Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ryan Harris, a prisoner at HMP Cardiff, on 1 October 2021

A report by the Prisons and Probation Ombudsman

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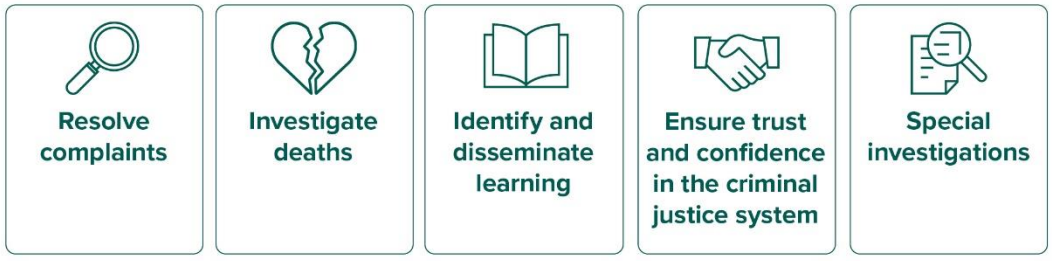
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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 Ryan Harris was found hanging in his cell at HMP Cardiff on 1 October 2021. He was 45 years old. I offer my condolences to Mr Harris' family and friends.

Mr Harris was recalled to prison custody on 15 September 2021 and arrived at Cardiff with a suicide and self-harm warning alert, because he had said he would hang himself if he returned to prison. Despite this, staff at Cardiff did not start suicide and self-harm monitoring (known as ACCT).

The investigation found that staff did not properly assess the information that arrived with Mr Harris and seemed to accept his assertions that he had no thoughts of suicide or self-harm at face value. We are concerned that staff continue to place more weight on a prisoner's presentation and what they say, rather than the information that arrives with them. Staff also failed to review Mr Harris' risk a week later, after he asked to speak to Listeners (prisoners trained by the Samaritans).

The investigation also found there was a short delay in the emergency response because the officer who found Mr Harris hanging wrongly believed that he could not enter a cell at night until other staff had arrived.

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

Sue McAllister CB
Prisons and Probation Ombudsman **January 2024**

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Summary

Events

1. Mr Ryan Harris was recalled to prison on 15 September 2021 and was sent to HMP Cardiff. He had been in prison, and at Cardiff, many times before.

2. Mr Harris had a long history of mental health problems. He was monitored using suicide and self-harm procedures (known as ACCT) at Cardiff in February and June 2021.

3. When Mr Harris arrived at Cardiff on 15 September, his Person Escort Record (PER) contained a suicide and self-harm warning alert, because Mr Harris had said he would hang himself if he returned to prison. Staff recorded that Mr Harris told them he had no thoughts of suicide or self-harm. They did not open an ACCT.

4. On 21 September, Mr Harris asked to speak to Listeners (prisoners trained by the Samaritans). It is unknown what was discussed as the conversation was confidential.

5. At around 9.00pm on 30 September, Mr Harris rang his cell bell and asked for paracetamol because he had a headache. An officer told him he would speak to healthcare staff once they had finished dealing with an incident. Ten minutes later, Mr Harris asked the officer if he had the tablets. When the officer said he did not, Mr Harris said not to worry and that he would try to sleep off his headache.

6. At 12.20am on 1 October, the officer noticed that Mr Harris' cell light was on and went to check on him. He saw him hanging from the top bunk bed. The officer called a medical emergency code and radioed the Night Orderly Officer (who was in charge of the prison at that time) to ask for permission to enter the cell, which was granted. The officer entered the cell once other staff had arrived.

7. Staff and ambulance paramedics tried to resuscitate Mr Harris but were unsuccessful. Mr Harris was pronounced dead at 1.13am.

Findings

8. We found that staff did not properly assess Mr Harris' risk of suicide and self-harm when he arrived at Cardiff on 15 September. It appears that reception staff placed little weight on the information contained in the PER and based their assessment of Mr Harris' risk on what he told them. It would appear the reception nurse did not even look at the PER.

9. The officer who saw Mr Harris hanging delayed going into the cell until he had been given permission by the Night Orderly Officer and other staff had arrived. He told the investigator that he would never go into a cell alone at night under any circumstances. We are concerned that he appeared to be unaware that staff can enter cells alone at night if there is a threat to life if it is safe to do so.

