Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shane Davies, a prisoner at HMP Cardiff, on 28 August 2022

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 Shane Davies died in hospital on 28 August 2022, after being found hanging in his cell at HMP Cardiff on 17 August. He was 33 years old. I offer my condolences to Mr Davies' family and friends. Mr Davies' was the eighth self-inflicted death at Cardiff since August 2019.

The clinical reviewer concluded that the clinical care Mr Davies received for his substance misuse and mental health at Cardiff was appropriate and equivalent to that which he could have expected to receive in the community.

We found that Cardiff's assessment of Mr Davies' mental health was based on an incomplete assessment at Bristol, some weeks earlier. Otherwise, we found that the non-clinical care provided to Mr Davies was of a reasonable standard.

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

Adrian Usher
Prisons and Probation Ombudsman **December 2023**

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Summary

Events

1. On 18 May 2022, Mr Shane Davies was remanded to prison for drug offences and taken to HMP Bristol. He moved to HMP Cardiff on 22 July and the following week was sentenced to a total of 25 months imprisonment.

2. Mr Davies had a history of substance misuse. He was also diagnosed with psychosis and social anxiety disorder, for which he was previously prescribed medication. During his time in prison, Mr Davies was not assessed as showing any signs of mental ill-health. Despite his many requests for medication, he was not prescribed any at Bristol or Cardiff.

3. At around 8.30pm on 17 August, Mr Davies requested to see a nurse. He said he could not breath and his face was swollen. He thought he was having an allergic reaction to something. When staff responded, they found that Mr Davies had blocked his cell door with furniture. They asked him to move to the back of the cell so staff could enter safely and examine him, but he said no. Mr Davies asked the nurse to enter on her own, which staff said no to due to the potential risks. The nurse observed Mr Davies through the observation panel and found no obvious issues.

4. The night shift operational manager attended half an hour later and Mr Davies responded to her request to move the furniture away from the back of the door. She requested that staff remove the anti-barricade bar on the door in case Mr Davies placed furniture behind his door again. She also instructed staff to complete a welfare check every half hour, to monitor Mr Davies' unusual behaviour.

5. At 11.30pm, during a welfare check, an officer looked through the observation panel in Mr Davies' cell door and saw him hanging. He radioed a medical emergency code (requesting assistance and triggering a call to the ambulance service) and prison and healthcare staff responded. They immediately started resuscitation and after around eight minutes they established a pulse. Mr Davies started to breathe on his own but remained unconscious. Paramedics arrived and continued to treat him.

6. Mr Davies was taken to hospital in an ambulance at 12.45am on 18 August. He was transferred into the intensive care unit but never regained consciousness. On 28 August at 2.00am, a doctor pronounced that Mr Davies had died.

Findings

7. When Mr Davies asked for help from staff on 17 August, they identified his unusual behaviour and implemented regular wellbeing checks. Staff did not think it was appropriate to start suicide and self-harm prevention procedures which we find reasonable in the circumstances.

8. The clinical reviewer found that overall, the clinical care provided to Mr Davies was equivalent to that which he could have expected to receive in the community. However, he found that the mental health team relied too heavily on an incomplete

assessment of Mr Davies' mental health from his previous prison, instead of completing their own. On 23 July, when Mr Davies was assessed by the mental health team at Cardiff, he should have been referred for a full mental health assessment.

9. Our interviews revealed that several staff at Cardiff had not received training on suicide and self-harm procedures in line with national policy. Following Mr Davies' death and other self-inflicted deaths at Cardiff, managers had been supported by the regional safety team to increase the number of trainers within the prison. This work has increased the number of staff receiving the training in the months following Mr Davies' death and therefore we do not make a recommendation.

Recommendations

- The Head of Healthcare at HMP Cardiff should ensure that decisions on mental health referrals are based on a full assessment of a prisoner's current mental health and circumstances.

The Investigation Process

10. We were notified of Mr Davies' death on 28 August 2022.

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 visited Cardiff on 31 August. She obtained copies of relevant extracts from Mr Davies' prison and medical records and visited the wing where Mr Davies lived.

