Report of an Independent Investigation into the case of Mr Idris.

Commissioned by the Secretary of State for Justice in accordance with

Article 2 of the European Convention on Human Rights

Sally Lester (February 2024)

Table of contents

Annexes

Executive Summary and Key Findings

Background to the investigation

Mr Idris was 23 years old when, in October 2015, he suffered life-threatening injuries whilst in custody at HMP Swansea. He had been received into prison the previous day, after being sentenced by Swansea Magistrates Court to a total of 16 weeks imprisonment, plus an additional 20 days for non-payment of fines, to be served consecutively.

At his reception and induction interviews with prison and healthcare staff, Mr Idris's presentation gave no cause for concern. He reported to healthcare that he had harmed himself seven or eight years ago, but that he had no current thoughts of self-harm.

He had struggled with substance misuse for some time, and at his initial screening interview with health care, Mr Idris tested positive for opiates and benzodiazepines. At the time, the policy in HMP Swansea, in common with other prisons in Wales, was to provide medication for the relief of the symptoms of withdrawal, but not to prescribe heroin substitutes. Mr Idris refused the available medication.

By the following morning, however, he said that he was suffering from withdrawal symptoms and at his induction appointment with the doctor at around 10:00 he was prescribed medication, which he would have collected in the afternoon.

At around 12.40 the prisoners had all collected their lunch and were locked in their cells. After investigating a cell bell call from a neighbouring cell, a prison officer glanced into cell B3-11 and noticed Mr Idris hanging from the window bars with a ligature around his neck.

The officer summoned help and an experienced prison officer, who was designated as a 'first responder' promptly commenced Cardiopulmonary Resuscitation (CPR).[1] The prison staff on the scene were supported by healthcare staff who arrived quickly with the necessary healthcare equipment. It is not entirely clear when the ambulance was called or by whom, but in the interim the appropriate emergency procedures were undertaken by the prison and healthcare staff on the scene.

Welsh Ambulance Trust responded quickly to the 999 call, arrived at the prison within minutes and took control of the situation. The Welsh Air Ambulance with a doctor and paramedic also attended and continued to stabilise Mr Idris ready for transfer to hospital.

Mr Idris was transferred by ambulance to the Emergency Department and later the Intensive Therapy Unit at Hospital A in Swansea. He remained in a coma for several days and was subsequently transferred to specialist facilities where his need for total care could be met.

[1] Cardiopulmonary Resuscitation (CPR) is a lifesaving technique. It aims to keep blood and oxygen flowing through the body when a person's heart and breathing have stopped.

On 4 November 2015, the hospital consultant reported to the governor that Mr Idris had suffered severe brain damage from lack of oxygen and that the neurological outlook was extremely poor.

On 12 May 2021, the Secretary of State commissioned this investigation under Article 2 of the European Convention on Human Rights (ECHR). Mr Idris's condition remains such that he requires total care, and he has not been able to participate in this investigation. His family have represented his interests.

We cannot know why Mr Idris attempted to take his own life. During the course of this investigation, we have interviewed a number of professionals who knew Mr Idris or who represented agencies who had worked with him. None would have predicted his actions. His pattern of offending, and sporadic compliance with Community Orders and drug treatment, suggest a young man who was trying to conquer his drug addiction and, as is so often the case, suffering from relapses. This impression was confirmed by others, including his family.

In our investigation we reviewed Mr Idris's background and what information was available to the prison on his reception. We read statements from those involved when Mr Idris was discovered in his cell, and we interviewed a number of those individuals. We also examined the broader context within which this incident occurred in HMP Swansea, including the prison's response to recommendations from HM Inspectorate of Prisons and from the Prison and Probation Ombudsman.

Our key findings are summarised below. We make a total of seventeen recommendations to Her Majesty's Prison and Probation Service (HMPPS), HMP Swansea, Swansea Bay/ Abertawe Bro Morgannwg University Health Board and to NHS Wales.

Key Findings

Finding 1.

Mr Idris was a young man with a history of offending, much of which was linked with his substance misuse issues. He had appeared in court a number of times, his response to community sentences had been sporadic, and he had accumulated financial penalties, most of which remained unpaid.

We recognise that the court in Swansea was following established guidelines; however, we question the wisdom of a policy under which a court may repeatedly impose such penalties, particularly in conjunction with sentences designed to facilitate rehabilitation. Mr Idris would have had little prospect of paying the outstanding amount within a reasonable timeframe.

Finding 2.

Records held by other criminal justice agencies contained brief details about previous reported self-harm, but the information systems were not joined up and this information was not on P-NOMIS, the prison case management system. The system used by the prison health department held some of this information, but information held by community drug agencies was not readily accessible.

Had all the relevant information about historical factors been available, the risk assessment would have been more complete, but the overall judgement may not have changed. Those assessing Mr Idris would have weighed the historical information against more recent information – firstly, that none of the agencies involved with him appear to have had any current concerns about self-harm; and secondly that there was nothing in his manner or behaviour that caused concern.

We have concluded that, although there was a systemic failure in information sharing between the relevant agencies, the available information is unlikely to have led to a conclusion that he was at imminent risk of self-harm.

Finding 3.

We have considered whether sufficient attention was paid to Mr Idris's current state of mind on reception. He had been in HMP Swansea for less than 24 hours when the life-threatening injury occurred. He had been asked on several occasions if he had any thoughts of self-harm; on each occasion he replied in the negative and there was nothing in his presentation to cause concern.

We observe that in several reports on deaths in the early days in custody, the Prison and Probation Ombudsman has noted that the individual showed no signs of suicidal intent. Making an accurate assessment on an individual's state of mind on reception can be difficult.

We have concluded that the risk of self-harm was appropriately considered on Mr Idris's arrival at HMP Swansea, and that there was no evidence to suggest that he was an imminent risk to himself, or that he should be monitored more regularly than usual.

Notwithstanding our conclusion, we have recommended that HMPPS should ensure that staff have both the time and the skills to conduct adequate risk assessments on new arrivals. We have also recommended that a private room should be available for interviews on reception and induction.

Finding 4.

The prison's processes for the reception and induction of new arrivals were, by and large, correctly followed.

A prison service instruction was, however, incorrectly cited as a reason for not allowing Mr Idris a telephone call on reception. This instruction had been superseded by an instruction which states that newly arrived prisoners must be given access to a telephone in reception to address urgent issues or to advise a family member where they are being held.

We found no documentary evidence that Mr Idris had been able to call his family, but it seems that he had told the chaplain that he had done so.

This issue was identified in the immediate post incident review which recommended that all prisoners should be given the opportunity to contact next of kin on reception; where there are public protection restrictions this should be completed by reception staff. We agree with this recommendation.

Finding 5.

On his first evening in prison, Mr Idris was offered, but refused, medication to ease the symptoms of withdrawal from drugs and alcohol. We found no evidence that he had been checked overnight. When he was checked on the following morning, he requested medication for withdrawal and, when he saw the doctor, this was prescribed.

The post incident review concluded that wing staff should be made aware of prisoners who are detoxing and who refuse medication. We agree with this recommendation.

Finding 6.

Mr Idris had sought help in the community for his substance misuse but once he was in prison the treatment options were limited by the policy and practice within Wales at the time. This inequality had been highlighted in reviews and reports, the findings of which are summarised in Part 5 of this review.

We have concluded, therefore, that in relation to his treatment for substance misuse, the care Mr Idris received on admission to HMP Swansea was not equitable to that which would have been available in the community.

Finding 7.

When Mr Idris was observed hanging in his cell, the officer summoned help. As the prison was in patrol state, the cell door was not opened until other staff arrived; however, prison staff arrived within seconds.

The officer had called a 'Code Blue', which should have triggered a 999 call for an ambulance, and this should have been recorded in the control room log. The only record of this call was in a handwritten paper attached to the logbook. In comparing the timelines reported by prison staff with the ambulance logs, there would appear to have been a delay of several minutes before the ambulance was called.

