Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John O'Driscoll, a prisoner at HMP Cardiff, on 29 December 2021

A report by the Prisons and Probation Ombudsman

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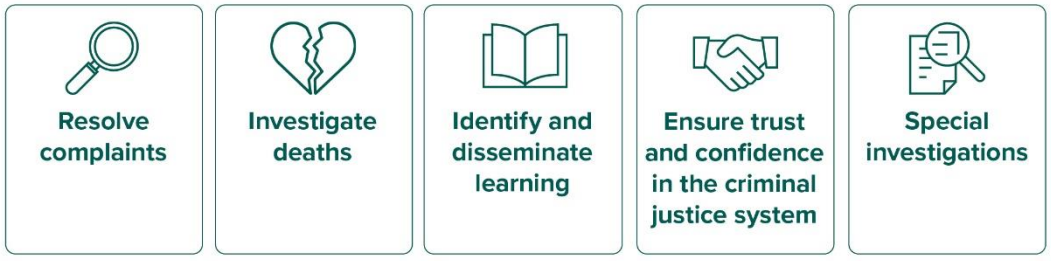
OUR VISION

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 John O'Driscoll died in hospital on 29 December 2021, after he was found hanged in his cell at HMP Cardiff. He was 35 years old. I offer my condolences to his family and friends.

Mr O'Driscoll had a long history of self-harm and mental ill-health. He continued to experience these issues when he was released from prison and living in an Approved Premises, in which he overdosed on his anxiety medication. We are concerned that when Mr O'Driscoll was recalled to HMP Cardiff, police and probation staff failed to highlight the very recent overdoses to prison staff responsible for completing initial risk assessments. Mr O'Driscoll died on the day he was recalled. Based on the information that was available to prison staff, we do not consider that they could reasonably have foreseen that Mr O'Driscoll might be at imminent risk of suicide. Had they known about the circumstances that led up to his recall, they might have put additional monitoring in place to safeguard him.

The clinical reviewer was satisfied with the level of healthcare Mr O'Driscoll received and concluded that it was equivalent to that which he could have expected to receive in the community.

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 **June 2023**

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Summary

Events

1. Mr John O'Driscoll was serving a 16-month prison sentence for burglary at HMP Cardiff. He had spent several periods in prison and had a history of substance misuse and mental ill-health. In April 2021, he told staff he had attempted suicide and was monitored under suicide and self-harm prevention procedures (known as ACCT).

2. On 20 December, Mr O'Driscoll was released on licence to Mandeville House Approved Premises (AP). He reported suicidal thoughts to staff, who monitored him under AP suicide and self-harm prevention procedures.

3. Between 23 and 29 December, Mr O'Driscoll reported further suicidal thoughts to staff and took a quantity of illicitly obtained anti-anxiety tablets. He was taken to hospital for monitoring.

4. On 29 December, in the early hours of the morning, Mr O'Driscoll again took a large quantity of anti-anxiety tablets and AP staff called an ambulance. When paramedics arrived, Mr O'Driscoll was aggressive. Senior AP and probation service staff decided to recall him to prison.

5. That afternoon, Mr O'Driscoll was arrested and taken to Cardiff Bay police station. When the custody sergeant completed the Person Escort Record (PER) for Mr O'Driscoll's transfer to prison, the suicide and self-harm risk assessment section was left blank and didn't include information on his recent self-harm.

6. Mr O'Driscoll arrived at HMP Cardiff shortly after 4.00pm. When prison staff completed an initial risk assessment, they referenced the paperwork they had received from police and probation and found no immediate safeguarding concerns. They put no additional monitoring in place. Officers took Mr O'Driscoll to his cell on C Wing shortly after 6.00pm.

7. At around 8.15pm, the night patrol officer completed a routine check on C Wing. He raised no concerns regarding Mr O'Driscoll. At 9.04pm, another officer completed a further roll check. When he looked through Mr O'Driscoll's cell observation panel, he saw that he was hanging from the window at the back of his cell by a piece of bed sheet. He immediately radioed a medical emergency 'code blue', indicating a life-threatening situation and triggering a call for help and for an ambulance.

8. Officers responded quickly to the code blue and began cardio-pulmonary resuscitation (CPR). At 9.08pm, healthcare staff arrived and took control of the CPR but could not find a pulse. At 9.22pm, paramedics arrived and, at 9.52pm, confirmed that Mr O'Driscoll had died.