13. The Health Inspectorate of Wales (HIW) commissioned a clinical reviewer to review Mr Davies' clinical care at the prison.

14. The investigator interviewed six members of staff and one prisoner at Cardiff in September. The clinical reviewer co-facilitated interviews with healthcare staff. She also asked a prison manager at Cardiff and healthcare manager at Bristol to respond to questions submitted by email.

15. The PPO investigation was suspended between 12 January and 15 May 2023 pending information from a key member of healthcare staff at Bristol.

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

17. The Ombudsman's family liaison officer contacted Mr Davies' mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Davies' mother wanted to know if he had received appropriate mental health care and who had made decisions regarding his medication. Mr Davies' mother also raised concerns about religious material left in the cell by the previous occupier, which had not been removed prior to Mr Davies moving to the cell the day before he died. We address these matters in our report.

18. Mr Davies' mother received a copy of the initial report. She raised a number of issues which we have responded to in separate correspondence. Mr Davies' mother identified a factual inaccuracy in that the prison had not in fact contributed towards the costs of his funeral.

19. The prison also received a copy of the report. They did not identify any factual inaccuracies. The healthcare provider identified a number of factual inaccuracies in the clinical review report. These have been amended and a revised clinical review report has been issued. A meeting between the PPO investigator, clinical reviewer and Head of Healthcare took place on 9 November to discuss the wording of the recommendation. Revised wording was agreed, and the report has been updated.

Background Information

HMP Cardiff

20. HMP Cardiff holds around 800 men, mostly from Southeast Wales. The majority of prisoners are 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

21. 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.

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

Independent Monitoring Board

23. 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 published 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

24. Mr Davies was the eighth prisoner to take his life at Cardiff since August 2019. Since Mr Davies' death, there has been one self-inflicted death and five deaths due to natural causes. We found no direct similarities between our findings in this investigation and those of previous deaths.

Assessment, Care in Custody and Teamwork

25. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system used by the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

26. Part of the ACCT process involves assessing immediate needs and drawing up support actions to identify the prisoner's most urgent issues and how they will be

met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all support actions are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody).

Key worker scheme

27. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework which says:

- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
- Key workers must have completed the required training.
- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
- Within this allocated time, key workers can vary individual sessions to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

28. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

29. On 18 May 2022, Mr Shane Davies was remanded to prison charged with drug offences and taken to HMP Bristol. He had been to prison before.

HMP Bristol

30. Mr Davies had a history of drug and alcohol misuse. He had tried to take his own life in 2011, after his father's death. When he arrived at Bristol, Mr Davies refused his initial healthscreen. A nurse noted obvious signs of drug and alcohol withdrawal (sweating, shaking and diarrhoea). The GP at Bristol examined Mr Davies and continued his methadone prescription (opioid substitute for supporting withdrawal) and medication to relieve the symptoms. Staff created and implemented a five-day withdrawal care plan and referred Mr Davies to the substance misuse and mental health teams for further assessment. Mr Davies was not assessed as presenting a risk of harm to himself.

31. During his first night, staff completed regular checks on Mr Davies and no concerns were raised. The next day, he refused to complete the initial healthscreen for the second time. Mr Davies also refused to attend his induction, but staff went to his cell to collect information on his needs and provide him with advice on the prison regime and support services.

32. On 20 May, Mr Davies agreed to complete the initial healthscreen. Healthcare staff recorded his substance misuse history and found his withdrawal symptoms had reduced. Mr Davies said that he had psychosis and social anxiety disorder, for which he had previously been prescribed medication (quetiapine, an antipsychotic drug, and mirtazapine for anxiety and depression). He was referred for a mental health assessment, to be undertaken once he had completed his five-day withdrawal care plan. He was also provided a naloxone kit (used to reverse the effects of an opioid overdose) and training on how to use this medication.

