Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Decland Mooney, a prisoner at HMP Cardiff, on 6 December 2020

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Decland Mooney died on 6 December of pneumonia caused by emphysema in his cell at HMP Cardiff. Mr Mooney was 64 years old. I offer my condolences to Mr Mooney's family and friends.

The clinical reviewer concluded that the clinical care that Mr Mooney received at HMP Cardiff was of a good standard and equivalent to that which he could have expected to receive in the community. Mr Mooney presented with challenging behaviour and the clinical reviewer commended healthcare staff for the care provided to Mr Mooney in difficult circumstances.

Mr Mooney had a history of schizophrenia and his behaviour at Cardiff was often odd and threatening. The clinical reviewer noted that there was nothing to show if healthcare staff considered referring Mr Mooney for a possible transfer to a secure psychiatric hospital (although this had no impact on his death).

I found two non-clinical issues of concern.

There was some missing paperwork for an incident on 6 November when staff used force to restrain Mr Mooney (although there is nothing to suggest that this played any part in his death).

I am also concerned that a welfare check was not conducted when Mr Mooney was unlocked on the morning of his death. He was found unresponsive in his cell about 30 minutes later. We cannot say whether Mr Mooney was still alive at the time he was unlocked or whether the outcome might have been different if he had been found earlier.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **August 2022**

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Summary

Events

1. On 16 October 2020, Mr Decland Mooney was remanded to HMP Cardiff charged with assault.

2. During his first few days in prison, staff noted that Mr Mooney's behaviour was hostile and unusual. On 20 October, Mr Mooney was seen by a mental health practitioner, who noted that his behaviour was consistent with a previous diagnosis of schizophrenia. The following day he was allocated a mental health worker.

3. On 22 October, Mr Mooney was seen making cuts to his legs and Prison Service suicide and self-harm procedures (known as ACCT) were started. Mr Mooney said that his actions had been misinterpreted as self-harm and denied any intention to hurt himself. The ACCT was closed that day.

4. On 6 November, Mr Mooney was restrained and returned to his cell after refusing to put his face mask on. There were no reported injuries to Mr Mooney or wing staff.

5. On 16 November, staff searched Mr Mooney's cell and found seven litres of fermented liquid. The items were seized, and Mr Mooney was placed on a disciplinary charge.

6. On 6 December, at around 7.00am, a prison officer began the morning roll check (count of prisoners). He checked Mr Mooney's cell and said he saw him getting dressed through the observation panel. At around 9.00am, the same officer began unlocking prisoners for morning association.

7. At around 9.30am, another officer began locking up cells. He found Mr Mooney unresponsive in his cell, curled around the lavatory and bleeding from the nose. A code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) was called and healthcare staff attended. An ambulance was called at 9.32am.

8. Mr Mooney had no pulse and was not breathing but was warm to the touch. Staff started CPR immediately. The ambulance arrived in the prison at 9.43am and paramedics reached Mr Mooney at 9.46am. They took over CPR but, at 10.02am, they confirmed that Mr Mooney had died.

Findings

9. The clinical reviewer concluded that the clinical care that Mr Mooney received at HMP Cardiff was of a good standard and equivalent to that which he could have expected to receive in the community. He commended healthcare staff for the care provided to Mr Mooney in difficult circumstances, given his challenging behaviour.

10. The clinical reviewer identified one concern – that it was not clear if healthcare staff considered referring Mr Mooney for transfer to a secure psychiatric hospital under the Mental Health Act - although this did not impact on Mr Mooney's death.

11. Although we are satisfied that Mr Mooney was seen by a nurse after staff used force on him on 6 November, the prison could not find the form on which her examination should have been recorded. There is, however, nothing to suggest that this incident played any part in Mr Mooney's death a month later.

12. On the morning of 6 December, prison staff did not carry out a welfare check. when Mr Mooney was unlocked. He was found unresponsive but still warm 30 minutes later. We cannot say if Mr Mooney was still alive when he was unlocked.

