JOSEPH McCARROLL

Failure to monitor suicide on CCTV

by **Nick Stanage**, Garden Court North

Joseph McCarroll was on remand at HMP Preston between 28 March 2002 until his death there on 27 May 2002. On admission to HMP Preston he was on a F2052SH form which had been opened at court.

During April 2002 prison staff became aware of the risk Mr McCarroll posed to himself. A brother reported that he wished to die; a listener alerted staff to the risk of self-harm; Mr McCarroll refused food, threatened to kill himself, attempted to hang himself with a shoelace and engaged in two further incidents of self-harm. He was placed in a gated cell for a few hours where he explained that his deceased father was calling for him.

A psychiatrist diagnosed depression and a high risk of suicide. In May 2002 Mr McCarroll, described as 'at times desperate' was placed in the health care centre in a cell for prisoners at highest risk. A CCTV camera monitored all four inmates in the cell.

The health care centre at HMP Preston, with 21 vulnerable prisoners, was at night routinely staffed by only one medically unqualified and untrained Officer Support Grade (OSG). A health care officer had repeatedly warned senior managers to no avail that this night staffing arrangement compromised patient care. The officer confirmed that the system at night posed a risk to the lives of all vulnerable health care centre inmates. The investigating governor knew of no health care centre in any other prison in which an OSG was left alone in charge.

Some three or four nights before the death of Mr McCarroll an inmate had warned an OSG to 'keep an eye' on him. The OSG failed to record the warning; no staff on later duties were aware of it.

The OSG in charge on the night of 26/27 May 2002 could not explain why over a period of about two hours prior to Mr McCarroll's death no pegging records existed. Pegs were absent from the printout on other nights when this OSG had been on duty.

She stated that, despite 3 years' service at HMP Preston, she was unaware that F2052SH prisoners must be checked four times per hour. In any event, in Mr McCarroll's F2052SH she recorded the false information that at 03.00h he was asleep on his back. He was in fact hanging in his cell, a fact not discovered until 04.13h when a cellmate awoke and raised the alarm.

The CCTV revealed that he had hanged himself at 02.52h. Joseph McCarroll's body had therefore been suspended from a ligature unnoticed for one hour and twenty minutes.

No procedure was in place as to the level of monitoring of the CCTV images from Mr McCarroll's cell. Observations depended on whether an officer happened to take a 'cursory glance' at the screen in the health care centre office. There was a conflict of evidence as to whether the CCTV camera was capable of relaying a clear image at night and whether the night-light in the cell was off. However, movement within the cell prior to death could be seen on the video tape.

The prison service investigation revealed that HMP Preston had failed to recognise that the OSG on the night was one whose previous pegging records showed a large number of missed pegs. It was 'suspicious' that a number of entries on Mr McCarroll's F2052SH even prior to death purported to be contemporaneous but were not.

Important observations were not recorded in Mr McCarroll's inmate medical record. HMP Preston, although aware of the high risk of suicide, had no specific management plan for the care of Joseph McCarroll. An officer confirmed that prison staff from other wings used to come to watch a television set in the landing of the health care centre and that this television was turned on during the night of Mr McCarroll's death.

The inquest commenced on 7 December 2004 and the jury found that the deceased killed himself and that a failure to monitor his condition during the night and significant failure to understand, comply with and monitor documented procedures contributed to his death.

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