33. Over the next few days, Mr Davies collected his prescribed medication but refused to have his clinical observations taken by staff who were monitoring his withdrawal. On 23 May, during a review with the substance misuse team, Mr Davies told a nurse that he was prescribed medication for his mental health in the community (olanzapine, an antipsychotic, and mirtazapine), but his prescription had lapsed, and he had not taken it since March. Later, he asked for the medications to be continued. A GP at Bristol reviewed Mr Davies' community medical record and noted that he had not been prescribed olanzapine or mirtazapine for some months (this was due to Mr Davies avoiding arrest for a period). He advised Mr Davies that no prescriptions could be provided until the mental health team had assessed him.

34. Mr Davies refused to attend court appearances on 25 and 31 May and 14 June. He told staff that he did not see the point of travelling and sitting in a van all day when he knew he would not be granted bail. On 26 May, healthcare staff went to visit Mr Davies to complete a mental health assessment, but he was under the influence of illicit substances and unable to properly engage. The substance misuse team completed an assessment and provided harm reduction advice. Mr Davies again asked to be prescribed medication for his mental health.

35. On 7 June, a healthcare administrator contacted a mental health nurse noting that Mr Davies had been presenting as extremely anxious. She said that despite numerous requests, he had not been added to the non-medical prescribers list for review (NMP – a qualified person, other than a doctor, who can prescribe medication for any condition within their competency). The mental health nurse could not see a request for Mr Davies but said she would review him the next day.

36. On 8 June, Mr James Roach, a healthcare assistant (HCA) met with Mr Davies to complete an initial mental health assessment in response to the previous day's request. He recorded that Mr Davies' community medical records confirmed he had been diagnosed with paranoid schizophrenia and a personality disorder in 2020 and had been prescribed quetiapine and mirtazapine. The HCA noted it was difficult to engage Mr Davies, who gave a conflicting account of his clinical history, but reiterated that he wanted to be prescribed medication. Mr Davies said he had not experienced any psychotic symptoms since completing his five-day withdrawal.

37. Mr Davies said his anxiety increased because he was due to appear in court. He said he did not have any thoughts of suicide or self-harm, but if he did not get his medication, he 'can't promise anything'. The HCA recorded that he did not start suicide and self-harm prevention procedures (known as ACCT) because he assessed there was no immediate risk, but informed wing staff of the comments. The HCA explained that Mr Davies would be assessed by the NMP and he was on the waiting list. Mr Davies said he did not think he should have to wait for an appointment. The HCA provided Mr Davies with information on the support services within Bristol and recorded that there was no need for further involvement with the mental health team.

38. On 10 June, Mr Davies was discussed at a healthcare multi-disciplinary team (MDT) meeting. It was recorded in the MDT notes that he had been requesting medication for his mental health and was frustrated about having to wait. The MDT noted that Mr Davies was on the waiting list for the NMP.

39. On 11 June, Mr Davies met with an officer for a key work session. The officer recorded that Mr Davies had no issues with his mental or physical health, that he did not like being locked in his cell for so long and wanted to start education. Mr Davies said he had strong family relationships and friends on the wing.

40. On 14 June, Mr Davies appeared in court via video link from Bristol and his case was adjourned until 22 July. The same day, a mental health nurse attempted to contact Mr Davies, but he had moved wings so was not seen.

41. On 21 June, an NMP met with Mr Davies to assess his mental health and review his medication. She told Mr Davies that he appeared sedated, which he responded to aggressively and abusively. He demanded medication and would not engage meaningfully in the assessment. She ended the assessment early and recorded that there were no clinical signs or symptoms of concern. She noted she would not prescribe medicines without a full assessment. A wing officer noted in Mr Davies' prison record that he had become aggressive when asked about his presentation and refused to engage with the nurse. Mr Davies was returned to the wing.

42. On 29 June, Mr Davies signed a consent form giving his permission for healthcare staff to share medical information with his mother, as part of care planning. There is no record that there was any contact between Bristol and Mr Davies' mother.

43. On 8 July, Mr Davies asked a member of the healthcare team when he would be prescribed medication for his mental health. A mental health nurse responded that Mr Davies had been assessed and there was no clinical indication to support prescribing medication. The next day, Mr Davies made an application to see a GP. He refused to be examined by a nurse but briefly showed his leg and said he thought he had a deep vein thrombosis (although the nurse noted there were no obvious signs). Mr Davies became verbally aggressive, and the nurse ended their contact.

