

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Jack Murray a prisoner at HMP Coldingley on 13 September 2018

**A report by the Prisons and Probation Ombudsman**

## 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 2018

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](http://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](mailto: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 Jack Murray was found hanged in his cell at HMP Coldingley on 9 September 2018, and died in hospital on 13 September. He was 32 years old. I offer my condolences to his family and friends.

Mr Murray had absconded from an open prison in May and had been arrested and returned to prison in July. He had been at Coldingley since 24 August, and appeared to have settled well and had a job in a prison workshop. I am satisfied that staff could not have anticipated that Mr Murray was at risk of suicide or self-harm.

When Mr Murray was found hanged, staff and ambulance paramedics responded promptly. However, I am concerned that staff were confused by the defibrillator's instructions during resuscitation efforts and that there was a delay in informing his family about the incident and that he had been taken to hospital.

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

**Elizabeth Moody**  
**Deputy Prisons and Probation Ombudsman**

**May 2019**

## **Contents**

Summary .....	1
The Investigation Process .....	2
Background Information .....	3
Key Events .....	4
Findings.....	8

# Summary

## Events

1. In August 2014, Mr Jack Murray was remanded to HMP Winchester, charged with aggravated burglary. He was later sentenced to 11 years in prison. He was transferred to open conditions in May 2018 but absconded 11 days later. He was rearrested on 13 July and taken back to Winchester. He received a further sentence of six months for absconding from custody. On 24 August, Mr Murray was transferred to HMP Coldingley.
2. Mr Murray settled quickly at Coldingley and got a prison job. Staff found that Mr Murray was polite, respectful, and complied with the prison regime. He was not being monitored under suicide and self-harm prevention procedures, and nothing took place which gave staff cause for concern about his welfare.
3. In the late evening of 9 September, Mr Murray pressed his cell bell to use the communal toilets. When they thought that Mr Murray had not returned to his cell, staff went to the wing to investigate. Staff found Mr Murray hanged in his cell. He had tied a ligature to the outside handle of the cell door and looped it across the top of the door.
4. Staff cut the ligature and went into the cell. An emergency ambulance was called and staff began cardiopulmonary resuscitation (CPR). Paramedics arrived ten minutes later and took over CPR. After several minutes of treatment, Mr Murray began to breathe spontaneously and he was taken to hospital. Mr Murray remained in intensive care, where he died on 13 September.

## Findings

5. Mr Murray had no history of attempted suicide or self-harm in prison and there was nothing to suggest to prison staff that he was at imminent risk.
6. Officers tried to resuscitate Mr Murray but they were confused by some of the defibrillator's instructions.
7. There was a delay in informing Mr Murray's mother that her son was critically ill and had been sent to hospital.

## Recommendations

- The Governor should ensure that staff understand how to deliver CPR both with and without rescue breaths in line with NHS guidance.
- The Governor should ensure that when a prisoner is taken to hospital seriously ill, their next of kin is informed without delay.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Coldingley informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded.
9. The investigator obtained copies of relevant extracts from Mr Murray's prison and medical records. He interviewed six members of staff at Coldingley on 25 October 2018 and subsequently spoke to one other witness by telephone.
10. NHS England commissioned a clinical reviewer to review Mr Murray's clinical care at the prison.
11. We informed HM Coroner for Surrey of the investigation. We have sent the Coroner a copy of this report.
12. We contacted Mr Murray's next of kin, his mother, to explain the investigation. The family did not have any specific matters they wanted us to consider.

# Background Information

## HMP Coldingley

13. HMP Coldingley is a Category C prison in Surrey, holding just over 500 adult male prisoners. Its primary purpose is to provide prisoners with the opportunity to experience a typical working day to prepare them for a purposeful life on release. Central and North-West London Foundation Trust provide for primary and mental healthcare needs. There are no nurses on duty at night.

## HM Inspectorate of Prisons

14. The most recent inspection of Coldingley was in February and March 2017. Inspectors found that the number of incidents of self-harm was relatively low and procedures to manage those at risk of suicide and self-harm were generally appropriate. Inspectors noted that in general, they observed reasonable staff interactions with prisoners, although wing-based staff did not always interact with prisoners during association. Inspectors found that prisoners had an exceptionally high amount of time out of their cells, with those attending activities being out of their cells for 11 hours on a week day and around eight hours at the weekend.

## Independent Monitoring Board

15. 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 report for the year to July 2018, the IMB noted that the workshop facilities at Coldingley were “first class” and spoke positively of the support that workshop instructors gave prisoners, along with other non-uniformed staff. The IMB also noted that it believed that prisoners were treated fairly. The IMB was critical of the physical fabric of the older accommodation wings.