We conclude that either there was no clear protocol for calling an ambulance or else that the correct procedures were not followed. This is unacceptable practice. In either event, the poor recording of the incident is unacceptable.

Finding 8.

When Mr Idris was found, prison and health care staff acted swiftly and appropriately to administer CPR, working effectively as a team. Because of the prompt actions of those on the scene, Mr Idris quickly received the necessary treatment. By the time the paramedics arrived, Mr Idris had already been stabilised.

We conclude, therefore, that despite the possible delay in calling the ambulance, the treatment he received was at least as prompt and effective as the treatment he would have received had a similar incident occurred in the community.

We note that the presence of a trained first responder appears to have enabled a prompt response to the incident. During the investigation we learned that, with the appointment of additional health care staff, fewer prison staff are trained as first responders. We believe that this is a retrograde step. The value of having an experienced first responder who was on the scene quickly was significant.

Finding 9.

The incident was reported promptly to the National Operations Unit. The post incident review was succinct but pertinent issues were identified. However, the prison has not been able to locate all the documents that should have been retained, including the bed-watch record. We have seen statements from some, but not all, of the staff involved and not all were involved in the immediate debrief.

Some of the staff involved in the incident appear to have had little opportunity to receive the support they may have needed in the aftermath of the incident.

Communication with Mr Idris's family appears to have been short lived and inadequate. We have concluded that a Family Liaison Officer should have been appointed to maintain contact when the extent of Mr Idris's injuries became apparent.

We conclude that actions following the incident were inadequate.

Finding 10.

The immediate post incident review reported comments from another prisoner that Mr Idris and his cellmate were 'off their face' shortly before the incident. We requested the toxicology report from the hospital. This showed nothing of concern, but the tests conducted were limited. Given the circumstances of Mr Idris's admission, we find this surprising and unhelpful. There is therefore no evidence to corroborate or refute this comment.

Finding 11.

It was apparent at an early stage that Mr Idris had suffered a life-threatening injury. We consider that the need for fuller scrutiny could have been identified at an earlier stage. The gap of over five years before this Article 2 investigation was commissioned was not in the best interests of Mr Idris's family.

Finding 12.

We have concerns about the context within which this incident occurred. As we have noted above (Finding 6), in 2015 HMP Swansea, in common with other prisons in Wales, was not following clinical guidance for managing drug dependence in prison (Department of Health, 2006). Treatment of opiate dependent prisoners was based on symptomatic relief rather than substitute prescribing. Both Her Majesty's Inspectorate of Prisons (HMI Prisons) (2015b) and the Prison and Probation Ombudsman (PPO) (October 2011) had identified this as problematic and had recommended changes.

We cannot know whether Mr Idris's substance misuse problems, or his experience of withdrawal had any bearing on his actions. Nonetheless we note that the prison had been made aware of issues relating to substance misuse and to the risk of self-harm in the early days in prison. Following an unannounced inspection in 2017, Her Majesty's Chief Inspector of Prisons (HMCIP) reported unequivocally that the prison had failed to act on previous findings and recommendations (HMI Prisons, 2018).

It is within this context that Mr Idris suffered a life-threatening injury. We conclude therefore, that the failures within the prison during this period should receive further public scrutiny.

Recommendations

To HMPPS

- HMPPS should seek to ensure that where information about an individual's risk of self-harm or risk of harm to others is held by criminal justice agencies, this is available to prisons on reception to inform the early assessment of the prisoner. This should include:
  - relevant information held by the police including, but not limited to, recent custody records;
  - relevant information available to courts and officers from the Prisoner Escort and Custody Services;
  - information available to the National Probation Service, which should be made accessible to prison staff through HMPPS digital case records.

- Where an incident involving an assault or self-harm is serious enough to be reported immediately by telephone to the National Operations Unit (in line with PSI 11/2012), the procedures set out in PSI 15/2014 should be followed to ensure that learning is promptly identified and disseminated.
  This should include:
  - ensuring that all relevant evidence is preserved after the incident
  - determining at the earliest reasonable opportunity whether to commission an Article 2 investigation.

- HMPPS should bring the findings and recommendations from this investigation to the attention of other criminal justice and health organisations to inform the development of cross government approaches to tackling drug misuse.

To HMP Swansea

- On reception all prisoners should be able to contact their next of kin/close contact. If the prisoner is subject to restrictions or other public protection procedures, the call should be completed by reception staff. The case management system should record whether the call has taken place.

- Prison staff should have both the time and the skills to conduct adequate risk assessments on new arrivals. Historical information about self-harm should be carefully considered, particularly where the individual claims to have no such thoughts at the present time. A private room should be available for interviews with prisoners on reception and induction.

- The Governor of HMP Swansea should ensure that staff are aware of the action to take if they discover a medical emergency in a locked cell: namely they should

notify the control room and, where there is no apparent danger to themselves or others, enter the cell immediately. (Reference PSI *24/2011 Management and security of nights).*

- The Governor of HMP Swansea should continue to ensure that the process for the use of 'Code Blue' and 'Code Red' alerts is updated regularly and to ensure that all relevant staff are clear about the process including healthcare staff, prison officers and administrative staff. In the event of an incident triggering a medical emergency response code, the control room should immediately call for an ambulance and keep a clear record of actions.

- Following an incident of serious self-harm, a Family Liaison Officer should be appointed to ensure timely and sensitive communication with the individual's family.

<u>To HMP Swansea and Swansea Bay/Abertawe Bro Morgannwg University Health Board</u>

- The Governor of HMP Swansea and the healthcare provider should ensure that there are regular checks by prison and healthcare staff on the well-being of all new prisoners, regardless of the level of risk identified.

- Prison and healthcare staff should be made aware of prisoners who have refused medication for relief of withdrawal symptoms. There should be a clear recording system to ensure that all welfare checks are carried out as necessary. Each check should be recorded separately and in a timely fashion.

- The Governor of HMP Swansea and the healthcare provider should review the provision of first responders within the prison officer cohort to improve the availability of suitably trained staff to deal with incidents requiring emergency interventions. Furthermore, the necessary emergency equipment should be readily available.

- The Governor of HMP Swansea and the healthcare provider should continue to implement recommendations (for example those in the thematic inspection report '*Changing patterns of substance misuse in adult prisons and service responses*', HMI Prisons, 2015a) that prisoners in England and Wales should have consistent access to equivalent substance misuse treatment.

- The Governor and Head of Healthcare in HMP Swansea should ensure that all staff have appropriate support following exposure to distressing incidents. Specifically:

  - all staff involved should be debriefed as soon as possible;

- the wellbeing of all staff involved should be considered and they should be offered both immediate and longer-term support;
- appropriate records should be kept to monitor that all staff have been offered access to support.

- The Governor and Head of Healthcare in HMP Swansea should ensure that records are kept of all post incident debrief sessions and interviews conducted. The prisoner's records should be collated and retained for an appropriate time period pending any investigation. This must include bed watch records.

<u>To Swansea Bay/Abertawe Bro Morgannwg University Health Board</u>

- The healthcare provider should seek to ensure that where relevant information about an individual is held by community health organisations, this is available to the prison on reception to inform the early assessment of the prisoner.

- All prisoners withdrawing from drugs and alcohol should receive comprehensive monitoring and prescribing according to the updated guidance – *Drug Misuse and Dependence UK Guidelines on Clinical Management (*Department of Health, 2017*)*. Prisoners continuing opiate substitution from the community should receive regular prescribing reviews.

<u>To NHS Wales</u>

- NHS Wales should ensure that when an individual is admitted to hospital following a serious non-fatal incident, appropriate toxicology tests are conducted.

Part 1. The Investigation

1.1 The investigation team

This investigation was led by Sally Lester, formerly Assistant Chief Inspector of Probation. At the time of the investigation, Ms Lester was also employed as an associate inspector of prisons but has not been involved in an inspection of HMP Swansea. The investigation was assisted by Louise Taylor, a retired prison governor. Michael Pulford, who conducted the clinical reviews, was formerly a senior NHS manager responsible for mental health and substance misuse services and is experienced in the investigation of deaths in custody. The purpose of a clinical review is to examine whether the medical care that a prisoner received in custody is of a sufficient standard and is equivalent to what might have been expected in the community.

The investigation was commissioned on 12 May 2021 by Andy Rogers, Deputy Director, Safety Group, HMPPS who represented the Secretary of State for Justice in this matter.

At the time of the incident the National Offender Management Service (NOMS) was the executive agency responsible for prison and probation services in England and Wales. On 1 April 2017, Her Majesty's Prison and Probation Service (HMPPS) replaced NOMS as the executive agency responsible for delivering prison and probation services.

1.2 The Terms of Reference:

The terms of reference were:

- to examine the circumstances of the incident on 24 October 2015 in which Mr Idris sustained a life-threatening injury, and his management by HMP Swansea from his reception on 23 October 2015 until that date, and in light of the policies and procedures applicable at the relevant time;

- to examine relevant health issues during the period spent in custody at HMP Swansea from 23 October 2015 until 24 October 2015, including mental health assessments and Mr Idris's clinical care up to the point of his life-threatening injury on 24 October 2015; (see below at paragraph 31);

- to consider, within the operational context of HMPPS, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved;

- to provide a draft and final report of your findings including the relevant supporting documents as annexes;

- to provide your views, as part of your draft report, on what you consider to be an appropriate element of public scrutiny in all the circumstances of this case. The Secretary of State will take your views into account and consider any recommendation made on this point when deciding what steps will be necessary to satisfy this aspect of the investigative obligation under Article 2 of the ECHR.

1.3 How we conducted the investigation

The investigation team conducted a detailed examination of the records that were disclosed to us at the outset and other documents that we requested as our enquiries progressed.

The clinical reviewer has critically examined the systems, processes and quality of healthcare services provided to Mr Idris from his reception by the prison on Friday 23 October 2015 until his admission to hospital on Saturday 24 October 2015. The clinical review has included: interviews with key prison healthcare staff, undertaken jointly by the Clinical Reviewer, the Lead Investigator and Supporting investigator; the examination of a range of primary evidence including prison and healthcare documentation. The reviewer has adopted the National Patient Safety Agency's root cause analysis methodology as a framework.

The investigation team visited HMP Swansea to observe the physical layout of the prison. Louise Taylor and I conducted an initial visit, including walking the route from the health care department to B wing, and from the ambulance entrance to the wing. Michael Pulford and I subsequently visited the prison, again walking the routes between key areas.

Louise Taylor and I met with Mr Idris's mother and two other relatives in December 2021 and noted their views and concerns, which we addressed in our investigation.

A chronology of the events leading up to the incident in which Mr Idris sustained life changing injuries was prepared to inform the investigation. In this we considered material facts about Mr Idris's background which we considered relevant to an understanding of how he ended up in prison and what information was available about him to those who were dealing with him following his sentence and reception into prison. Much of this chronology is incorporated into this report.

At an early stage, letters explaining the nature of the investigation and our Terms of Reference were sent to prison and health staff whom we proposed to interview. These interviews were originally scheduled for January 2022 but had to be postponed because of issues related to Covid-19.

Michael Pulford and I visited the prison in March 2022 and conducted interviews with health staff and managers. In April 2022 we returned with Louise Taylor to interview prison staff and some additional health staff in both the prison and the community.

Due to circumstances beyond our control, we were not able to tape record interviews on site. The notes of the meetings have been agreed with those concerned.

Unfortunately, we were not able to interview Mr Idris's cell mate who was himself unwell at the time of the investigation.

A list of all those interviewed is included at Annex C.

As a result of the incident Mr Idris suffered a life-threatening injury and now requires constant care. It was not possible to interview him for this enquiry. Our thoughts are with his family. In this investigation we have attempted to address all aspects of the care and management of Mr Idris during his time in HMP Swansea.

1.4 Lines of enquiry

In the early stages of our investigation, we identified a number of lines of enquiry. The issues we examined included:

- What was Mr Idris's background and how did this contribute to him being in prison?
- What did the prison know about Mr Idris when he arrived?
- Did the prison follow the correct procedures on reception and induction?
- How well were Mr Idris's needs assessed and met on his arrival at the prison and during the short period before the incident?
- Was the healthcare Mr Idris received equitable with what they could have expected to receive in the community? Was he provided with appropriate medication?
- Was the level of care provided to Mr Idris appropriate and timely in response to the incident?
- What happened after the incident? Did the prison comply with the required procedures?

The key questions considered by the clinical review included:

- Was the care Mr Idris received equitable with what they could have expected to receive in the community? And was Mr Idris provided with appropriate medication
- Was the incident preventable? Was it foreseeable?
- Was the level of care provided to Mr Idris appropriate and timely?

We have set out our findings in Part 4 of this report.

Having read various reports about HMP Swansea, we concluded that it was important to examine the context in which this incident occurred. We have summarised this in Part 5 of this report.

Part 2. HM Prison Swansea

2.1 HM Prison Swansea

HMP Swansea is situated about half a mile from the city centre, on the coastal road. Building started in 1845 and was completed in 1861. It functioned as a prison for both male and female prisoners until 1922 when females were transferred to Cardiff Prison. Swansea has since operated as a Local Prison, holding prisoners up to and including Cat B. The unlock roll was 437 on the date of the incident.

In the early 1980s, Swansea started the Samaritan-trained prisoner Listener Scheme, which involves the Samaritans training prisoners to work with prisoners at risk of self-harm, that has now developed into a nationwide provision.

2.2 Healthcare in HMP Swansea

At the time of the incident the healthcare team was employed and directly managed by the governor of HMP Swansea with some governance oversight from the local health board.

A multi-disciplinary team consisted of a head of healthcare supported by a team of nurses (psychiatric and adult branch). Medical cover was provided through local general practice and was available daily in the morning. There was a small pharmacy team (one pharmacist technician and a half time pharmacist technician). The prison did not have a Detoxification Unit but 'crisis beds' were available for acute episodes of withdrawal or illness. Healthcare emergencies and those in need of specialist care were transferred to the Abertawe Bro Morgannwg University Health Board acute hospital facilities.

On 1 July 2016 full responsibility for employment and management of health services within the prison was transferred to Swansea Bay/Abertawe Bro Morgannwg University Health Board. Healthcare staff were transferred to the new provider. Since then, the healthcare team has expanded and now includes a crisis team.

Part 3. The Events in detail

3.1 Background of Mr Idris

While Mr Idris's criminal record is not directly relevant to the terms of reference of this investigation, it is outlined here to present the context within which he ended up serving the short prison sentence during which he attempted to take his own life. We also consider that it is relevant to summarise what was known about Mr Idris from the start of his sentence, and whether this was taken into account in his management by the prison.

From 2008 (when he was aged 16) to 2015, the PNC records 13 convictions for 22 offences. These included: burglary, assault, possession of drugs, criminal damage, and possession of a bladed article. These offences resulted in fines, a Community Order (CO) and short suspended sentences.

In July 2013 Mr Idris appeared in court for failure to comply with a Community Order and for breach of a suspended sentence. He was sentenced to a total of 28 weeks imprisonment[2]. In December of the same year (shortly after his release) he committed a further offence of shoplifting, for which, on 16 Jan 2014 he received a Community Order (12 months) with a Drug Rehabilitation Requirement (DRR).

During the period from 2010, Mr Idris had regular if not frequent contact with his General Practitioner (GP)[3], for a range of issues including medical, psychological and substance misuse. He also engaged with substance misuse services on several occasions, both as a voluntary client and as part of a criminal justice requirement from 7 April 2013. During this time, he was on occasion prescribed Methadone or Buprenorphine[4] by specialist community treatment services to assist him in reducing his drug use. While he was involved with the community team (the Integrated Offender Interventions Service (IOIS) – now known as Dyfodol), he visited the building every day to pick up his prescription.

His shoplifting did not abate and on 8 August 2014 he appeared in court again for two further offences relating to the theft of goods to the value of £160 and £80. By this point he had started to comply with his Community Order. The author of the Pre-Sentence Report[5] noted that the offences corresponded with a period of chaos. He had offended to fund his drug needs when he was using 3 – 4 bags [of heroin] daily; it was said that now he was not using drugs and was on a Subutex script. He was attending with a substance misuse service (IOIS)[6] and said to be doing well. He was living with his mother.

[2] PNC
[3] Notes of meeting with Dr 1
[4] See glossary for further information about the drugs referred to in this report.
[5] Pre-Sentence Report
[6] Wales Integrated Offender Intervention Service (IOIS) became known as Dyfodol in 2016. We note that the terms are used interchangeably in the case records.

He received a further 12-month Community Order, with 100 hours of unpaid work – a requirement which was proposed to give Mr Idris positive experience of work and less time to use drugs. He was said to be happy to comply and now highly motivated.

In addition to compensation for the stolen goods, he was ordered to pay prosecution costs of £85 and a victim surcharge of £60[7].

The total amount that he was required to pay was £385. Records held by the fines office indicate that this would be consolidated with existing accounts and an order made for deduction from his benefits.[8] Electronic records do not go back further than 2014; for the purposes of this report, no information has been sought about any earlier financial penalties.

In August and September 2014 Mr Idris kept appointments with his probation officer and with his worker at IOIS. He had obtained casual work two days a week. In September he reported having relapsed and was using heroin intravenously. He reported that he was in a low mood but that working was helping. When he reported in November, he was said to be 'tired, fed up, but not suicidal'.[9]

In summary, in community treatment, Mr Idris did not cause any problems in terms of his behaviour, and he did not present as heavily under the influence of drugs or alcohol. He appears, however, to have been ambivalent regarding his drug use and was therefore difficult to keep in treatment, with frequent requests from services for him to improve his level of engagement. There were periods when his treatment was suspended or stopped due to the lack of commitment shown.

In November 2014 he failed to keep two appointments with probation, triggering breach action to return him to court for non-compliance with his Community Order.[10]

On 16 December 2014, Swansea Magistrates Court dealt with an offence of littering which occurred on 13 March 2014. Mr Idris is said to have dropped and left a cigarette in High Street, Swansea, contrary to the Environmental Protection Act 1990. The case was proved in his absence. He was fined £200, was ordered to pay costs of £212.20 and a victim surcharge of £20 – making a total of £432.20 to be paid by 13 January 2015.[11] In the absence of the defendant, the court is likely to have dealt with a batch of similar cases and

[7] For offences committed on or after 1 October 2012, magistrates' courts must order a surcharge. The amounts are specified in sentencing guidelines. This is a mandatory requirement set out in section 42 of the Sentencing Code – although courts can reduce the amount if the defendant cannot afford to pay this in addition to another order (e.g. compensation). For offences committed before 8 April 2016 a community sentence attracts a surcharge of £60 and immediate custody £80 (for six months or less). REF – sentencingcouncil.org.uk (accessed 1 April 2022)

[8] Fines account from 16 January 2014

[9] Notes of interview with Senior Probation Officer 7 April 2022 with reference to Delius probation records

[10] Statement of facts breach of Community Order

[11] case no. 1400731011 Register 16/12/2014

would have applied the principle of assumed earnings (currently £440 per week).[12] The court appears not to have been aware of Mr Idris's earlier fine, nor the fact that this fine was being deducted from his benefits.[13]

Mr Idris was not in contact again with probation until January 2015[14] when he got in touch and said that he was 'lost in himself' and had lost touch with his mother. He was advised that a warrant had been issued for his arrest for the failed appointments.

In July 2015 Mr Idris was arrested twice, but no further action was taken in relation to the allegations.[15] He was also reported as a missing person by his partner, who said that after they had an argument Mr Idris tried to stab himself, then left the home but returned later and they made up, but she remained concerned about him.

Mr Idris was ultimately dealt with for the breach of Community Order when he appeared in Swansea Magistrates Court on 24 July 2015 when the court made a further Community Order, including a Drug Rehabilitation Requirement (DRR)[16] which was to be reviewed monthly by the court.

Probation records show that in the next four weeks Mr Idris attended (at least) nine appointments with probation and IOIS.[17] He was given advice about intravenous drug use and the dangers of using drugs on top of his Subutex prescription.

The last opiate substitution prescription of Buprenorphine, which he received in the community was prescribed by IOIS on 11 August 2015. Mr Idris was required to attend daily to receive this medication. He was last seen by his GP on 6 August 2015 when he was provided with a repeat 'med3' (Statement of fitness for work) for 13 weeks. He was not in receipt of any prescribed medication from his GP at the time of sentencing.[18]

For the following two weeks, Mr Idris failed to keep appointments for drug testing (which is a requirement of the DRR). This gap triggered the policy of IOIS that he would have to wait before he could receive another prescription for opiate substitute. When he attended IOIS on 11 September he said that he was going to buy drugs as he anticipated a wait for 10 – 11 weeks.[19] Throughout September and October his attendance at both probation and IOIS was sporadic. On 18 September 2015, Mr Idris committed a further offence of shoplifting (value £58.50). On 2nd October he was arrested at his home address for the shoplifting offence.

---

[12] https://sentencingcouncil.org.uk/explanatory-material/magistrates-court/item/fines-and-financial-orders/ (accessed 20th April 2022)
[13] Notes of meeting with Team Manager HMCTS Wales Enforcement Office 31 March 2022
[14] Notes of meeting with Senior Probation Officer, 7 April 2022
[15] National Research Report (NRR)
[16] PNC and Community Order
[17] Notes of meeting with Senior Probation Officer, 7 April 2022 with reference to probation records
[18] Notes of meeting with Dr 1.
[19] Notes of meeting with Senior Probation Officer, 7 April 2022, with reference to probation records

3.2 Arrest and time in police custody

Mr Idris arrived at the custody suite at Swansea Central Police Station at 9.40 on 2 October.[20] A risk assessment was completed by the custody officer. A series of standard questions elicited the information that Mr Idris was suffering from depression which had been diagnosed by his GP, but he was not taking prescribed medication for this. He had tried to harm himself seven years ago but had no current thoughts of self-harm. He identified himself as a heroin user. The custody officer's assessment was that there was no apparent risk of self-harm.

Mr Idris was identified as a DRR client and was seen by the arrest referral worker. He was given a 'brief intervention' focused on harm minimisation and needle exchange. He did not want anyone to be informed of his arrest, other than a named solicitor. A different solicitor, who was available, later visited and interviewed him.

The custody officer observed that he was very emotional and sorry for his actions. He refused a hot meal and drink. At 13.27 he was charged with the offence and was bailed to appear at court 21 October. He was given sterile needles and advised to see his GP.

3.3 From arrest to court appearance

Mr Idris failed to keep appointments with IOIS on 9 October and 16 October 2015.

On 20 October, Mr Idris referred himself to the Community Drug and Alcohol Team – Abertawe Alcohol and Drug Assessment Service (AADAS) open access clinic and was seen by Newid Cymru (SM) Western Bay.[21]

He reported that he was using one gram of heroin a day and injecting three or four times daily. This had been his pattern of use since February 2015. He had started using cannabis and cocaine as a teenager, and first used heroin at the age of 17. There were periods of abstinence before he first injected when he was 21. He reported that his ex-girlfriend had left him when he was in prison, and he couldn't cope so started using drugs again.

During the interview he was tearful at times, particularly when discussing his children. He reported that when he was 17, he cut his arm and superficially cut his throat. He also said that he attempted to hang himself when he was under the influence of drink and drugs but was stopped by his girlfriend. He also reported that he had accidentally overdosed 12 months previously.[22] At the time of the assessment interview with AADAS, he reported no suicidal thought or intent.

[20] Custody record
[21] Notes of meeting with Head of CDAT 16 March 2022
[22] PARIS records - Risk assessment/ risk management plan – CDAT (RPT_SMAT_RISK)

Mr Idris had in the past been on a prescription and he was seeking longer term prescribing and support. He was suffering from withdrawal symptoms. Following the assessment, Mr Idris was referred to the Complex Needs team[23] for substitute prescribing to enable him to cease daily intravenous drug use and gain stability. The aims of the service also included harm reduction, overdose awareness and education/awareness about the effects of substance misuse and the impact on parenting. He was referred to Barod (known at the time as DrugAid) – a support service for people experiencing substance misuse issues – and was also referred to the Community Drug and Alcohol Team (CDAT) waiting list. Given the risk of intravenous drug use, he may have been assessed for a fast-track approach to prescribing, but this decision had not been made before he appeared in court.

Mr Idris does not appear to have disclosed that he was due to attend court the following week.

3.4 Court appearance and sentence

Mr Idris appeared in court on 23 October 2015, the case having been adjourned from 21 October so that he could appear at the specialist drug court held on Fridays, when drug agencies and the Probation Service are in attendance. Mr Idris was represented at this hearing.

No Pre-Sentence Report was requested, and none prepared,[24] although it is possible that a probation representative in court provided some information. Mr Idris received a prison sentence comprising: 12 weeks for the new offence; 4 weeks consecutive – resentencing for the earlier offence of shoplifting value £160; and 4 weeks concurrent – resentencing for the offence of shoplifting value £80.

During 2014 and 2015 Mr Idris had accrued financial penalties totalling £1042.20. He had paid a total of £70 and £145 was remitted by the court; this left a balance of £827.20 for which he was sentenced to 20 days imprisonment consecutive to the new sentence[25] – a period that was commensurate with court guidance on non-payment.[26] [27]

He also received 5 days concurrent imprisonment for non-payment of the fine of £25 imposed on 24 July 2015 for the offence of failing to comply with the requirements of a Community Order.[28]

[23] PARIS records - Initial and review Assessment/Care Plan – CDAT (RPT_SMAT_INTRV)
[24] Delius entry 23 Oct 2015 screenshot
[25] Mr Idris – 1500731277 – non-payment of fines 23.10.15
[26] Notes of meeting with Team Manager HMCTS Wales Enforcement Office 31 March2022.
[27] On 3rd August he had been ordered Mr Idris to serve a period of 21 days imprisonment for default, but suspended this on condition that he continued to pay at £20 per week. Only one further payment of £20 was received. Email from NCES regional support unit.
[28] Mr Idris – Fines account 24.07.15

In summary, Mr Idris was sentenced to 16 weeks imprisonment for:

- Theft v.£58.50 (new offence)
- Theft v. £160 (originally sentenced 8/8/14 and resentenced 24/7/15)
- Theft v. £80 (originally sentenced 8/8/14 and resentenced 24/7/15)

AND

- £827.50 unpaid financial penalties – 20 days imprisonment consecutive
- £25 – 5 days imprisonment concurrent.

In total the sentence was 112 days + 20 days; and 5 days imprisonment concurrent.[29] [30]

In addition, he was ordered to pay compensation of £58.50 for the new offence, a victim surcharge of £80 and a criminal courts charge of £150[31].

3.5 Transfer from court to prison

At 13:10 Mr Idris was received into the custody of GEOAmey who provide Prisoner Escort and Custody Services (PECS), under contract to the Ministry of Justice.

The custody officers are required to complete a Person Escort Record (PER) form which includes a risk assessment, a property record and a log of activity whilst the individual is in the court cells and until they are received into the prison.

The PER form noted[32] that Mr Idris had previous experience of prison and detailed his earlier convictions for an offence of ABH (2010) and possession of a bladed article (2013) – offences regarded as relevant to a risk assessment.

The form also reported that he was a 'heroin addict'. A box on the form to identify 'suicide/self-harm' is answered 'no'. No medical or mental health issues were identified, and he had no prescribed medication. His allocated location within the transport van confirmed that he was not treated as a risk.[33]

Under Standard Operating Procedures in place at the time, escort staff were required to complete a Suicide and Self-Harm (SASH) form if there was known to have been an incident

[29] Extract from register of West Glamorgan Magistrates Court: Swansea 23.10.2015 1500683868 –5
[30] Warrant for custodial sentence
[31] From 24 Dec 2015 the CCC could no longer be imposed, following concerns about how it worked in practice. www.gov.uk/government/speeches/courts (accessed 1 April 2022)

[32] PER form
[33] Notes of interview with GEOAmey staff 5 April 2022

of self-harm in the previous month. Where there was any history beyond the last month, the escort staff should speak to the prisoner to establish if there was any current risk.[34]

At the time of the incident, the PER was a handwritten form. In addition to this form, a separate electronic form was completed by GEOAmey staff. This electronic form also noted 'rights forms all refused – been in HMP before – no suicide issues now or in past – not on meds – complaints and cell call bell explained – not on meds – no injuries'.[35] The handwritten form was the one that accompanied an individual to the prison; the electronic form was predominantly designed to allow monitoring of compliance with the PECS contract.

Mr Idris received no visits whilst in the court cells. His property included £8.50 in cash, a mobile phone and a small amount of smoking equipment.

Mr Idris was handed over to vehicle staff at 15:45 and from the escort service to prison staff at 16.32. [36]

3.6 Prison reception and induction – Friday 23 October 2015

The PER and sentencing warrant were received by the prison as required. PNC records did not accompany the documents. This omission is noted in the post incident review.[37] Information about previous convictions supports the decision-making process on the risk of cell sharing. Under the procedures in place at the time, the PNC was not a mandated document.[38]

A Cell Sharing Risk Assessment (CSRA) was completed.[39] The form notes that all avenues of support were explained to Mr Idris. He stated that he was not suicidal. There were no indications that Mr Idris should not share a cell and stated that he was happy to do so.

He was issued with a reception smoker's pack including 25g tobacco. The induction document[40] also notes that Mr Idris was not given a PIN (i.e. the ability to make a phone call) 'due to PSO 4400'.[41] We assume this refers to a recorded concern of domestic abuse (dating from 2013).[42] This Prison Service Order (PSO) had, however, been superseded by *Prison Service Instruction (PSI) 08/2009 Public Protection Manual* and subsequently by *PSI 07/2015 Early Days In Custody – Reception In, First Night In Custody, And Induction To*

[34] GEOAmey SOP 063 Self harm and suicide prevention v11 Oct- Nov 2015 – now obsolete
[35] ePER
[36] ePER
[37] Background information serious self-harm
[38] Notes of meeting with Compliance Manager, GEOAmey, 11 April 2022
[39] CSRA 1 Reception
[40] Induction
[41] Prison Service Order (PSO) 4400 Prisoner Communications
[42] NRR. Also notes of meeting with Senior Probation Officer 7 April, with reference to probation records.

Custody which states that newly arrived prisoners must be given access to a telephone in reception to address urgent issues or to advise a family member where they are being held. If the prisoner is subject to public protection restrictions, a member of staff should make the call on the prisoner's behalf. We found no documentary evidence that Mr Idris had been able to call his family, but it seems that he had told the chaplain that he had done so.[43]

At 17:23 Mr Idris was seen by Nurse C. Although Nurse C did not recall Mr Idris (this was Nurse C's only contact with him) the details of the interview were recorded on SystmOne.[44] A '*First Night Suicide/Self-harm Screening Tool*' was completed and this indicates 'no current thoughts of self-harm or suicide', but there is a record of historic self-harm – 'has cut wrists in past – 7 – 8 years ago'. This was consistent with an entry that had been made when he was in HMP Swansea in 2013.

Mr Idris provided a urine sample for drug screening which was positive for opiates and benzodiazepines. His injection sites were examined and found to have 'track marks' present although sites were clean without any obvious signs of infection. He self-reported use of opiates 0.75g of heroin daily, intravenously.

He also reported having drunk 56 units of alcohol in the previous week but stated that he was not dependent on alcohol.

WIISMAT (Wales Integrated In-depth Substance Misuse Assessment Tool) questionnaire was also commenced during the induction on 23rd October 2015 and completed on 24 October 2015. No additional information resulted from this assessment.

He was offered but refused medication that could be prescribed under Patient Group Directions (PGD)[45] medication for the relief of symptoms of withdrawal from drugs.

The healthcare contribution to the 'First Night Suicide/Self-harm Screening Tool' recognises that Mr Idris was experiencing a detoxification from illicit drugs. Mr Idris is recorded as a 'heroin user' and it was noted that he has 'declined all PGD medication'. The form also indicates that there are 'no' mental health issues to be considered. The written response to questions on the form also indicates 'mental health stable'. Mr Idris was described as 'fit and well, polite during interview'.[46]

The screening tool shows that Nurse C made referrals to: the 'primary care mental health team' for drug dependence; the doctor due to substance misuse; and to the prison substance misuse services (nursing). Nurse C stated, during interview, that Mr Idris would

[43] Notes of meeting with chaplain 7 April 2022
[44] Patient records (prison)
[45] Patient Group Directions (PGDs) provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber.
[46] Patient records (prison)

have been asked on more than one occasion if he required medication to reduce the impact of drug withdrawal, but the offer was refused. Nurse C also stated that the question about self-harm/suicide is carefully discussed with new prisoners as it is well known that the first few days of detention are the riskiest with respect to self-harm.[47] Nurse C was unable to access the limited information available from external sources due to the limitations on the SystmOne which was available in isolation from other systems.

Once he had finished the reception process, Mr Idris was located on B wing, the induction unit, by about 19:30[48] He was allocated to Cell B3-11, sharing with a cellmate who had arrived in previous days. The young men were known to each other and were content to share.[49] Officer A remembered Mr Idris presenting as 'fine' – almost 'bubbly'. This officer described induction as an information gathering process, and one that provided the opportunity to settle a new prisoner onto the wing.

Mr Idris was also seen by the duty chaplain as part of the induction process.[50] He reiterated that he had no thoughts of suicide or self-harm. Mr Idris said that he had been able to contact his family – although we have no other evidence that this occurred.

He was also seen by the 'insiders'[51] on the first night unit. They later reported that he had presented as okay, and they had no concerns about him.[52]

The prison case management system NOMIS was updated with information from the reception and induction processes, noting 'he states he has no thoughts of self-harm or suicide'.[53]

In summary, as a new prisoner, Mr Idris was seen by several staff during the afternoon and his first evening in prison. At no point did he cause anyone to be concerned about his wellbeing. Since his sentence he had been asked several times about any thoughts of suicide or self-harm and on each occasion had replied in the negative.

<u>Sentence calculation</u>

Release dates must be calculated within five working days of reception.[54] Documents show that Mr Idris would have been released from the 16-week sentence on 17th December 2015,

[47] Notes of meeting with Nurse C
[48] OEL
[49] Notes of meeting with Officer A, 5 April 2022
[50] Notes of meeting with managing chaplain 7 April 2022. The chaplain who conducted the interview is no longer in post. This is also referenced in the document Background Information on Serious Self Harm – report by Regional Safer Custody Lead.
[51] Trusted prisoners who provide support to other prisoners – sometimes known as 'Listeners' who are trained by the Samaritans.
[52] Background Information on Serious Self Harm
[53] C-NOMIS
[54] *PSI 03/2015 Sentence Calculation – Determinate Sentenced Prisoners*

but the additional days for non-payment of fines made his release date 27/12/2015[55]. We have verified that this calculation was correct. He would not have been informed of his sentence calculation dates before his self-harm.

3.7 Events of Saturday 24 October 2015

At 6.24 the following morning (24 October) Nurse D – a member of the health care team – checked the cell and noted that Mr Idris was apparently asleep.[56] Nurse D said that Mr Idris would have been checked three times during the night in accordance with the policy in place[57], but where there was nothing of note, only one entry would be made. Mr Idris's records state that he was 'checked during the night – appeared sleeping'.[58]

It is possible that the check at 6.24 disturbed Mr Idris because at 6.30 he apparently 'requested an officer to his cell as he was withdrawing from heroin'.[59] The police investigation log states that staff do not have access to medication at that time. This is not strictly true as it would be possible in an emergency.[60] However, at 6.30 staff would have been in the process of handing over from the night patrol state to the normal daytime regime. It is possible that Mr Idris would have been advised to wait, particularly as he was shortly due to see the doctor as part of his induction. At this time providing medication under PGD arrangements at that point may have pushed back the prescription of medication by the doctor later that morning.[61]

At 8.30 the Occurrence Enquiry Log (OEL) states that Mr Idris again spoke to officers regarding medication, saying that he was withdrawing from heroin. We found no other record of this.[62] A further entry in the OEL (recorded from a police interview with the cell mate) states, 'Overnight Mr Idris had not slept much. He [Mr Idris] told his cellmate he was withdrawing from heroin and didn't think he could cope with the situation. Cellmate said that he told Mr Idris he could get medication in the morning to assist and that he would get over it. He [cellmate] said that Mr Idris had no concerns over his prison sentence only the fact that it was the first time he was withdrawing whilst in prison. Cellmate told him to be positive and think of his family.'

The health induction process involved three stages for all prisoners: an initial screening on reception; a second health screening the following morning; and an interview with the doctor.

[55] Core record 2
[56] Patient records (prison)
[57] IR3
[58] Patient records (prison)
[59] Occurrence Enquiry Log (OEL) – a police document
[60] *PSI 24/2011 Management and security of nights*
[61] Notes of meeting with Nurse B 16 March 2022
[62] OEL

At 9.42 Mr Idris was seen by Nurse B.[63] The second reception screen was carried out at this point. This assessment indicates: Alcohol abuse, substance misuse behaviour – specifically heroin intravenously, resulting in referral to substance misuse service. The questions on the form indicate that 'there are no thoughts of deliberate self-harm or suicide' and 'no concerns over mental state'.

An Alcohol Use Disorder Identification Test (AUDIT) was carried out which indicated hazardous drinking and possible dependence.[64]

At 9.53 Mr Idris was seen by the duty doctor[65] for his induction assessment. The doctor reviewed the screening record. No significant medical problems were identified, and his mental state was described as 'stable'. It was stated that 'Mr Idris had refused PGD on the previous night.' The doctor noted that Mr Idris was 'agitated, restless and shaking but co-operative' The plan was for 'opiate detox as per regime'. The prescription was the standard medication regime under the protocol for alcohol and drug withdrawal current at that time. The regime included Lofexidine, Diazepam, Loperamide, Mebeverine, Metoclopramide, Promethazine Hydrochloride, Quinine Sulphate and Paracetamol to reduce the discomfort caused by withdrawal from opiates.

We understand that the medication would not have been administered until after lunch – usually around 15:00[66] - as it would have been too late for the morning dispensing.

Officer A recalled coming on duty that morning and observing that Mr Idris and his cell mate were both in good spirits. A post incident report[67] records that the insiders who served their food described Mr Idris and his cell mate as 'off their face' on Saturday whilst collecting lunch.

At around 11.45 to 12.00 prisoners were provided with lunch and cells were locked.

At around 12.40 Officer A[68] was in an area outside B wing when the officer heard a noise coming from a first-floor window. There had earlier been a discussion about shouting that was occurring between wings, so the officer assumed this was part of the general clamour on the wings.

Officer A returned to 'B' wing and heard a call bell ring from cell B3-12. On going to investigate, Officer A passed cell B3-11 which was next door and, glancing in, noticed someone standing in front of the window. Officer A continued to B3-12 where the

[63] Patient records (prison)
[64] Email from current lead GP for HMP Swansea, 17 May 2022
[65] Patient records (prison) and interview with Dr 2.
[66] Notes of meeting with Officer A, 5 April 2022.
[67] Background Information on Serious Self Harm – report by Regional Safer Custody Lead
[68] Notes of meeting with Officer A, 5 April 2022. There is no statement on record from this officer.

occupants were in good spirits. Officer A advised them that their request would be actioned once the wing was unlocked.

On returning to the wing office, Officer A again looked into the next-door cell B3-11 through the observation hatch and, taking a closer look, realised that the person in front of the window was Mr Idris with a ligature around his neck. He had a grey pallor and was drooling from the mouth. Officer A immediately called for assistance by radio using Code Blue.[69]

The call was received by officers B, C, D and F [70] who were on their lunch break in the nearby tearoom. They ran towards B wing and up the stairs to B3 landing – a distance that they would have covered in seconds.

As they approached, Officer A opened the cell door and entered accompanied by Officer B and Officer C. Officer C lifted Mr Idris up whilst Officer A used an anti-ligature knife (known as a fish knife[71]) to cut the cord, which was made from a ripped bed sheet, and was attached to the window. It then became apparent that the ligature was secured with additional knots and was tight. Using the knife, Officer C cut the knots, releasing the tension from the ligature while Officer B helped to support Mr Idris. Mr Idris was lowered down the side of the bunk beds and placed on the floor. Officer B commenced CPR.

Officer B[72] is an experienced prison officer and trained first responder, with significant experience of providing emergency aid, both in prison and in a former role. The officer checked for any signs of life and was initially unable to detect a pulse, signs of breathing or response to verbal or pain stimulus. Officer B started chest compressions and continued until health care staff arrived and had set up the defibrillator and oxygen.

Mr Idris's cell mate, who had been sleeping on the bottom bunk, awoke whilst Officer B was administering CPR. He was ushered out of the cell onto the landing and to a different cell. He appeared shocked and 'not able to compute what was going on'.[73] It seems that he had taken his medication and fallen asleep after lunch.[74]

At the point when Officer A had opened the cell door, Officer D had also entered the cell and, observing the situation, immediately radioed health care. The call was not answered and, aware that there had been a previous difficulty with radio reception in health care[75], Officer D ran down the stairs towards health care shouting for assistance. Officer D was met

[69] PSI 03/2013 *Medical Emergency Response Codes*. 'Code Blue' incident alarm advises that there is someone who is having difficulty with, or not breathing
[70] Statements of officers B, C and D. Notes of meetings with officers B, C, D and F. We have not seen any statement from officer F.
[71] Fish Knife – a knife that is supplied to all prison staff and its purpose is to cut through ligatures
[72] Statement of Officer B and notes of meeting with Officer B, 5 April 2022
[73] Notes of meeting with Officer A. 5 April 2022
[74] Background Information Serious Self Harm
[75] Statement Officer D

on route by health care staff[76] who appear to have heard the call through the radio or pager system or had heard Officer D shouting. They made their way to cell B3-11, on route collecting the emergency equipment, contained within the green first responder bags; this equipment consists of three separate bags containing the defibrillator, oxygen, and other equipment to assist in the resuscitation and treatment of a patient. The delay caused by the lack of radio contact was minimal and would not have had a significant impact on the delivery of CPR which was ongoing at the time.

On arriving at cell B3-11 the healthcare team split their duties and prepared to give emergency treatment. Nurse E checked for vital signs, applied oxygen at 100%, and was supported by Nurses F and G.

A 'Geudel'[77] airway was inserted by Nurse E and supplementary breaths applied via an 'Ambu bag' (a balloon like instrument for mechanically passing air into a patient through a tube).

Officer B and Nurse E continued with CPR interventions. A clear airway was secured, and the defibrillator pads connected whilst compressions continued to be administered by Officer B. Mr Idris at this point made a 'gurgling' sound. A mechanical suction tube was utilised to clear the airway of the yellow secretions present. Mr Idris started to take breaths without assistance. Oxygen was continually supplied via the Ambu bag and oxygen saturations[78] were maintained at 99% throughout the intervention.[79]

The ambulance had been called at 12:55[80] and arrived outside the prison at 13:03 and were on site at 13:07.[81] Officer D guided them into the prison.[82]

Paramedics take control of the situation at this point. Officers and Healthcare staff stepped aside as requested. Paramedics continued to administer CPR. No further assistance from nursing staff was required and they stood down.

The paramedics called for the doctor and emergency critical care ambulance.[83]
At 13:15 a member of the prison's Independent Monitoring Board (IMB) arrived, having been called by the prison at 12:50.[84]

---

[76] Nurses E, F and G are no longer employed by Swansea Bay Health Board and have not been interviewed for this investigation. Nurses E and F made statements at the time of the incident.
[77] A Guedel is a rigid plastic tube which sits along top of mouth and ends at base of tongue (an adjunct to help keep airway open).
[78] Blood oxygen level (blood oxygen saturation) is the amount of oxygen you have circulating in your blood. The normal blood oxygen saturation level will be around 95–100%.
[79] Patient records (prison)
[80] Ambulance summary
[81] Handwritten notes – incident log. And Sequence of Events (ambulance log)
[82] Statement of Officer D
[83] Statement of Nurse F
[84] Statement of IMB member

At 13:20 Oscar 1 (Officer E) informed the control room that Mr Idris was to be taken to hospital.[85]

At 13.23 prison control was informed that the air ambulance was to land on the beach - a few minutes from the prison. Officer D assisted by guiding them into the prison.[86]

At 13:27 the air ambulance team arrived on scene[87] and supported the paramedics on site. The doctor administered an anaesthetic to further stabilise Mr Idris and communicated with the Emergency Department at Hospital A with an update on the condition of the casualty.

At 13:30 paramedics administered 400mcg Naloxone in case of the presence of opiate overdose.[88]

At approximately 14:11 Mr Idris was considered to be stable enough for transfer by stretcher to the ambulance and the crew proceeded to the Emergency Department at Hospital A accompanied by two prison officers.[89]

At 14:26 the ambulance arrived at Hospital A[90] and Mr Idris was transferred by stretcher to the Emergency Department. Mr Idris had not regained consciousness to this point.

3.8 What happened after the incident?

After the cell was vacated it was secured, pending attendance by the Scene of Crime investigators. The police were contacted at 13.36.[91] They arrived at the prison at 14:40 and interviewed Mr Idris's cellmate.[92] The cellmate reported that he and Mr Idris had lived near each other as children. He had not seen him for around 18 months but was aware from associates that Mr Idris was using heroin. He said that neither of the men had slept since about 03:30 and Mr Idris told his cellmate that he was withdrawing. The latter told Mr Idris that he could get medication in the morning and would get over it. He said that Mr Idris had no concerns over his prison sentence except that it was the first time that he was withdrawing in prison.

The police investigation report (logged at 20:05) records that the scene was attended and examined. This occurred at around 17:15.[93] Digital images were taken of the interior of the cell and the location of the recovered exhibits. Paramedic equipment was recovered along

[85] Handwritten note
[86] Statement of Officer D.
[87] Sequence of Events (ambulance log)
[88] Patient clinical record (post incident)
[89] Handwritten notes – incident log. And Sequence of Events (ambulance log)
[90] Sequence of Events (ambulance log)
[91] OEL
[92] Duty Governor's Report
[93] Fact finding report

with a piece of knotted green sheet from the floor next to the bunks, a piece of knotted sheet from the window bars and a ripped green bed sheet from the top bunk.