Recommendations

- The Head of Healthcare should ensure that where a patient has a confirmed history of a serious mental illness and there is evidence of risk to others, the mental health team should:
    - document whether they have considered detention under the appropriate section of the Mental Health Act;
    - if this is not felt to be appropriate, record a rationale for this decision; and
    - record all considerations and decisions in the multi-disciplinary meeting notes and SystmOne clinical record.
- The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of a prisoner's safety and welfare and that there are no matters that need immediate attention.
- The Governor and Head of Healthcare should ensure all key Use of Force documentation is appropriately retained and stored, and that clinical staff record all interventions on the patient's medical record.

The Investigation Process

13. HMPPS notified us of Mr Mooney's death on 6 December 2020.

14. The investigator wrote to Cardiff on 7 December 2020. He obtained a range of documents including copies of relevant extracts from Mr Mooney's prison and medical records, as well as CCTV and Body-Worn Camera (BWC) footage. He requested and received a statement from a member of staff.

15. Health Inspectorate Wales commissioned a clinical reviewer to review Mr Mooney's clinical care at the prison.

16. We informed HM Coroner for South Wales Central of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. Our family liaison officer wrote to Mr Mooney's next of kin, his daughter, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. His daughter raised a number of matters, including questions about to his physical and mental health care, his location within the prison, the use of force against Mr Mooney, and the prison's communication with her. We have addressed questions relating to his health and care in our report.

18. Mr Mooney's daughter received a copy of the initial report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

19. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

20. Following discussion between the prison and the PPO, we agreed to remove the recommendation relating to a specific member of staff. We are satisfied that there was a lack of clarity in the local policy about welfare checks. We accept this was a systemic issue rather than an individual failure. The Prison Service have accepted a recommendation about welfare checks.

21. The mental healthcare provider at HMP Cardiff did not accept the clinical recommendation.

Background Information

HMP Cardiff

22. HMP Cardiff is a medium security prison holding remand and sentenced adult male prisoners. As part of its role, it serves the courts of South Wales. The prison is operated by HM Prison Service.

23. Physical and mental healthcare services are provided by Cardiff and Vale University NHS Health Board. HMP Cardiff has an inpatient healthcare unit and 24-hour nursing provision. Substance Misuse services are provided by Cardiff and Vale University NHS Health Board with the Dyfodol consortium.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Cardiff was carried out in July 2019. Inspectors reported that there was a high demand for mental health services in the prison and long waits for treatment. They found that the mental health team was not sufficiently staffed to meet the needs of prisoners. They also noted a rising number of use of force incidents and recommended that the prison should investigate this.

Independent Monitoring Board

25. 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 2020, the IMB reported that, despite improvements, they considered that the prison' mental health services were understaffed. They noted there were over 30 referrals a week to mental health services and nearly 30 referrals a month to the psychiatrist. They were also concerned about the increasing use of force on prisoners by staff.

Previous deaths at HMP Cardiff

26. Mr Mooney was the eighth prisoner to die at Cardiff since December 2018. Of the previous deaths, four were from natural causes. There are no similarities between Mr Mooney's death and the previous deaths.

Key Events

27. On 16 October 2020, Mr Decland Mooney was remanded to HMP Cardiff charged with assault. He began a 14-day period of isolation in line with the Prison Service COVID-19 guidelines on new arrivals in prison.

28. On arrival at the prison, he had a reception health screen completed by a nurse. Mr Mooney reported several physical health issues including asthma and said that he had had a stroke and a heart attack in the recent past. He also reported a history of bipolar disorder and schizophrenia. The nurse made a referral to the prison's mental health team.

29. On 17 October, Mr Mooney had a secondary health screen with a prison GP. She noted his community prescriptions and prescribed these again. The prison waited for the remainder of Mr Mooney's NHS community records to arrive.

30. On 19 October, a nurse recorded that Mr Mooney had signs of an infected leg wound (which had occurred seven days prior to coming to prison while climbing through a broken window). He was prescribed appropriate dressings and an antibiotic.