Findings

Clinical care

11. The clinical reviewer concluded that the clinical care Mr O'Driscoll received at Cardiff was equivalent to that which he could have expected to receive in the community.

Risk of suicide and self-harm

12. When probation staff completed a licence recall notification document for Mr O'Driscoll, they did not share information on his recent suicidal thoughts or self-harm with the prison. This, coupled with the same omission in the Person Escort Record (PER) completed by the police, meant prison staff were unaware of Mr O'Driscoll's recent overdoses when they completed initial suicide and self-harm risk assessments. No additional safeguarding measures were put in place on his first night. In response to early learning from Mr O'Driscoll's death, Wales Prison and Probation Service developed guidance that aims to improve the communication of urgent risk information between the probation and prison services at the point of recall. We are satisfied that if implemented appropriately, the guidance will help to address the communication problems identified in this case.

13. When Mr O'Driscoll was transferred from police custody to prison following his recall, the suicide and self-harm risk section in his Person Escort Record (PER) transfer notes was blank and the marker was not ticked, despite recent self-harm incidents and disclosures. The actions of the police are outside of the PPO's remit and therefore we make no recommendation on their involvement in the care of Mr O'Driscoll.

Body worn camera footage

16. The staff involved in the emergency response for Mr O'Driscoll did not turn on their body worn cameras.

Staff statements

17. Staff involved in the emergency response did not complete written statements following the incident. The lack of body worn camera footage and written statements limited our ability to investigate the staff response.

Recommendations

- The Governor should remind staff to switch on their body-worn cameras during reportable incidents and ensure that control room operators prompt staff to do so during an incident.

- The Governor should ensure that staff directly involved in a death in custody complete incident statements as soon as practicable following the death.

The Investigation Process

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

19. The investigator visited HMP Cardiff on 16 February 2022. He obtained copies of relevant extracts from Mr O'Driscoll's prison and medical records.

20. The investigator interviewed four members of staff while at the prison on 16 February, and two further members of staff via video-link on 22 and 23 March.

21. NHS England commissioned a clinical reviewer to review Mr O'Driscoll's clinical care at the prison. He attended the interviews alongside the investigator.

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

23. The Ombudsman's family liaison officer contacted Mr O'Driscoll's next of kin, his father, to explain the investigation and to ask if he had any matters that he wanted the investigation to consider.

24. Mr O'Driscoll's father told the family liaison officer that he believed his son had tried to assault an officer and was forcibly taken to his cell by officers as a result. He said he believed they were in the cell for a while and was suspicious as to what might have happened. During our investigation, we found no evidence to support these concerns.

25. Mr O'Driscoll's father also asked us whether staff completed a suicide risk assessment for his son when he arrived at the prison. We have addressed this matter in our report.

26. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not identify any factual inaccuracies.

27. Mr O'Driscoll's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Cardiff

28. 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

27. The most recent inspection of HMP Cardiff was in July 2019. 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

28. 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

29. Mr O'Driscoll was the tenth prisoner to die at Cardiff since December 2019. Of the previous deaths, four were self-inflicted and five were from natural causes. We found no similarities in the findings across these investigations. Three further self-inflicted deaths have occurred at Cardiff since Mr O'Driscoll's death. At the time of writing, there are no similarities in the learning across these investigations.

Assessment, Care in Custody and Teamwork (ACCT)

30. ACCT is the HMPPS 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.

31. 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.

32. 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.

Approved Premises (AP)

33. Approved premises (formerly known as probation or bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision, as well as a supportive and structured environment that prepares offenders for the transition into the community. Residents are responsible for seeking their own healthcare and are expected to register at a local GP surgery.

34. On 20 December 2021 Mr O'Driscoll was released on licence to live at Mandeville House AP. Mandeville House is managed by the Probation Service and provides accommodation for male offenders. It has 18 single rooms, one double room, one room catering for people with disabilities, one two-person flat and one three-person flat. It is staffed 24 hours a day.

35. Alcohol and illegal drugs are prohibited in all APs, which conduct random room searches and other protocols to ensure compliance. This is in addition to any individual licence or bail conditions and curfews that residents must comply with.

Person Escort Records (PERs)

35. PERs must be completed for all prisoners before any escorted movement or transfer. They provide escort staff and receiving prisons with relevant information on a prisoner and the risks they may pose during and after the movement. The PER is not itself a risk assessment, however it conveys information about a prisoner's assessed risks to those who may need to know about them.

36. Correct completion and storage of the PER will help to prevent incidents of suicide/self-harm, escapes, assaults, releases in error and other serious incidents.

