Wing. We make the following recommendation:

The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which allows officers to get to know prisoners, identify their needs and make regular case history notes.

Unlock procedures

72. Officer A unlocked Mr Jacques' cell at around 9.05am on the day of the incident. He did not check his wellbeing or that of any other prisoners. He said he was not aware of any instruction to check the welfare of prisoners when unlocking their cells.
73. When officers unlock cells they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that, "Prior to unlock, staff should physically check the presence of the occupants of every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner had not escaped, is ill or dead".
74. PSI 10/2011 also expects officers to check prisoners when unlocking their cells and this is reflected in a local instruction at Liverpool, Governor's Order 12/2013 which requires that staff "satisfy themselves that the prisoner is responsive" when unlocking cells.
75. Officer B found Mr Jacques hanged in cell around 50 minutes after Officer A unlocked it. We cannot say whether Mr Jacques' death could have been prevented if he had been checked earlier, but failure to get a response from a prisoner and check their wellbeing when unlocking a cell could prevent an effective emergency response. As the Governor reissued the local instruction about this three days after Mr Jacques died, we make no further recommendation.

Family liaison

76. PSI 64/2011 instructs that wherever possible a family liaison officer from the prison and another member of staff must visit the deceased prisoner's next of kin to break the news of their death. It notes that it is important that this is done quickly and that where a prisoner is located a long way from their next of kin, the prison should consider requesting the assistance of a family liaison officer from the prison nearest to their family. Liverpool considered that it was too far to visit Mr Jacques' mother in Doncaster to inform her of his death. We are slightly surprised at this, as Doncaster is just over two hours drive from Liverpool and it takes additional time to contact another prison and brief them. However, we accept that this was not an unreasonable decision.
77. The duty manager at HMP Doncaster refused Liverpool's request to ask a family liaison officer to inform Mr Jacques' mother of his death. He told us that, as a privately operated prison, Doncaster would not normally do this. He said that their family liaison officer would not know any details of the death and would not therefore be able to answer any questions put to them.
78. The PSI makes no distinction between public and privately operated prisons and the instruction applies to both sectors. We do not consider that there is any reason why a privately operated prison should not assist a public prison to break the news of a death when this is necessary. The prison where the death occurred should brief the family liaison officer before they visit to ensure they have sufficient information about the circumstances to answer initial questions and then refer families to the family liaison officer at the prison. A SO told us that the duty manager gave her all the information she needed before she visited Mr Jacques' mother. We make the following recommendation:

The Director of HMP Doncaster should ensure that prison staff inform a prisoner's family of their death quickly and in person, in line with national instructions, when reasonably requested to do so by another prison.

**Prisons &
Probation**

Ombudsman
Independent Investigations