31. During his first few days at Cardiff, staff noted that Mr Mooney's behaviour was hostile and unusual. On 20 October, Mr Mooney was seen by a mental health practitioner. She noted that his behaviour was consistent with a previous diagnosis of schizophrenia. She also noted that he had not been on any psychiatric medication in the community and had not engaged with community mental health services. She considered that he needed to be moved to the prison's healthcare unit, and Mr Mooney was moved later that day.

32. On 21 October, Mr Mooney made threats to kill nursing staff. This was reported to prison staff who conducted a search of Mr Mooney's cell and found an improvised weapon. Staff held an urgent mental health case review and Mr Mooney was allocated a mental health worker. Over the following days, mental health staff recorded that they could see no evidence of serious mental health issues or psychotic symptoms.

33. On 22 October, Mr Mooney was seen making cuts to his legs and Prison Service suicide and self-harm procedures (known as ACCT) were started. An officer assessed Mr Mooney and discussed his actions, feelings and wellbeing with him. Mr Mooney said that he had been trying "to release fluid" and his actions had been misinterpreted as self-harm. He denied any intention to hurt himself. The ACCT was closed that day with a post-closure review set for 29 October.

34. On 27 October, Mr Mooney saw his allocated mental health worker. Mr Mooney denied any problems with his mental health. However, he continued to display hostility towards staff. He made threats to staff which were reported to the police and sent a sexually explicit letter to a female healthcare worker.

35. On 28 October, the remainder of Mr Mooney's community GP records arrived, and a prison GP noted that Mr Mooney had a history of Chronic Obstructive Pulmonary Disease (COPD), asthma and throat cancer. She requested blood and other

investigative tests. When the results of these tests were received on 31 October, she started Mr Mooney on medication to reduce his cholesterol.

36. On 30 October, Mr Mooney met with staff for his ACCT post-closure review. Mr Mooney reported that he had no problems and had sources of support. The ACCT was not reopened, and staff assessed no further reviews were needed.

37. On 31 October, Mr Mooney completed his period of COVID-19 isolation and healthcare staff assessed there was no clinical need for him to remain in the healthcare unit. He was moved onto F Wing.

38. The following day he racially abused his cellmate, who was moved to another cell for his safety. Mr Mooney was assessed as high risk for cell sharing, which made him unsuitable to share a cell.

39. On the morning of 6 November, staff on F Wing asked Mr Mooney to put his face mask back on, in line with COVID-19 policy. Mr Mooney refused and made threats to staff. He was then told to return to his cell which he refused. Two officers then applied guiding holds to Mr Mooney's arms to take him back to his cell. Mr Mooney resisted. Officers placed Mr Mooney in arm locks and a head hold and returned him to his cell. Mr Mooney was debriefed by staff as to why he had been restrained. He was seen by a nurse following the incident. There were no recorded injuries to Mr Mooney or officers.

40. On 16 November, staff searched Mr Mooney's cell and found seven litres of fermented liquid ('hooch'). The items were seized, and Mr Mooney was placed on a disciplinary charge.

41. On 18 November, Mr Mooney's mental health worker saw him, but he refused to engage with her. The mental health team decided he needed to be seen by the prison psychiatrist.

42. Over the following days, Mr Mooney flooded his cell and posted abusive messages to staff under his cell door. On 25 November, the mental health team met and carried out a screening assessment for Mr Mooney. It was agreed that he should be seen by a consultant psychiatrist, and Mr Mooney was added to the next clinic list. He was not seen before his death.

43. Mr Mooney phoned his family on 30 November, 1 December and again on 3 December. In one of the calls, he told his family that he was struggling to breathe and had a tight chest. He said that the prison would not provide him with a nebuliser.

Events of 6 December 2020

44. At around 7.00am, an officer began the morning roll check. He checked Mr Mooney's cell and said he saw him through the observation panel sitting on his bed, apparently bending down to adjust his shoes, and that Mr Mooney looked at him and acknowledged him. At around 9.00am, he began unlocking prisoners for morning association. He unlocked Mr Mooney's cell door and said that he did not see anything out of the ordinary.