44. On 13 July, Mr Davies appeared in court via video link for a theft offence and the case was adjourned. (On 3 August Mr Davies received a non-custodial sentence and an anti-social behaviour order.)

45. On 22 July, Mr Davies appeared at Merthyr Tydfil Court for drug offences. The case was adjourned until 29 July, and he was taken from court to HMP Cardiff.

HMP Cardiff

46. During his initial healthscreen, Mr Davies told the reception nurse that he had not been prescribed medication for his mental health for a few weeks and struggled without it. Staff referred Mr Davies to the substance misuse and mental health teams for further assessment. Staff noted his history of self-harm but assessed that no additional monitoring was needed. Mr Davies telephoned his mother before he moved to the induction unit.

47. On 23 July, a substance misuse worker assessed Mr Davies. She noted his history of illicit substance misuse but that there were no signs of withdrawal. Mr Davies' methadone prescription was continued, and he was referred to the psychosocial substance misuse team for ongoing support. A care plan was created to monitor him over the next five days.

48. Later the same day, a mental health nurse met with Mr Davies. She noted that he had transferred from Bristol and that they had assessed no further input from the mental health team was required. Mr Davies asked if he could be prescribed quetiapine and mirtazapine, but she explained that his last assessment had concluded that there was no clinical indication that he should be prescribed this medication. Mr Davies explained that in the previous review he had argued with the nurse and requested another medication review. She told Mr Davies he could request a GP appointment, which he accepted. Mr Davies told her that he had no thoughts of suicide or self-harm and there was no requirement for ongoing support from the primary mental health team. There is no evidence a full mental health assessment was completed during this contact.

49. Over the next few days, Mr Davies collected his methadone as advised. On 25 July, he met with a substance misuse worker, who provided advice on harm minimisation and overdose awareness. On 27 July, Mr Davies met with his offender manager and told them he was waiting to see a GP and psychiatrist. He said he was hoping to be prescribed medication for psychosis, anxiety and depression.

50. On 29 July, Mr Davies was sentenced to a total of 25 months for drug offences. The next day, he moved from the induction wing to a standard residential wing.

51. On 3 August, Mr Davies collected his methadone and became angry towards staff because he had not been prescribed quetiapine and mirtazapine. A nurse referred him to the primary mental health team and noted that Mr Davies should be seen by two practitioners due to his aggressive behaviour.

52. On 7 August, an occupational therapist reviewed the referral and noted that there were no GP appointments until 1 September. She sent a letter to Mr Davies advising that he was on the waiting list and would be seen within 28 days. He was provided with information on other support services within the prison. (On 13 August, Mr Davies was sent a letter informing him that a GP appointment had been booked for 19 August.)

53. Between 7 and 15 August, Mr Davies made six calls. The investigator listened to these calls. On 15 August, at 6.06pm, Mr Davies made his last call to his mother. During this call Mr Davies said there were rumours in the prison about him and that it was a conspiracy. Mr Davies' mother reassured him and reflected that he was feeling like that because he was not taking his medication. Mr Davies told her that he had asked for a doctor's appointment but that it did not matter about his medication, and that he was not paranoid or taking drugs. Mr Davies spoke about a large sum of money and told his mother that if anything big happened that she should look into it. The conversation was confused and difficult to follow. Mr Davies did not mention any thoughts of suicide or self-harm. (All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample.)

54. On 16 August, Mr Davies moved to another wing and a double cell with another prisoner. His cell mate said that Mr Davies acted 'weirdly', spoke to himself, and paced the floor. Mr Davies told his cell mate that other prisoners thought he was a sex offender and were out to get him. Mr Davies' cell mate said that he did not always understand what Mr Davies was saying and wanted to move out of the cell as he felt 'wary' of him. The next day, Mr Davies' cell mate was moved to another cell along the same landing and Mr Davies remained in the cell on his own.