## Previous deaths at HMP Coldingley

16. Mr Murray’s death was the second self-inflicted death at Coldingley since September 2015. There were no similarities between that death and that of Mr Murray.

## Toilets at HMP Coldingley

17. The cells in wings A, B, C, D and F at Coldingley do not have in-cell sanitation. Instead, they have communal toilet and washroom blocks. An automated unlocking system allows prisoners to access the toilets during lock-up periods. A prisoner must ring his cell bell and his door will be unlocked remotely, provided that no other prisoner is out of his cell. The prisoner has eight minutes to complete his visit and, on return to his cell, must enter a code to confirm his return. His door is then locked and the next prisoner waiting can be let out. If the prisoner fails to return to his cell after eight minutes, an announcement is made on the tannoy system that they are overdue and must return. (Mr Murray’s cell was in C Wing.)

## Key Events

18. In August 2014, Mr Jack Murray was charged with aggravated burglary and was remanded to HMP Winchester. He was subsequently convicted and received a sentence of 11 years.
19. On 4 May 2018, Mr Murray was transferred from Winchester to HMP Spring Hill, a Category D open prison. He absconded from Spring Hill on 15 May. He was arrested on 13 July and taken back to Winchester. On 13 August, he received a further sentence of six months for absconding from custody.
20. On 24 August, Mr Murray was transferred to Coldingley. The reception nurse noted that Mr Murray was fit and well and that he did not have problems with either alcohol or drugs. He said that he had never been treated at a psychiatric hospital. He said that he had never harmed himself and that he had no current thoughts of suicide or self-harm.
21. Mr Murray spent his first night on Coldingley's reception wing and moved to C Wing the next day.
22. On 26 August, an officer made an entry in Mr Murray's electronic prison record to say that he had not had enough time to assess Mr Murray, but in his two days on C wing, he had been polite and respectful to staff and he did not appear to have any concerns.
23. At a secondary health screen on 30 August, Mr Murray was again noted to be fit and well. The nurse noted that he was fit to use the prison gym and that he had no outstanding hospital or doctors' appointments.
24. The Head of Safer Custody at Coldingley, told the investigator that he had met Mr Murray when he had previously worked at HMP Winchester. The Head of Safer Custody said that Mr Murray had worked as a healthcare orderly at Winchester. This was a responsible job which included helping elderly prisoners and those with mental health problems. He said that Mr Murray would spend time reading to a prisoner with dementia. Mr Murray was also a Samaritans-trained Listener and had worked on the 'Inside or Out' project. This entailed working with Youth Offending Teams to explain to young people the adverse consequences of offending behaviour.
25. The Head of Safer Custody said that he had not seen Mr Murray for around 18 months, but they accidentally met on C Wing towards the end of August. He said that they asked one another what they were doing at Coldingley. Mr Murray explained that he had absconded from Spring Hill, which he said had been a mistake. He said that he told Mr Murray that he believed that Coldingley was a good prison and he thought Mr Murray would do well. He told Mr Murray to come to see him if he had any problems. The Head of Safer Custody told the investigator that they chatted for around ten minutes and nothing occurred to cause him concern about Mr Murray's welfare.
26. On 3 September, Mr Murray started a full-time job at a workshop at Coldingley, refurbishing airline headphones. One of the workshop instructors told the investigator that Mr Murray attended work regularly and was a hard worker who

always exceeded the minimum work quota. He said that Mr Murray would chat to other prisoners but seemed happier to work alone or in a small group. He said that Mr Murray always seemed comfortable in the environment and he raised no concerns.