45. At around 9.30am, an officer began locking prisoners in their cells at the end of the association period. When she entered Mr Mooney's cell, she found him unresponsive, curled around the lavatory and bleeding from the nose. She called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and healthcare staff attended. A 999 call was made at 9.32am to Wales Ambulance Service.

46. Mr Mooney had no pulse and was not breathing but was warm to the touch. Staff started CPR immediately. The ambulance arrived in the prison at 9.43am and paramedics reached Mr Mooney at 9.46am. They took over CPR but at 10.02am, they confirmed that Mr Mooney had died.

Contact with Mr Mooney's family

47. At 11.20am, the prison Family Liaison Officer (FLO) rang Mr Mooney's daughter to tell her that her father had died. Over the following days the FLO spoke with Mr Mooney's daughter and other family members to offer condolences and to help make arrangements for the funeral.

48. Mr Mooney's funeral was held on 29 December 2020. In line with prison policy, Cardiff made a financial contribution to the cost of the funeral.

Support for prisoners and staff

49. After Mr Mooney's death, a Custodial 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.

50. The prison posted notices informing other prisoners of Mr Mooney'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 Mr Mooney's death.

Events following Mr Mooney's death

51. Mr Mooney's next of kin wrote to us in April 2021. She told us that Mr Mooney rang her in the days before his death and told her that prison officers had used force against him and thrown him on his back. We asked the prison for all use of force records relating to Mr Mooney. The only record the prison had relating to Mr Mooney was an incident almost a month earlier on 6 November.

Post-mortem report

52. The post-mortem found that Mr Mooney died of pneumonia (inflammation of the tissues of the lungs) caused by emphysema (damage to the air sacs in the lungs). A COVID-19 test was negative.

53. The pathologist noted that Mr Mooney had a 0.7cm superficial laceration to the right side of his nose. The clinical reviewer considered that this injury was probably caused when Mr Mooney collapsed.

Findings

54. The clinical reviewer concluded that the clinical care that Mr Mooney received at HMP Cardiff was of a good standard and equivalent to that which he could have expected to receive in the community. He noted that Mr Mooney displayed challenging behaviour and he commended healthcare staff for the care provided to Mr Mooney in difficult circumstances.

55. Mr Mooney told his daughter that prison healthcare staff had refused to provide him with a nebuliser when he reported that he was struggling to breathe and had a tight chest in the last week of his life. The clinical reviewer found that Mr Mooney was issued with a salbutamol inhaler on 3 November and again, at his request, on 2 December. There is no record that he asked for a nebuliser or that healthcare staff refused to prescribe one. There is no medical record to suggest Mr Mooney required a nebuliser.

Mental Health Act assessment

56. The clinical reviewer did, however, identify some shortcomings in relation to documenting Mr Mooney's mental health treatment (although these did not impact on his death).

57. He noted that Mr Mooney had a confirmed diagnosis of schizophrenia. In the first days in prison, Mr Mooney displayed hostile, paranoid and threatening behaviour towards staff, including fashioning a weapon. He was reviewed by the prison mental health team within four days of arrival and allocated a case worker.

58. The clinical reviewer found that Mr Mooney was appropriately undergoing assessment and observation of his behaviour at Cardiff to determine the nature and extent of his psychiatric illness in a safe and secure environment and was appropriately escalated for review by a senior psychiatrist to produce a formulation within one month of his arrival at the prison. The review did not happen as Mr Mooney died prior to his appointment with the psychiatrist. We note from the most recent HMIP and IMB reports that demand for psychiatric assessments at HMP Cardiff was high.

59. However, the clinical reviewer found that it was not clear if the prison's mental health team had considered whether Mr Mooney should be assessed under the Mental Health Act 1983, given that he was showing evidence of risk towards others. The clinical reviewer considered that there was reasonable evidence from the records that Mr Mooney's reported behaviour warranted consideration for assessment with a view to a possible transfer to a secure psychiatric hospital. If the mental health team felt Mr Mooney did not need such an assessment they should have documented why not.

    The Head of Healthcare should ensure that where a patient has a confirmed history of a serious mental illness and there is evidence of risk to others, the mental health team should:

    - **document whether they have considered detention under the appropriate section of the Mental Health Act;**

- **if this is not felt to be appropriate, record a rationale for this decision; and**
- **record all considerations and decisions in the multi-disciplinary meeting notes and SystmOne clinical record.**

Welfare Checks

60. Prison Service Instruction (PSI) 75/2011, *Residential Services*, say:

> "The appropriate arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock. For example, if a prisoner is expected to leave their cell for an activity shortly after being unlocked, then it will be sufficient for there to be a check on any prisoner who does not do so. Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

61. In his statement to the police which has been shared with the PPO in lieu of an interview, an officer said that when he unlocked Mr Mooney's cell at around 9.00am, he looked into Mr Mooney's cell but could not remember what Mr Mooney was doing at that time, although he said that he would have noticed had Mr Mooney been slumped on the floor.

62. The prison conducted a review for the coroner of CCTV on Mr Mooney's wing and reported that between the officer unlocking the cell at around 9.00am and the second officer finding Mr Mooney unresponsive at around 9.30am, Mr Mooney had not left the cell, and no one had entered it.

63. Due to the format of the footage provided by the prison and the limited IT options available to the investigator due to COVID-19 restrictions, we could not view the prison's CCTV footage to confirm that the first officer looked into Mr Mooney's cell when he unlocked it at about 9.00am.

64. We are concerned that no-one completed a welfare check on Mr Mooney at the point of unlock or shortly after unlock. No-one obtained a response from Mr Mooney to confirm that he was well.

65. When Mr Mooney was found unresponsive in his cell, he was still warm to the touch, which means he may have been alive but unwell when he was unlocked half an hour earlier. We cannot say that the outcome would have been different for Mr Mooney if he had been found sooner, but it could prove to be critical in future cases.

66. We make the following recommendation:

The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of a prisoner's safety and welfare and that there are no matters that need immediate attention.

Use of Force record keeping

67. On 6 November, Mr Mooney was subject to use of force by staff after refusing to comply with the prison's COVID-19 rules about wearing a face mask in a communal area. We have not looked at this incident in detail as it took place a month before Mr Mooney's death and there is nothing to suggest that it played any part in his death. However, we did confirm that prison staff completed use of force paperwork in line with Prison Service policy.

68. Prison Service Order (PSO) 1600 and PSI 30/2015 which set out the prison policy on use of force require that a doctor or nurse must examine any prisoner who has been subject to a use of force as soon as possible afterwards. The use of force paperwork completed by the supervising officer in charge records that Mr Mooney was seen by a nurse, who assessed he had suffered no injuries. Mr Mooney's medical records show that the nurse saw him twice on 6 November after the use of force incident. However, her entries do not refer to the use of force or that she assessed Mr Mooney for any injuries.

69. PSO 1600 states that report of injury to prisoner form (known as a F213) must be completed on all prisoners after a use of force and a copy must be kept in the use of force incident file. The F213 should be completed by the doctor or nurse who has seen the prisoner after the use of force and must provide an account of their examination of the prisoner, regardless of whether any injuries are found.

70. When we asked for the use of force documentation, Cardiff could not find the F213. This is poor practice. We make the following recommendation:

    The Governor and Head of Healthcare should ensure all key Use of Force documentation is appropriately retained and stored, and that clinical staff record all interventions on the patient's medical record.

71. Mr Mooney's daughter said that he told her that staff had also used force on him and had thrown him on his back in the days before his death. The prison has no record that force was used on Mr Mooney apart from the incident on 6 November. There is nothing in the post-mortem report to suggest that a use of force by staff (or anyone else) played any part in Mr Mooney's death.

Inquest

12. The inquest, heard on 10 and 11 September 2024, concluded that Mr Mooney died from natural causes.

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