Following two separate inquests with a jury Coroner of Inquests Graeme Cook, on 15th August 2024, sent the following report to the Minister for Home Affairs and Justice and to the Chief Executive of Manx Care.

This single report arises after two separate inquests into the deaths of Craig Anderson and Christopher Corkill. Each was an inmate at Jurby prison at the time of their respective deaths.

Craig Anderson died on 25th November 2022. His cause of death was plastic bag suffocation and ligature compression of neck with a jury verdict of suicide whilst the balance of his mind was affected. The inquest before a jury was held between 15th April and 25th April 2024.

Christopher Corkill died on 24th February 2023. His cause of death was plastic bag overhead causing suffocation and ligature around neck (dressing gown cord) with a jury verdict of suicide The inquest before a jury was held between 15th July and 19th July 2024.

Both deaths had been caused by a plastic bag being secured over each inmate's head by a ligature.

I said at the conclusions of both inquest that I would consider making a report to yourself as the Minister in charge of an authority that has power to take action to prevent future similar deaths, and this I now do. I also make this report to the Chief Executive Officer of Manx Care, as a further authority that I find has power to take action to prevent future similar deaths.

Certain improvements have already been made by both the Prison service and Manx Care, so I do not intend to consider such improvements already made in this report.

It is not the place of myself, as Coroner of Inquests, to recommend action that should be taken to prevent future similar deaths. Such decisions must be taken by the Department and/or Manx Care, but having had the benefit of considering all the evidence with respect to the two deaths to which I have referred, it appears to me that the following may be matters that the Department and/or Manx Care would wish to consider:

1. Both the HMIP Report and the PPO Report make a number of recommendations and consideration should be given to all such recommendations being implemented.
2. Manx Care to have a dedicated clinical governance lead responsible for Prison Healthcare at the Isle of Man Prison to ensure that practice is compliant and underpinned by National Guidance, legislation and evidence-based guidance.
3. Improved access to mental health professionals and mental health provision within the prison.
4. Treatments such as CBT and DBT to be provided to prisoners with appropriate needs.
5. Prison healthcare to have automatic access to prisoners' health records on initial arrival at the prison.
6. Manx Care to ensure a medication review on each prisoner's arrival.
7. For there to be an input from a mental health professional into the opening and closing of the now ACCT.
8. The prison officer who makes the decision to open a ACCT to be involved in the decision to close the ACCT.
9. Information contained in ACCT documents to be contained on PIMS and vice versa.
10. Peer support to always be available.
11. A trigger point for an ACCT to be when a prisoner is sentenced and constant cell observations should be in place for the first 48 hours.
12. For there to be regular inspections carried out HMIP.

As you would no doubt expect, I will be providing a copy of this letter to the other properly interested persons at the inquest. I would ask that you provide a reply to this letter within the next 56 days setting out what, if any, action you intend to take further to my report. I would intend to share your reply with the properly interested persons.