27. Mr Murray's personal officer, told the investigator that he spoke to Mr Murray most days to check how he was getting on. The officer said that Mr Murray was quiet and tended to keep to himself. While he would speak to other prisoners daily, he did not seem the type of person who would gravitate towards large groups. The officer said that Mr Murray was always polite and was confident approaching and speaking to officers.
28. Another officer told the investigator that he worked on C Wing and he spoke about Mr Murray in a similar way to the personal officer. He said that Mr Murray seemed to be settling in well and although Mr Murray did not mix much with other prisoners or appear to join any groups, his behaviour raised no concerns: he came out of his cell to use the telephone and to collect meals.
29. A friend of Mr Murray since they had met at Winchester, told the investigator that he lived on E Wing but he saw Mr Murray most days at work. He last saw him at about midday on 7 September. He said that Mr Murray was in a fairly low mood and said that his girlfriend had not visited him at Coldingley. The friend advised Mr Murray to write to her to explain his feelings and worries. He said that Mr Murray denied thoughts of self-harm. He told Mr Murray to shout across to E Wing if he wanted to speak to him again. He said that he asked one of the managers if Mr Murray could move to a cell on E Wing but was told that there were no free cells. He said that he did not believe that staff at Coldingley could have anticipated Mr Murray's actions.
30. Another prisoner on C Wing and a friend of Mr Murray from the community, told the investigator that Mr Murray was selective with the prisoners to whom he spoke and tended to talk to those he already knew. He said that Mr Murray would come to his cell most days for a chat. He said that he last saw Mr Murray at around 4.30pm to 5.00pm on 9 September. Mr Murray said that he had just had an argument with his girlfriend as she would not say whether she would visit him on 10 September. He told the investigator that he did not believe it was Mr Murray's intention to take his life. He thought that Mr Murray expected to be saved and that his girlfriend would then give him more attention.
31. Mr Murray's last day of work was on 7 September. His shift ended at lunchtime.
32. On 9 September, an officer made an entry in Mr Murray's records to say that at that time, he did not meet the eligibility criteria to move to E Wing. (He had not been in Coldingley long enough at that point.)
33. The investigator listened to Mr Murray's telephone calls. Most of his calls were to his girlfriend and many of their conversations indicated that Mr Murray believed that she wished to end their relationship. Mr Murray had four conversations with his girlfriend on 9 September. Their last conversation was at just after 4.00pm. Mr Murray asked her whether she would visit him the next day, as she had previously arranged, but she said that she was not going to do so as she had other arrangements.

## Evening of 9 September

34. In the late evening of 9 September, Mr Murray pressed his cell bell to use the toilets. His door was released at 10.59pm. An operational support grade (OSG) was working in the communications office and at about 11.10pm saw from her computer screen that Mr Murray had still not apparently returned to his cell. She called him on the tannoy several times to return. At 11.16pm, she contacted an officer on C Wing to ask him to check on Mr Murray. She also asked other officers, including the duty manager, to go to C Wing.
35. The C Wing officer said that he received a call from the communications room to check on Mr Murray, who was not responding to requests to return to his cell. He said that he went to the second landing and looked through the wing door but he could not see Mr Murray on the landing. As officers are not allowed to go onto a landing alone at night he waited for the other officers to arrive. The three officers went onto the second landing at just before 11.20pm. As they approached Mr Murray's cell, they saw that his cell door was closed, but there was a strip of a bed sheet tied to the outside door handle and looped over the top of the door and running into the cell.
36. One officer cut the bed sheet and the officers could see through the observation panel that Mr Murray was slumped on the floor bedside the door. The officers pushed the door open and one officer pulled the remnants of the ligature off Mr Murray's neck. Another officer said that Mr Murray was not breathing so he and one of his colleagues took turns in giving chest compressions.
37. The officers also radioed the communications room and asked for an emergency ambulance. No one called a medical emergency code blue. A third officer collected a defibrillator but that instructed that no shock could be given and that attempts at resuscitation should continue. Body-worn camera footage shows the officers giving chest compressions at the pace indicated by the defibrillator. At 20 second intervals, the defibrillator instructed that two rescue breaths should be given before resuming audio prompts for chest compressions. In addition, the defibrillator periodically instructed staff to move away while it checked whether a shock should be given. At no stage did it find that a shock should be given.
38. The staff did not give any rescue breaths. Two officers explained that there was fluid coming from Mr Murray's nose and mouth, possibly a mixture of vomit, blood and mucus, so the officers did not consider that it would be safe for them to give rescue breaths. Nor did the officers deliver compressions during the two second intervals when they were instructed to give rescue breaths. Both officers believed that they should only deliver compressions while the defibrillator was specifically instructing them to do so.
39. Ambulance paramedics arrived at 11.30pm. They asked staff to move Mr Murray onto the landing so that they had more room and they took charge of resuscitation efforts. After several minutes' treatment, Mr Murray began to breathe spontaneously. The paramedics continued to treat Mr Murray for the following hour and then took him to hospital at around 40 minutes past midnight. No handcuffs or other restraints were applied to Mr Murray but two officers went with him as escorting officers.

40. Mr Murray had left a brief note on his bed in which he apologised to his mother and girlfriend for being a burden and said that they would be better off without him. He also left in his cell a separate letter to his girlfriend which was dated 7 September. He wrote that if she failed to visit him on 10 September, he would take that as her intention to end their relationship and that without her, he had nothing to live for. He added that if there is a “next life”, that they would possibly meet again there.