Key Events

Background

37. On 25 March 2021, Mr John O'Driscoll was convicted of burglary and given a 16-month custodial sentence. He had been to prison several times and had a history of substance misuse, including misuse of prescription medication. He also had a history of anxiety and depression and was monitored by ACCT procedures during previous periods in custody.

38. Mr O'Driscoll's mother had died around six months before he arrived at Cardiff. When prison staff identified this, they offered support.

39. On 29 April, Mr O'Driscoll told a member of staff that he had tried to hang himself in his cell two weeks earlier and was feeling suicidal again. Staff began monitoring him under ACCT procedures. A prison GP reviewed Mr O'Driscoll later that day and prescribed an antidepressant.

40. On 6 May, at an ACCT case review, staff noted information in Mr O'Driscoll's medical records, detailing previous attempts to take his own life using ligatures.

41. While under ACCT monitoring, Mr O'Driscoll was aggressive and intimidating towards prison staff on several occasions. To ensure staff safety, three officers had to be present when his cell was unlocked.

42. On 13 May, staff closed Mr O'Driscoll's ACCT when they felt that he was no longer at risk of suicide or self-harm. Mr O'Driscoll continued to display violent and offensive behaviour towards staff.

43. Mr O'Driscoll's brother died during his time at Cardiff. Staff were aware and offered appropriate follow up support.

HMP Parc

44. On 2 August, Mr O'Driscoll was transferred to HMP Parc. In his induction record, staff noted the deaths of his mother and brother, his substance misuse issues and mental health history.

45. Staff identified no serious mental health concerns, but Mr O'Driscoll continued to be supported by the mental health team and his antidepressant medication was continued.

46. On 1 December, Mr O'Driscoll was transferred to the segregation unit due to continued disruptive behaviour. Healthcare staff monitored him regularly and raised no concerns. He remained in the segregation unit until his release from prison on 20 December.

Mandeville House Approved premises (AP)

47. On 20 December, Mr O'Driscoll was released from Parc on licence, to Mandeville House AP. During his induction, he told staff that he had no history of self-harm and was not experiencing any suicidal thoughts.

48. The next day, AP staff completed a suicide and self-harm assessment interview, followed by a 'Support and Safety Plan (SaSP) Guided Welfare Assessment', to assess Mr O'Driscoll's level of risk to himself and others. During the process, Mr O'Driscoll told staff he had attempted suicide in April and was experiencing active suicidal thoughts. He said he had been prescribed antidepressants in prison but had thrown them away because they made him feel worse. AP staff referred Mr O'Driscoll to the Community Psychiatric Nurse (CPN) and began monitoring him under AP suicide and self-harm monitoring procedures, known as a 'CARE' plan. (The term 'CARE plan' is an acronym which stands for, 'Collaborative Assessment of Risk and Emotion', based on which residents considered to be at risk of self-harm or suicide are monitored by staff.)

49. On 22 December, Mr O'Driscoll presented as intoxicated for his midday curfew, and again for his 8.00pm curfew. He told staff that he had taken diazepam (an anti-anxiety medication), which he had obtained illicitly. Mr O'Driscoll denied having any more tablets in his possession.

50. On 23 December, Mr O'Driscoll telephoned the out of hours GP service. He told them that he had taken a large amount of diazepam tablets, which he had again obtained illicitly. The GP referred Mr O'Driscoll to the Crisis Resolution and Home Treatment team ("crisis team") for an assessment, and a member of AP staff went with him. Mr O'Driscoll reported suicidal thoughts and was referred to the Community Mental Health Team (CMHT) for further monitoring. His condition was not deemed serious enough for him to be admitted to hospital and he was discharged by the CMHT. According to the AP staff member who accompanied Mr O'Driscoll, when asked if and how he would kill himself, Mr O'Driscoll stood up and took a ligature from his pocket and threw it on the ground in frustration, stating that was how he was going to do it.

51. On 24 December, AP staff contacted the crisis team when Mr O'Driscoll reported further suicidal thoughts. The crisis team assessed him over the phone and advised him to go to the hospital emergency department, but Mr O'Driscoll chose not to. The on-call AP manager, increased Mr O'Driscoll's level of observations to hourly, then to half hourly.

52. On 25 December, Mr O'Driscoll reported further suicidal thoughts to AP staff. He was admitted to Cardiff Royal Infirmary for monitoring. A hospital doctor prescribed antidepressants to help settle Mr O'Driscoll's mood. After returning to the AP from hospital, staff felt that Mr O'Driscoll had settled slightly, and although he continued to struggle emotionally, he did not express any further suicidal thoughts over the next few days.