Events of 17 August

55. On 17 August, no significant events or issues were recorded about Mr Davies during the day.

56. Closed circuit television (CCTV) shows that at around 8.30pm, Mr Davies pressed his emergency cell bell. He asked an Operational Support Grade (OSG) if he could see healthcare as he said he could not breath and that his face was swollen. A nurse attended the wing. An officer asked Mr Davies several times to move to the back of his cell so they could open his door and escort the nurse to examine him. Mr Davies refused, saying he only wanted the nurse in his cell. The nurse observed through the window in the cell door that there were no obvious physical signs of swelling, and that Mr Davies was breathing normally. Mr Davies said he no longer needed the nurse. The officer noted Mr Davies had placed a mattress and furniture behind his door so he contacted a Custodial Manager (CM), the night operational manager, for assistance.

57. At around 9.24pm, the CM went to Mr Davies' cell, accompanied by several officers. Body Worn Video Camera (BWVC) footage shows that she asked Mr Davies several times to remove the mattress and furniture and encouraged him to settle down and go to sleep. BWVC footage shows that there were no obvious signs of anything physically wrong with Mr Davies. He was using a vape and talking and there were no signs of any difficulty breathing. The CM spoke to Mr Davies for about three minutes. He was concerned staff were going to enter his cell and Mr Davies said he no longer needed to see a nurse. She reassured Mr Davies that staff would not enter and requested that he remove the furniture from behind the door, which he did. She asked staff to remove the anti-barricade bar from around the outside of the door in case Mr Davies barricaded his door again. She instructed officers to complete a welfare check every half an hour. She said although Mr Davies' behaviour was 'odd', neither she nor other staff had any concerns about the risk of suicide or self-harm.

58. CCTV shows that welfare checks were completed at unpredictable times, at least every half an hour.

59. At around 11.30pm, an officer went to Mr Davies' cell to complete a welfare check. He saw Mr Davies hanging by a bed sheet attached to the window at the back of his cell. He radioed a code blue (requesting assistance from staff and triggering a call for an ambulance). The CM and nurse acknowledged the call and that they were responding. The CM told the officer to enter the cell immediately, however another officer radioed a different instruction, advising him not to enter the cell until other officers arrived. The officer decided to enter the cell immediately. Mr Davies had made another barricade with his furniture, but officers were able to open the door outwards due to the removal of the anti-barricade bar. Another officer responded to the emergency and he and the first officer cut the ligature, placed Mr Davies on the floor and started cardiopulmonary resuscitation (CPR). Other staff attended, including the nurse, and they moved Mr Davies to the landing floor where there was more space.

60. The nurse checked for signs of life while officers continued chest compressions. They attached a defibrillator, which advised there was no shockable rhythm and the nurse inserted an airway. Resuscitation continued for about eight minutes before a pulse was found and Mr Davies started to breathe on his own.

61. Welsh Ambulance Service records show they received a request for an emergency ambulance at 11.33pm. Paramedics arrived at 11.38pm and took over Mr Davies' treatment. A second ambulance arrived, followed by an air ambulance and HEMS doctor (the helicopter emergency medical service provides advanced emergency and medical care). Mr Davies was stabilised but remained unconscious. At 12.45am on 18 August, Mr Davies was taken by ambulance to hospital. Prison staff escorted Mr Davies, but he was not restrained.

62. Staff found a letter in Mr Davies' cell addressed to his mother. It was not dated, and it was unclear when it was written. Mr Davies wrote that he felt threatened and worried he would be killed. He wrote that there were rumours about him on the wing and that things were put in his drugs and food which made him paranoid.

Contact with Mr Davies' family

63. An officer telephoned Mr Davies' mother to inform her that Mr Davies had been taken to hospital and that hospital staff had encouraged her to attend as soon as possible. Later, Cardiff appointed a family liaison officer and a deputy. The deputy later became the main point of contact.

64. Mr Davies' funeral took place on 27 September. The prison did not contribute to the funeral costs. They have accepted that they should have done more to ensure Mr Davies' mother had understood the offer of a financial contribution and have agreed to make a retrospective contribution towards the costs.

Support for prisoners and staff

65. After Mr Davies was taken to hospital, a CM debriefed staff involved in the emergency response to ensure they had the opportunity to discuss any immediate issues arising, and to offer support. The prison care team and the TRiM manager (trauma risk management) also contacted the staff involved in the emergency response.

66. The prison posted notices informing other prisoners of Mr Davies' 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 Davies death.

Post-mortem report

67. There was no post-mortem examination as Mr Davies died in hospital. No toxicology screen was completed because bloods taken when Mr Davies was admitted to hospital were no longer available when he died. We asked the Coroner for further information on Mr Davies' samples, but were unable to establish why there were no longer available when he died.

Findings

Assessment of risk of suicide and self-harm

68. 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 that staff must follow when they identify that a prisoner is at risk of suicide and self-harm. It requires the identification of risk factors and triggers and use of Assessment, Care in Custody and Teamwork (ACCT) measures where there is a risk of harm.

69. When Mr Davies arrived at Cardiff, the information about his previous attempt to take his own life in 2011 was considered. Prison and healthcare staff did not assess that it was necessary to ACCT monitoring, which was reasonable in the circumstances.

70. Mr Davies' previous cell mate said that although Mr Davies' behaviour was 'weird' and paranoid, he thought this was a combination of his mental health and drug issues. He encouraged Mr Davies to speak to a doctor. Mr Davies told his cell mate that he would not harm himself.

71. In the hours before he was discovered, Mr Davies asked to see a nurse but then refused to comply with reasonable instructions and could not be examined. He later said he no longer needed a nurse. The night operational manager was concerned about Mr Davies' behaviour and put wellbeing checks in place, but neither prison staff nor the nurse assessed that Mr Davies was in crisis or at increased risk of suicide or self-harm. We are satisfied that this was appropriate in the circumstances.

ACCT training

72. PSI 64/2011 requires that all staff in contact with prisoners must be trained in *Introduction to Safer Custody*, which includes ACCT procedures. Refresher training must be provided according to local training needs.

73. Although we found Mr Davies risks were appropriately managed, our interviews revealed that not all staff had received ACCT training at Cardiff. Including the nurse who completed Mr Davies' reception health screening and who was responsible for identifying risks. The reception health screening found no suicide or self-harm risks and made appropriate referrals to substance misuse and mental health teams for further assessment of Mr Davies, but it is important that healthcare staff understand and can implement procedures for identifying risks.

74. The Head of Safety at the time Mr Davies was at Cardiff said that ACCT training had not taken place for several years, due to staffing issues at Cardiff and the impact of Covid-19. This meant there were no staff in the prison who could provide the training. At the time of our investigation, she said Cardiff was receiving support from the regional safer custody team due to the number of self-inflicted deaths that had happened there. The regional team delivered up-skilling training sessions for staff around risks, triggers and protective factors and the new ACCT process which was rolled out in 2021 as staff had not been updated on it. New staff joining around the time that Mr Davies was at Cardiff completed suicide and self-harm training as

part of their initial training course (40.64% of staff trained in August 2022). We asked what progress had been made in July 2023 and the new Head of Safety confirmed improvements had been made. At the time of writing, Cardiff had six members of staff able to deliver training within the establishment which increased the number of staff being trained (to date 61.40%). We do not make a recommendation.

Clinical care

75. The clinical reviewer concluded that overall, the physical and mental healthcare Mr Davies received was equivalent to that which he could have expected to receive in the community.

Mental health

76. Bristol organised a mental health assessment for Mr Davies when they identified his history of mental-ill health. The assessment took place on 21 June but was ended early due to Mr Davies' behaviour. The notes recorded there was no evidence of serious mental illness and medication was therefore not prescribed.

77. On 23 July, Mr Davies' initial health screen at Cardiff suggested he required an initial mental health screening, which was completed. The next day, during his secondary mental health screening, it was concluded that no further input from the mental health team was required based on Mr Davies' previous, incomplete assessment at Bristol. Mr Davies was provided with information on other support services available at Cardiff and told that he could make an appointment with a GP at Cardiff if he had any concerns. He was initially told he would have to wait 28 days for an appointment, but this was brought forward.