10. The clinical reviewer found that Mr Harris received a very good standard of care from the prison's mental health team.

Recommendations

- The Governor and Head of Healthcare should ensure that reception and induction staff:
    - consider all information that arrives with the prisoner, particularly the PER and suicide and self-harm warning alerts, when assessing risk of suicide and self-harm;
    - assess risk based on all the information available and not just on how the prisoner presents and what they say; and
    - record the risk factors they have considered and the reasons for their decisions.
- The Executive Director of Transforming Delivery Directorate, HMPPS, should ensure that national policy and guidance are clear that a request to see a Listener may be an indication of increased risk of self-harm or suicide, and that staff are required to note all such requests and to consider what further action may be necessary, such as a welfare check or opening or reviewing an ACCT.
- The Governor should ensure staff are aware that where there is a threat to life, they may enter a cell alone at night if they feel safe to do so.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Cardiff informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Harris' prison and medical records.

13. Health Inspectorate Wales commissioned a clinical reviewer to review Mr Harris' clinical care at the prison.

14. The investigator and clinical reviewer jointly interviewed six healthcare staff, and Ms Blyth interviewed a further six members of staff. Due to coronavirus restrictions, all interviews were conducted by telephone or video.

15. We informed HM Coroner for South Wales Central of the investigation. We have given the Coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Harris' mother to explain the investigation. Mr Harris' mother asked the following questions:

    - Was Mr Harris receiving mental health support?
    - Was Mr Harris being supported by suicide monitoring procedures?
    - When was Mr Harris last checked, and how long was it between the last check and being discovered?

    These have been addressed in this report.

17. We shared our initial report with HMPPS. They found no factual inaccuracies but following discussions, we amended our second recommendation to a national recommendation.

18. We sent a copy of our report to Mr Harris' mother. She did not notify us of any factual inaccuracies.

Background Information

HMP Cardiff

19. HMP Cardiff holds around 800 men, mostly from Southeast Wales. Many of the prisoners come on remand from local courts. Cardiff and Vale University NHS Health Board provides primary, physical and mental health services at the prison. Healthcare staff are on duty 24 hours a day.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Cardiff was in July 2019. Inspectors found that reception was relatively busy, but staff were generally relaxed and reassuring and prisoners were positive about their treatment on arrival. Inspectors noted that in the first night centre prisoners were seen by an induction peer representative (a prisoner) and had a private first night interview with an officer, which they found were generally good and focused on safety.

21. Inspectors found that 65% of new prisoners had mental health problems, and half had drug issues. Inspectors noted self-harm had risen and there were enormous demands on the healthcare provision, especially mental health care.

Independent Monitoring Board

22. 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 the year to 31 August 2021, the IMB reported that although self-harm remained a concern, incidents had reduced by around 25%. The IMB reported that there had been a vast improvement in staffing within healthcare and mental health.

Previous deaths at HMP Cardiff

23. Mr Harris was the ninth prisoner to die at Cardiff since October 2019. Of the previous deaths, three were self-inflicted and five were from natural causes. We have previously made a recommendation about staff properly assessing prisoners' risk of suicide and self-harm. We were told that the prison had delivered training to staff in December 2020.

Assessment, Care in Custody and Teamwork

24. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

25. 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.

26. 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.

Key Events

Background

27. Mr Ryan Harris spent frequent, short periods in prison, for theft and burglary offences. Between July 2020 and when he was sent to prison for the final time in September 2021, he had seven periods in prison, the majority of time at HMP Cardiff. Mr Harris had bipolar disorder, attention deficit hyperactivity disorder (ADHD), depression and had had a brain injury as a child. He also had a history of drug use. He was prescribed an antipsychotic (given as a fortnightly depot injection) and antidepressants.

28. Mr Harris' behaviour was often challenging. He frequently damaged items in his cell and misused his cell bell. He struggled with his mental health and was under the care of the prison's mental health team and a psychiatrist. He also got support from the prison's substance misuse team.

29. During two previous sentences at Cardiff, in February and June 2021, staff managed Mr Harris using suicide and self-harm procedures (known as ACCT). On the first occasion, Mr Harris self-harmed by cutting and told staff he was depressed and struggling to cope. On the second occasion, Mr Harris appeared agitated and confused, and made comments that suggested he might self-harm. Staff closed the ACCT on 18 June and Mr Harris was released from prison on 23 June.