### **Contact with Mr Murray’s family**

41. The Duty Governor arrived at the prison at around ten minutes after midnight. He told the investigator that he asked staff to establish who should be treated as Mr Murray’s next of kin as he wished to ensure that he contacted the correct person. He said that Mr Murray had named his girlfriend as his next of kin, but staff had told him that it was possible that their relationship had ended. Staff listened to Mr Murray’s many recent telephone calls and the Duty Governor then decided that Mr Murray’s mother should be treated as his next of kin. He telephoned her at 6.00am on 10 September to inform her that her son was in hospital.
42. Mr Murray remained in intensive care but died at 3.50pm on 13 September. Mr Murray’s mother, step-father and other family members and friends were with him when he died. Coldingley subsequently contributed to the cost of Mr Murray’s funeral in line with national instructions.

### **Support for prisoners and staff**

43. The Duty Governor held a debrief meeting at 1.00am on 10 September. He informed staff about the support available from the care team.
44. The prison subsequently posted notices informing other prisoners of Mr Murray’s death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by his death.

### **Post mortem report**

45. We have not received a copy of the post-mortem report or toxicology results at the time of writing this report. However, Mr Murray did not have a history of substance misuse in prison and there was no intelligence to indicate that he used drugs.

# Findings

## Assessment of risk

46. All the evidence indicates that Mr Murray settled quickly at Coldingley and he obtained a job in one of the prison workshops. He attended work regularly and was a diligent worker. Officers found that Mr Murray was respectful and compliant with the prison regime. He appears to have been selective with his friendships with other prisoners but there is nothing to suggest that he was fearful of other prisoners.
47. Mr Murray's overwhelming concern was his belief that his relationship with his girlfriend was at an end. Although Mr Murray spoke to two of his friends about his concerns, neither of them believed that Mr Murray was at risk and one said that Mr Murray specifically assured him that he was not having thoughts of self-harm. There is no evidence that Mr Murray spoke to staff or anyone else at the prison about his concerns. We do not consider therefore that staff could have anticipated Mr Murray's actions.

## Response to Mr Murray's discovery

48. Body-worn camera footage shows officers giving chest compressions at the pace indicated by the defibrillator. However, the staff did not give rescue breaths and they gave no compressions during the two second intervals when the defibrillator indicated that breaths should be given. Staff told the investigator that they decided not to give rescue breaths as they were concerned about fluids from Mr Murray's mouth and nose. We do not criticise the staff for this decision.
49. We appreciate that the staff were in an unusual and difficult situation and that they did their best to resuscitate Mr Murray. However, once they decided that they would not give rescue breaths, they should have continued giving chest compressions, only pausing when the defibrillator was checking whether a shock should be given. We note that the NHS has published guidance on the delivery of CPR without rescue breaths which explains that compressions should continue at a rate of 100 to 120 per minute until an ambulance arrives. We make the following recommendation:

**The Governor should ensure that staff understand how to deliver CPR both with and without rescue breaths in line with NHS guidance.**

50. When staff discovered Mr Murray, they did not radio a medical emergency code blue but instead asked directly for an emergency ambulance be called. We would ordinarily be critical of a failure to use the code blue system but in this instance, the three officers at the scene worked together to manage the emergency, including collecting a defibrillator, and the duty manager responded promptly.

## Liaison with Mr Murray's family

51. PSI 64-2011 on safer custody requires that when a prisoner has "suffered sudden life-threatening harm", the prison must contact their next of kin, or a

nominated person, and give an accurate account of what has happened, whether they are in hospital and give information about visiting them in hospital.

52. Mr Murray had listed both his mother and his girlfriend as his next of kin. The Duty Governor said that he asked staff to listen to Mr Murray's telephone calls to ensure that the correct person was contacted. The Duty Governor arrived at the prison shortly after midnight and it was clear by then that Mr Murray was unconscious and would have to be sent to hospital. Mr Murray's mother was not contacted about what happened until 6.00am.
53. We appreciate that the different strands of a prisoner's family can be fractured and we understand that the Duty Governor wanted to avoid potential conflict. Nevertheless, we consider that it took too long to notify Mr Murray's mother about what had happened. We make the following recommendation:

**The Governor should ensure that when a prisoner is taken to hospital seriously ill, their next of kin is informed without delay.**

### **Clinical care**

54. The clinical reviewer, concluded that Mr Murray's care was equivalent to that which he could have expected to receive in the community. She noted that Mr Murray appeared emotionally well, with no indication throughout his contact with prison healthcare professionals that he had any thoughts of suicide or self-harm. She noted that Mr Murray had been treated for anxiety at the beginning of his sentence which appeared to have been well managed with medication. She found that his physical health improved during his prison sentence and that he received prompt treatment for minor ailments.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations