TERENCE GASKELL

No effective system to identify prisoners at risk

by **Nick Stanage,** Garden Court North

Terence Gaskell, aged 33, was on remand at HMP Durham from 27 June 2002 until his death there on 7 October 2002. He had no criminal history. The day before his remand he had attempted to take his own life; a F2052SH was opened on arrival at HMP Durham where he was placed in the health care centre.

The medical officer's instruction on the discharge note stated 'comm cell at all times', an instruction in place until his death. It was conceded that no written guidance for such a term existed and therefore staff were confused about the level of supervision, inspection or management required. Some staff believed that 'at all times' meant 'only while on F2052SH'. The investigating governor understood it to mean that a prisoner should never be left alone.

A further medical instruction stated 'keep F2052SH open for at least one month'. Two prison staff saw fit to contravene it. Only four days later at a case review they closed the F2052SH because the instruction was 'unusual' and Mr Gaskell seemed 'a lot happier'.

Correspondence intercepted one week later by censors showed suicidal ideation. A second F2052SH was opened. Prison staff who opened this second form were unaware of the previous one. As practitioners are aware, the format of the F2052SH does not provide an opportunity to record whether or when previous forms have been opened. Closed F2052SHs are not kept on personal files.

In any event, the second form was closed on 2 August 2000, again contrary to medical instruction, by staff who noted Mr Gaskell to be 'very positive'. No records of concern about Mr Gaskell were made in the two months which followed. No procedure to monitor post-F2052SH progress was in place.

On the morning of 7 October 2002 Mr Gaskell, left alone and unsupervised while his cell mate was on exercise, took his own life by hanging.

A prison chaplain warned of the need for more staff, facilities and training to identify prisoners at risk and avoid further fatalities.

The inquest started on 1 December 2004. The jury were asked *inter alia* 'Do you believe that there was existing at HMP Durham during the period June to October 2002 an effective system for any member of staff to identify prisoners who may have been at risk of ending their own lives? If not, why?

The jury answer was 'No': (i) lack of linkage (between) and systematic use of existing documentation; (ii) serious concerns on the effectiveness of the form F2052SH, mainly the ease of closure, and the exchange of information (between) F2052SHs; (iii) concerned about the monitoring system beyond the F2052SH process if previously identified as high risk'.

The jury further found that Mr Gaskell's death was in part due to the failure to identify him as a person who may self-harm and that confusion in the minds of prison staff as to the meaning of 'comm cell at all times' played a further part in his death.

H.M. Coroner A. Tweddle made several Rule 43 recommendations. In order to prevent the recurrence of similar fatalities he urged the prison service to amend the front cover of form F2052SH so as to show (a) whether previous forms had been opened and (b) the date of closure thereof. Further, H.M. Coroner recommended written guidance on the meaning of 'comm cell' and the level of supervision which that term requires. Yet further, HM Coroner recommended written instructions to officers chairing F2052SH case reviews as to the minimum quorum of attendees and their qualifications.

If the prison service adopts such Rule 43 recommendations the inquest into the death of Terence Gaskell will have prompted change to the format of the F2052SH and to the conduct of case reviews throughout the prison system.

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