30. Mr Harris was recalled to prison on 1 July, for breaching his licence conditions, and was returned to Cardiff. He was released on 3 September.

15 September 2021 onwards

31. Mr Harris was recalled to prison on 15 September, for breaching his licence conditions. He returned to Cardiff. His release date was 26 October. Mr Harris' Person Escort Record (PER – a document that accompanies prisoners between police custody, courts and prisons, which sets out the risks they pose) had a suicide/self-harm warning alert which noted, "states he will hang himself in prison". It also said he was on constant observations.

32. The reception officer responsible for assessing Mr Harris' risk of suicide and self-harm when he arrived told the investigator that he saw the PER and the suicide/self-harm warning alert. He said that he could not remember exactly what he said to Mr Harris but that he would have spoken to him about the statement he had made. He said that he would have considered opening an ACCT if there had been signs that Mr Harris was suicidal but that he had seemed okay and he had no concerns about him. He noted on the PER, "States not suicidal".

33. A nurse carried out Mr Harris' reception health screen. She told the investigator and clinical reviewer that she knew Mr Harris and had a good relationship with him. They discussed his long history of mental health in prison and in the community. Mr Harris told her he was happy to be back at Cardiff and had no thoughts of suicide or self-harm. In response to an email query from the investigator, the nurse said she could not remember whether she had seen Mr Harris' PER.

34. The officer that completed Mr Harris' Cell Sharing Risk Assessment (CSRA) noted that he was a high risk prisoner for medical reasons and that he had been in the healthcare unit throughout his previous stay at Cardiff. The officer wrote that although the reception nurse had said Mr Harris was not at any increased risk, he had kept him as high risk so that he would be seen by the mental health team. He noted that Mr Harris had no thoughts of suicide or self-harm. When interviewed, he said that he took this from the note made by the reception officer.

35. The officer that carried out Mr Harris' first night interview noted in Mr Harris' NOMIS record, "History of S/H [self-harm] in custody noted and discussed. It has been established that the prisoner does not deem this history to be of any issue anymore." and, "Verbally stated no current thoughts of suicide or self-harm…". When interviewed, she said the PER would have been available to her, but she could not specifically recall seeing the suicide and self-harm warning alert. She said she would have discussed it with him had she seen it. She said Mr Harris was happy and chatty and raised no concerns at all.

36. The next day, a nurse carried out Mr Harris' secondary health screening. The nurse had met Mr Harris before. He noted that Mr Harris spoke about his brain injury and said he had "lots" of mental health problems, but that he was calm and in good spirits. He noted that Mr Harris would be seeing someone from the mental health team later that day. A prison GP re-prescribed Mr Harris' medication.

37. A nurse met Mr Harris later that day. He noted that Mr Harris was well known to the prison's mental health team. Mr Harris mentioned he was concerned about his medication but was assured it had been prescribed earlier that day. Mr Harris said he had no thoughts of suicide or self-harm.

38. A resettlement caseworker interviewed Mr Harris on behalf of his community probation officer on 20 September. She noted that Mr Harris was very sensitive to noise. His mood was initially quite happy, but he became sad and started to cry when discussing his mother. Mr Harris said he had not spoken to her as there was a restraining order in place, but then said there was no restraining order and she wanted him home. He was told this was being checked. They then discussed Mr Harris' accommodation on his release, and the resettlement caseworker said she would complete a housing application form on Mr Harris' behalf.

39. On 20 September, a nurse saw Mr Harris in his cell on E Wing. Mr Harris said he was happy to see her. He told her he was back in prison because he went to see his mother. Mr Harris said he found the wing very noisy and other prisoners hated him, which affected his mental health, and asked to move to B1. A prison officer who was passing the cell heard this and said he would look into it. (Shortly after this Mr Harris was moved to A Wing.) Mr Harris told the nurse he thought he should be in hospital rather than prison. She reassured him that he did not need that at this time. He then asked for diazepam or zopiclone to help him sleep. The nurse said she would speak to the psychiatrist.

40. On 21 September, at 7.55pm, staff arranged for Mr Harris to speak to Listeners (prisoners trained by the Samaritans). This is a confidential service so there is no record of what was discussed.

41. The psychiatrist prescribed Mr Harris zopiclone on 22 September, for three nights. Mr Harris was also given a distraction pack he had requested. It was agreed Mr Harris should re-join the nurse's caseload.

42. The nurse gave Mr Harris his depot injection on 27 September. She noted he had no concerns or issues.

43. Officer A responded to Mr Harris' cell bell during the evening of 29 September. Mr Harris was concerned about vapes he had ordered. The officer told him there was nothing he could do that night but advised him to speak to a member of staff the next day. Mr Harris said he would and seemed fine.

44. Staff were aware that Mr Harris was due for release on 26 October and were trying to find accommodation for him. A nurse met Mr Harris on 30 September. He asked her whether his mother had been in touch as she had not replied to his letters. The nurse did not know but tried to reassure him. Mr Harris said he was looking forward to leaving prison and she said she was waiting for an update on his housing situation. Mr Harris said he now found A Wing too noisy. She said she would discuss this with the wing manager with a view to moving him to the healthcare unit for the rest of his sentence. Mr Harris thanked her. At that moment a general alarm sounded, so she had to leave the cell. As she did, Mr Harris "fist-bumped" her and thanked her again. She noted that Mr Harris seemed neither agitated nor distressed.

45. At approximately 9.00pm, Officer A responded to Mr Harris' cell bell. Mr Harris asked for some paracetamol because he had a headache. The officer said he would speak to healthcare staff as soon as they had finished dealing with an incident on another wing. Ten minutes later Mr Harris rang his bell again and asked whether the officer had the tablets. When he said he did not, Mr Harris said not to worry and that he would try to get some sleep. The officer advised him to ring his cell bell if his headache became worse.

1 October

46. At approximately 12.20am on 1 October, while patrolling the wing, Officer A saw that Mr Harris' cell light was on. He went to the cell, looked through the observation panel and saw Mr Harris was hanging from the frame of the top bunk bed. He had used his shower curtain as a ligature.

47. Officer A immediately radioed an emergency code blue and shouted for staff assistance. The control room immediately telephoned for an ambulance. He radioed the Night Orderly Officer (senior officer in charge), a custodial manager (CM), for permission to enter the cell, which was granted. After two more officers had arrived, Officer A unlocked the cell door and went in. Another officer and the CM also arrived at the cell.

48. Officer B cut the ligature and the officers lowered Mr Harris to the floor. They felt for a pulse and initially thought they had detected one, so put Mr Harris in the recovery position. Officer C immediately checked again for a pulse, but could not find one, so staff rolled Mr Harris onto his back to begin cardiopulmonary resuscitation (CPR). Officer A started chest compressions until healthcare staff arrived and took over. The CM checked that an ambulance had been requested, which it had.

49. A nurse and a healthcare assistant arrived at the cell at approximately 12.24am. She took over chest compressions from Officer A and told the healthcare assistant to collect the emergency bag, which was on the wing.

50. The nurse gave Mr Harris oxygen and applied defibrillator pads to his chest. The defibrillator machine advised a shock, so she did so, and then continued chest compressions.

51. The paramedics arrived at the cell at 12.33am and took over CPR. They moved Mr Harris out of his cell for more space and gave him adrenaline. Shortly afterwards, at 12.38am, a second team arrived with a doctor. They tried to resuscitate Mr Harris for a further 45 minutes, before the doctor pronounced his death at 1.13am.

Contact with Mr Harris' family

52. The prison assigned two family liaison officers (FLOs). At 3.01am, on 1 October, one FLO telephoned Mr Harris' next of kin, his mother. (Due to COVID-19 restrictions in place at the time, the prison was unable to break the news to Mr Harris' mother in person.) She received no answer, but Mr Harris' mother called the prison back at approximately 3.15am and was told of her son's death.

53. The prison contributed to the cost of Mr Harris' funeral in line with national instructions.

Support for prisoners and staff

54. After Mr Harris' death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

55. The prison posted notices informing other prisoners of Mr Harris' 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 Mr Harris' death.

Post-mortem report

56. The post-mortem and toxicology reports were not available at the time of issuing this report.

Findings

Assessment of Mr Harris' risk of suicide or self-harm

57. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm. Mr Harris had been monitored using ACCT during previous sentences at Cardiff but was not monitored during his final stay there.

58. When Mr Harris arrived at Cardiff on 15 September, his PER contained a suicide and self-harm warning alert which noted that Mr Harris said he would hang himself if he returned to prison. However, staff did not start ACCT procedures.

59. The reception officer said he would have been aware of the suicide and self-harm warning alert and would have discussed it with Mr Harris, though there is no record that he did. His only note was, "States not suicidal". When interviewed, he told the investigator that he would have opened an ACCT had he had concerns about Mr Harris but that he seemed alright.

60. We are concerned that the reception nurse could not recall seeing the PER. An officer thought the PER would have been available to her, but she did not recall seeing the suicide and self-harm warning alert. Both noted that Mr Harris told them that he had no thoughts of suicide or self-harm, and both described him as happy and chatty.

61. We are concerned that staff based their assessments on Mr Harris' presentation and what he said to them, rather than the information contained in the suicide and self-harm warning alert. Had staff discussed with him his intention to hang himself if returned to prison, we would expect that to have been noted and for staff to have recorded their reasoning for not opening an ACCT. We recommend:

    The Governor and Head of Healthcare should ensure that reception and induction staff:

    - **consider all information that arrives with the prisoner, particularly the PER and suicide and self-harm warning alerts when assessing risk of suicide and self-harm;**
    - **assess risk based on all the information available and not just on how the prisoner presents and what they say;**
    - **record the risk factors they have considered and the reasons for their decisions.**

62. Mr Harris asked to speak to Listeners on 21 September, nine days before he died. While conversations with Listeners are confidential, the fact that a prisoner has asked to speak to them should prompt staff to check on them and consider whether they need to reassess the prisoner's risk of suicide and self-harm. There is no evidence that staff did this. We recommend:

    The Executive Director of Transforming Delivery Directorate, HMPPS, should ensure that national policy and guidance are clear that a request to see a

Listener may be an indication of increased risk of self-harm or suicide, and that staff are required to note all such requests and to consider what further action may be necessary, such as a welfare check or opening or reviewing an ACCT.

Emergency response

63. When Officer A saw Mr Harris hanging, he called a code blue and radioed the Night Orderly Officer for permission to enter the cell. He waited for permission and for other staff to arrive before entering the cell. He told the investigator that he would never go into a cell alone during night state.

64. Prison Service Instruction (PSI) 24/2011, Management and Security of Nights, gives national guidance on entering cells at night. The PSI says that under normal circumstances, authority to unlock a cell at night must be given by the Night Orderly Officer (NOO) and a minimum number of staff (according to local risk guidelines) should be present when it is opened. However, it goes on to say that preservation of life must take precedence, and where there appears to be a threat to life, cells may be unlocked without the authority of the NOO and an individual member of staff may enter a cell on their own, if they feel safe to do so.

65. Cardiff's local policy on Night Orders, revised in July 2020, says:

"Under normal circumstances, authority to unlock a cell at night must be given by the NOO and no cell will be opened unless two members of staff are present one of whom must be the NOO. Where there is, or appears to be, immediate danger to life, an Urgent Message must be given over the net giving precise location before entering the cell. Personal safety must be considered before entering a cell alone during night state. Staff have a duty of care to prisoners & to themselves and to other staff. The preservation of life must take precedence over security concerns, but night staff should not take action that they feel would put themselves or others in unnecessary danger".

66. We are concerned that Officer A appeared unaware of the circumstances in which staff can enter cells alone at night. We recommend:

The Governor should ensure that staff are aware that where there is a potential threat to life, they may enter a cell alone at night if they feel safe to do so.

Mr Harris' mental health

67. Mr Harris had been in Cardiff six times between 2019 and 2021 and was well known to staff, particularly the mental health team.

68. The clinical reviewer noted that Mr Harris' overall care at Cardiff was appropriate and timely. He was medicated appropriately and given additional medication to alleviate anxiety and sleep problems.

69. The clinical reviewer added that the involvement and responses from the mental health team should be highlighted as good practice. Mr Harris regularly saw members of the multidisciplinary team and there was evidence of a close therapeutic relationship.

Inquest

70. The inquest, held on 2 July 2024, concluded that, “Ryan Harris died by ligaturing himself in circumstances where his intention could not be ascertained.”

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