78. Cardiff based their assessment of Mr Davies' mental health on an incomplete and out of date assessment which did not consider his recent transfer, despite this being a key risk factor for suicide and self-harm. He was clearly distressed about his mental health and lack of medication. Mr Davies should have been referred for a full mental health assessment. We therefore make the following recommendation:

The Head of Healthcare at HMP Cardiff should ensure that decisions on mental health referrals are based on a full assessment of a prisoner's current mental health and circumstances.

Emergency response

Entering the cell

79. When the CM instructed the officer to enter Mr Davies' cell immediately, another officer radioed a different instruction, asking him to wait for other staff. This contradicted the Local Security Strategy (LSS) instructions which state that a member of staff can enter a cell alone when there is a risk to life, and on the instruction of the operational manager. The second officer said he was aware of the LSS night instructions, but not fully. We have identified delays entering a cell in at least three previous investigations at Cardiff and made recommendations, accepted

by the prison, to address this problem. While there was no delay in entering Mr Davies' cell because the first officer made the right decision, all officers should be aware of the policy of entering a cell immediately when there is a potentially life-threatening situation.

80. The Deputy Governor conducted a disciplinary investigation into the behaviour of the second officer. He noted that despite the officer's instruction, there was no delay in entering Mr Davies' cell. The officer was aware that preservation of life must take precedence over security concerns, but that night staff should not take action that they feel would put themselves or others in unnecessary danger. He explained that the staff working on Mr Davies' wing were inexperienced and he had concerns based on Mr Davies earlier behaviour. He wanted to keep his colleagues safe.

81. The Deputy Governor concluded that the officer should be provided with advice and guidance, to improve his practice. Since Mr Davies' death, all custodial managers have been asked to ensure they brief night staff prior to commencing duty and the need to be aware of the LSS night instructions, particularly around entering cells. The local training centre have also been instructed to ensure they teach officers about night duties, in particular cell entry during the night. As Cardiff have already addressed this issue, we do not make a recommendation.

Delay requesting an ambulance

82. PSI 03/2013, Medical Emergency Response Codes, sets out the actions staff should take in a medical emergency. It says that if a medical emergency code is radioed, an ambulance must be called immediately.

83. The officer immediately called a code blue when he discovered Mr Davies at 11.30pm, but control room staff did not call an ambulance until around three minutes later. The response from the Ambulance Service was swift, but it is important that there are no delays in requesting an ambulance in a medical emergency.

84. The Governor issued a Notice to Staff on the use of medical emergency codes and the expected response, reiterating the mandatory requirement for the control room to call the ambulance service immediately. The operational support grade in the communications room at the time Mr Davies was discovered received individual guidance. We do not make a recommendation.

Resuscitation

85. Prison and healthcare staff worked tirelessly to resuscitate Mr Davies and should be commended for their efforts.

Good practice

86. When Mr Davies barricaded his door on the day of his death, the CM instructed staff to remove the anti-barricade bar from around the outside of the door and requested they complete half hourly welfare checks based on his unusual behaviour. Removal of the anti-barricade bar enabled staff to quickly enter Mr Davies' cell when the emergency was identified, and we commend her actions.

Governor to note

Cell condition

87. When Mr Davies moved cells on 16 August, he was located in a cell which contained personal documents belonging to the previous occupant. In addition, we found a significant amount of religious material stuck to the walls and religious text made into the shape of a large cross. When Mr Davies' mother visited his cell after he died, she was incorrectly informed these were Mr Davies' belongings. When she was then told that they did not belong to him but the previous occupant, she was distressed by the state of the cell. We do not know if the condition of the cell had any impact on Mr Davies' mental health, but he should never have been placed in such an environment.

88. We asked the Head of Safer Custody about Mr Davies' cell. She said that Cardiff's local policy requires the clearing and tidying of cells before new prisoners move in, but that it had not been followed on this occasion. We are unable to measure the impact on Mr Davies and could not verify whether this was a systemic issue when we visited Cardiff. We do not make a recommendation but bring the learning to the attention of the Governor, to ensure future practice is improved.

Inquest

89. The inquest into Mr Davies' death concluded on 7 October 2024. The inquest gave a narrative verdict and concluded that Mr Davies died by ligaturing himself in circumstances to where his intention could not be ascertained.

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