53. On 28 December Mr O'Driscoll saw his family. In the early hours of 29 December, he told AP staff that he was experiencing chest pains and needed an ambulance. Staff called an ambulance at 2.25am but were advised that it would take two to four hours to arrive. At this point, Mr O'Driscoll told staff that he had taken illicitly obtained diazepam, in addition to what was prescribed to him, that afternoon. Staff searched Mr O'Driscoll's room and found alcohol.

54. At around 3.00am, Mr O'Driscoll became more agitated. He telephoned emergency services and was rude to the ambulance service call handler, telling them he had taken 60-70 diazepam tablets. He fell asleep shortly afterwards. The ambulance crew arrived at around 6.00am, and when they tried to wake Mr O'Driscoll, he

became very aggressive. AP staff called the police, who arrived shortly afterwards. At around 7.30am, Mr O'Driscoll was taken to hospital in an ambulance, accompanied by police officers. He returned to the AP later that morning.

Recall to HMP Cardiff

55. At around 9.30am on 29 December, the AP area manager, and the Head of the local Probation Delivery Unit (PDU), discussed Mr O'Driscoll's behaviour and associated risks. They concluded that all available interventions had been tried and that his risk was no longer manageable in the AP. They requested an emergency recall to custody.

56. The duty probation officer completed Mr O'Driscoll's licence recall report (known as the 'Part A') in the absence of his offender manager, who was not available that day. She wrote in the 'vulnerability issues' section of the Part A that Mr O'Driscoll had made threats to harm himself, and that he had a suicide and self-harm CARE plan in place at the AP, involving regular observations. The Part A was then processed by the national Public Protection Casework Section (PPCS), who extracted the relevant risk information and collated it on a document called the 'licence recall notification', as per the standard procedure. The licence recall notification was transferred to the Police National Computer (PNC) for the attention of the police actioning the recall arrest and, further down the line, prison reception staff.

57. At 2.36pm, police officers arrived at the AP and arrested Mr O'Driscoll, and took him to Cardiff Bay police station. The custody sergeant completed a suicide and self-harm risk assessment. Mr O'Driscoll said that he had taken 300 diazepam tablets the previous night but said "they did not work". He also said that he had gone to hospital but discharged himself, and when asked if he was suffering from mental health problems or depression, he replied, "yes, anxiety, the lot". The sergeant recorded "suicidal thoughts and alleged attempt hanging" in the suicide and self-harm risk assessment. Mr O'Driscoll's level of suicide and self-harm risk was recorded as "low".

58. At around 3.30pm, a healthcare practitioner (HCP) based at the police station assessed Mr O'Driscoll and concluded that he was fit to transfer to prison. The HCP also recorded that no suicide or self-harm risks had been identified.

59. The custody sergeant updated Mr O'Driscoll's custody record with the HCP's comments and completed a PER for Mr O'Driscoll's transfer to HMP Cardiff. He recorded that he had checked the PER form and confirmed that it was accurate. However, the risk section of the PER received by the prison was blank and contained no reference to Mr O'Driscoll's risk of suicide or self-harm and the events which had taken place while at the AP.

HMP Cardiff

60. Mr O'Driscoll arrived at HMP Cardiff shortly after 4.00pm. When an officer booked him in, he found that the suicide and self-harm section of Mr O'Driscoll's PER was blank. The officer also received and reviewed the licence recall notification and police HCP's medical report. In interview, the officer told us that although the documentation stated that Mr O'Driscoll had vulnerability issues, had made threats

to self-harm and was being monitored by AP staff, he denied having any current thoughts of self-harm and did not present any obvious signs of crisis.

61. At around 5.00pm, a nurse completed an initial healthcare screening for Mr O'Driscoll. To inform the assessment, she reviewed his electronic medical record, licence recall notification, police HCP's medical report, PER and other documentation. She identified a previous attempt Mr O'Driscoll had made to take his own life noted in his medical records. She recorded that he reported his current mood as "ok". However, she also recorded that he described himself as being, "all over the place". Mr O'Driscoll told her that he did not have any thoughts of suicide or self-harm. In interview, she told us that after assessing Mr O'Driscoll and reviewing the available documentation, she did not have any immediate concerns about his wellbeing. She also told us that Cardiff has a system in place whereby someone from the mental health team will assess every new prisoner the day after their arrival, providing a second opportunity to identify concerns. She did not think action was required before the next day.

62. At around 5.20pm, an officer completed a Cell Sharing Risk Assessment (CSRA) for Mr O'Driscoll. The officer recorded the following: "PER & Warrant/recall notice checked, no increased risk". (The officer confirmed at interview that when he wrote 'recall notice', he was referring to the recall notification and HCP's medical report.) He also noted, "verbally states no thoughts of SASH (suicide and self-harm), previous self-harm markers discussed and deemed to be no issue anymore". The officer concluded that there was no increased risk and cell sharing was appropriate. He placed Mr O'Driscoll in a double cell by himself, pending security checks (these are required for all prisoners).

63. Shortly after 6.00pm, an officer carried out Mr O'Driscoll's Introduction to Custody interview and raised no concerns. She showed Mr O'Driscoll to his cell on C Wing and went to his cell twice a short while later to resolve issues with his television.

64. At around 8.15pm, an officer completed a routine check of all prisoners on C Wing and raised no concerns.

Emergency response

65. At around 9.00pm, an officer began another routine check of all prisoners on C Wing. At 9.04pm, when he arrived at Mr O'Driscoll's cell, he looked through the cell observation panel and saw that Mr O'Driscoll was hanging from the back window by a piece of bed sheet. He immediately radioed a medical emergency 'code blue', indicating a life-threatening situation. Staff in the control room immediately called for an ambulance.

66. Staff ran straight to the cell and the officer opened the cell door. An officer cut the ligature and laid Mr O'Driscoll on the floor. Another officer began cardio-pulmonary resuscitation (CPR).

67. At 9.08pm, a nurse arrived and took control of the CPR. She could not find a pulse, and the defibrillator showed that there was no shockable heart rhythm.

68. At 9.22pm, paramedics arrived and, alongside the nurse, continued to try to revive Mr O'Driscoll. They could not regain a pulse and confirmed his death at 9.52pm.

Contact with Mr O'Driscoll's family

69. Initially, staff were unable to locate a next of kin for Mr O'Driscoll, which led to a delay in notifying the family of his death. At around 7.15am on 30 December, the prison family liaison officer (FLO) telephoned Mr O'Driscoll's father and told him that Mr O'Driscoll had died. This was in line with exceptional guidance in place during the COVID-19 pandemic, which reduced face-to-face visits for the purposes of family liaison.

70. After Mr O'Driscoll's father had been informed, the Governor and deputy FLO shared the news of Mr O'Driscoll's death with his brother, who was also a resident at HMP Cardiff.

71. Cardiff contributed to the costs of Mr O'Driscoll's funeral, in line with Prison Service instructions.

Support for prisoners and staff

72. After Mr O'Driscoll's death, a deputy governor 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.

73. Staff members involved in the emergency response did not make statements following the incident, as they are required to do by prison policy.

74. The prison posted notices informing other prisoners of Mr O'Driscoll's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm, and who might have been adversely affected by Mr O'Driscoll's death.

Post-mortem report

75. A post-mortem examination identified Mr O'Driscoll's cause of death as pressure on the neck due to hanging by a ligature.

76. Post-mortem toxicology tests found traces of diazepam and mirtazapine in Mr O'Driscoll's system. These were antidepressants that had been prescribed to Mr O'Driscoll and there was no evidence to suggest they had, within the scope of analysis, contributed to his death.

77. At an inquest held on 28 November 2024, the Coroner concluded that Mr O'Driscoll died from hanging.

Findings

Clinical care

78. The clinical reviewer concluded that the clinical care Mr O'Driscoll received at Cardiff was equivalent to that which he could have expected to receive in the community. He made no recommendations.

Risk of suicide and self-harm

79. Prison Service Instruction (PSI) 64/2011 'Managing prisoner Safety in Custody' requires that staff who have contact with prisoners are aware of the risk factors and triggers that might increase suicide and self-harm, so that they can take relevant action.

80. Mr O'Driscoll had a history of poor mental health, suicidal thoughts and attempts, and self-harm. He presented with a range of known risk factors including a recent recall, bereavement and a history of violence. In the week between his release from Parc and his recall to Cardiff, Mr O'Driscoll expressed further suicidal thoughts and was monitored by suicide and self-harm procedures while at Mandeville House AP. He also reported low mood and anxiety. Mr O'Driscoll had a history of substance misuse and took a large quantity of anti-anxiety medication on two occasions in the nine days before his recall to custody, for which he received hospital care. We have considered whether prison staff were aware of this information when they assessed Mr O'Driscoll's risk of suicide on arrival at Cardiff.

81. Mr O'Driscoll told the custody sergeant at Cardiff Bay police station that he had recently overdosed on medication. The sergeant recorded on the police custody system that Mr O'Driscoll had thoughts of suicide. However, this information was not recorded in the PER, in which the relevant section was left blank. The suicide/self-harm warning alert box on the front cover of the PER was not ticked as it should have been.

82. The suicide and self-harm risk information in Mr O'Driscoll's probation recall notification noted his threats to self-harm and the fact he was monitored under a CARE plan while in the AP. However, it did not reflect the two overdoses taken by Mr O'Driscoll before his recall and what they might have indicated about his suicide and self-harm risk. This created a mixed picture of his level of risk which prison and healthcare staff did not feel gave them any immediate cause for concern. Our interviews with prison staff identified that they did not understand the relevance of the AP "CARE" or "care plan" process when assessing a prisoner's risk of suicide or self-harm.

83. We are aware that prison reception staff do not always have access to licence recall notifications and often rely on the PER for risk information to inform the care planning for individuals. However, the licence recall notification is another source of risk information that staff should refer to and was reviewed (in conjunction with the PER) by staff at Cardiff upon Mr O'Driscoll's arrival. We consider that the recall notification received by prison staff did not accurately reflect Mr O'Driscoll's level of risk to himself, because it downplayed the extent of the suicidal thoughts and behaviour he had exhibited at the AP.

84. When a nurse spoke to Mr O'Driscoll as part of his initial healthcare screening, he did not share any thoughts of suicide or self-harm. She combined this information with the electronic information available to her and concluded that there was no additional risk. When prison officers checked the available documents, they also concluded that no further support was required to reduce the risks. No measures were put in place to safeguard Mr O'Driscoll on his first night.

85. Having reviewed the evidence, we consider that the nurse and the officers who booked in and inducted Mr O'Driscoll could not have foreseen an imminent risk to his safety based on his presentation and the information available to them. The outcome of their assessment might have been different if the PER and recall notification had accurately reflected Mr O'Driscoll's risk.

86. The actions of police officers are outside the remit of the PPO. A referral was made to the Independent Office for Police Conduct (IOPC) to investigate the actions of officers at Cardiff Bay police station following Mr O'Driscoll's arrest on 29 December. The IOPC has since investigated the actions of the police officers at Cardiff Bay Station and concluded that they have a case to answer for misconduct. They have made a number of recommendations to ensure that training and systems are improved, so that a prisoner's suicide and self-harm risk information is appropriately reflected in documentation provided to receiving prisons in future.

87. In response to early learning from Mr O'Driscoll's death, Wales Prison and Probation Service have developed guidance that aims to improve the communication of urgent risk information between the probation and prison services at the point of recall. The guidance states that if there is urgent risk information about an individual who is being recalled, staff should contact the receiving prison control room and ask to speak to the Duty Custodial Manager or Duty Governor to tell them about it personally. This should then be followed up with emails to any relevant individuals or departments. We are satisfied that if implemented appropriately, the revised process will help to address the communication problems identified in this case.

Body worn camera footage (BWVC)

88. PSI 04/2017 states that, "In those establishments where it is authorised for use, BWVC must be deployed and set to record during a response to any reportable incident". BWVC footage is an important source of evidence for the PPO and other bodies.

89. Although some officers involved in the emergency response on 29 December were wearing body-worn video cameras (BWVC), none were turned on. We recognise that during a traumatic event, staff might not remember to do so, but this is an important source of evidence for the PPO in learning from deaths in custody. We make the following recommendation:

The Governor should remind staff to switch on their body-worn cameras during reportable incidents and ensure that control room operators prompt staff to do so during an incident.

Staff statements

90. PSI 64/2011 sets out the mandatory requirements for managing prisoners at risk of harm. It says that staff directly involved in a death in custody, particularly those who were first on scene, must complete incident statements as soon as practicable. Statements are a key source of evidence for the PPO and other external bodies investigating incidents in custody.

91. In Mr O'Driscoll's case, staff did not complete incident statements. While this did not impact materially on our investigation into Mr O'Driscoll's death, it has impacted on other investigations undertaken by the PPO and might make a difference in future. We make the following recommendation:

The Governor should ensure that staff directly involved in a death in custody complete incident statements as soon as practicable following the death.

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