The Chaplain arrived at the prison at around 14:30, having been contacted by the governor at 13:28.[94] (This was not the same chaplain who had seen Mr Idris on reception). Having been briefed about the events, the chaplain made contact by telephone with Mr Idris's mother.[95] Because of her distress, the chaplain spoke to Mr Idris's stepfather and explained what had happened. They arranged to meet at the hospital. When the chaplain arrived at the hospital at 16:30 he was informed that Mr Idris had just been moved to the Intensive Therapy Unit (ITU), where he met with Mr Idris's family, who, understandably, were in a state of shock. The chaplain left the hospital around 19:00 and subsequently had contact with the family the following week.

The National Operations Unit were informed of the incident at 14:50.[96]

Prison medical records[97] indicate that from 24 October to 28 October, the prison health care team retained contact with the hospital and with prison escort staff and were updated about Mr Idris's condition. On 28 October it was reported that Mr Idris was not sedated and was breathing on his own but had not yet woken up. Further tests were planned, including an electrocardiogram (ECG)[98] and scan.

We have requested the bed watch records from the prison, but these have not been located.

With permission of the family, the consultant shared information about Mr Idris. In a letter to the governor[99], he records that Mr Idris has failed to regain consciousness since the incident and that the scans showed severe brain damage from lack of oxygen. He was deeply comatose with no response to voice or pain. He was able to breathe but was still attached to a breathing machine. Intermittent fits were controlled with medication. The neurological outlook was extremely poor although an accurate prognosis was difficult to give at that time. 'It is likely that he will remain in hospital for weeks to months and is likely to remain in an institution for the rest of his life due to severe neurological disability.'

On 10 November 2015, on application of the governor, the Public Protection Casework Section of NOMS (on behalf of the Secretary of State for Justice) released Mr Idris from prison on compassionate grounds, technically on a licence which would expire on 27th December 2015.[100]

[94] Handwritten notes – incident log
[95] Chaplain statement and notes of meeting with managing chaplain 7 April 2022
[96] Duty governor report
[97] Patient records (prison)
[98] Electrocardiogram – a test to check the heart's rhythm and electrical activity.
[99] Statements – letter from consultant
[100] Core Record 2

On 11 February 2016, the police investigation report[101] was updated to note that Mr Idris had been transferred from ITU to Anglesey Ward at Hospital A. His care requirements were described as 'total care'.

3.9 Response to the critical incident

The Duty Governor[102] completed a fact-finding report[103] (dated 28 October 2015) noting that the police had no concerns but had requested Scenes of Crime Officers (SOCO) to attend. The fact-finding report notes that initial discussions between them (police and crime scene investigators) confirmed that there was no evidence of foul play.

The investigator subsequently maintained contact with hospital A to check on Mr Idris's progress, until the investigation was closed in February 2016 under the category 'concern for safety' to be reopened if anything changed. The police have confirmed to this investigation that they were satisfied that there were no suspicious circumstances, and the case was closed.[104]

An Assessment, Care in Custody and Teamwork (ACCT) [105] Part 1 was opened recording the incident of self-harm. The form was updated by prison staff on return from the hospital, noting that there would be continuous observations of Mr Idris's condition.

The Regional Safer Custody Lead[106] completed a report.[107] His report into the incident is undated but appears to have been completed in the immediate aftermath – the author recalled that it was the following day. The report notes that the first night screening was completed using available supporting documents, that there was no indication of suicide or self-harm and that Mr Idris declined detoxification medication. The reviewer had spoken to the insiders who had observed Mr Idris and his cell mate at lunchtime on Saturday. He had also spoken to Mr Idris's cell mate who said that Mr Idris 'did not give any indications that he was to attempt suicide. He did say that Mr Idris stated that he missed his kids and his partner.' The cell mate had offered to support him through this early time in custody.

The head of healthcare also completed a review.[108] At the time of the incident, healthcare staff were employed by the prison, so this was an internal document. The head of healthcare liaised with the hospital medical director.

---

[101] OEL
[102] The duty governor has now left the service and has not been available for interview.
[103] Fact Finding Report
[104] Email exchange with police disclosure officer, May 2022
[105] Assessment, Care in Custody and Teamwork (ACCT) is the care planning process for prisoners identified as being at risk of suicide or self-harm.
[106] This role that had been introduced as a result of a rise in self-inflicted deaths and incidents of self-harm across the prison estate Include figures if they are available. Notes of meeting with Regional Safer Custody Lead 7 April 2022
[107] Background Information on Serious Self Harm – report by Regional Safer Custody Lead
[108] IR3

Part 4. Issues related to the incident that were examined in the investigation

4.1 What was Mr Idris's background, and how did this contribute to him being in prison?

Findings

Mr Idris was a young man with a lengthy criminal record, mostly for relatively minor offences. In recent years it seems likely that much of his offending was driven by the need to finance his use of drugs, particularly heroin. It was clear that the court had tried various sentencing options, including community sentences, but these had not made a sustained impact on his behaviour, and his compliance had been variable. From the information available, we can surmise that he was caught in a cycle where, for a period of time he appeared to achieve some stability, but this was followed by relapse. Such a cycle is not unusual for those who struggle with substance misuse.

The court may have felt that, with Mr Idris's repeated offending and sporadic compliance, they had exhausted the available options. In the event, Mr Idris was sent to prison for 20 days for shoplifting goods to the total value of £240 (plus another theft for which no compensation was ordered). The remainder of his outstanding debts was made up of victim surcharges and court costs. We recognise that the court in Swansea was following established guidelines[109]; however, we question the wisdom of a policy under which a court may repeatedly impose such penalties, particularly in conjunction with sentences such as Community Orders and DRRs which are designed to facilitate rehabilitation. Those persistently committing minor offences will be particularly affected by repeated financial penalties. Mr Idris would have had little prospect of paying the outstanding amount within a reasonable timeframe. [110]

In fixing a fine the court must 'take into account the circumstances of the case, including, among other things, the financial circumstances of the offender so far as they are known, or appear, to the court'.[111] Where an individual has been convicted in their absence or has failed to cooperate with an inquiry into their financial circumstances, 'and the court considers that it has insufficient information to make a proper determination of the financial circumstances of the offender, it may make such determination as it thinks fit'. [112]

[109] *Coroners and Justice Act 2009* s.125
[110] 'Normally a fine should be of an amount that is capable of being paid within 12 months though there may be exceptions to this'. https://www.sentencingcouncil.org.uk (accessed 1 April 2022)
[111] *Criminal Justice Act 2003* s164 (3)
[112] *Criminal Justice Act 2003* s164 (5)

We note that there is an anomaly in the fact that a large penalty for littering was imposed on the basis of an 'assumed income' of around £440[113] (because Mr Idris did not appear for the hearing) whilst at the same time, it was apparent that he was on benefits, as these were subject to deduction for previous penalties.[114]

When Mr Idris appeared in court on 23 October, it seems that he was expecting the 20 days imprisonment for non-payment but was perhaps surprised to receive a custodial sentence for the new offence.[115]

Recommendation

In light of our exploration of Mr Idris's background and how it contributed to his imprisonment, we make the following recommendation to HMPPS:

- HMPPS should engage with other criminal justice and health organisations to consider the most appropriate and timely approach to dealing with persistent drug users.

4.2 What did the prison know about Mr Idris when he arrived?

Findings

When Mr Idris was received into the custody of GEOAmey staff at court, they were reliant on what he told them about his state of mind, medical conditions etc. Had he appeared in court direct from police custody, the information obtained during his arrest interview would have been recorded on a PER started by the police. The fact that he was bailed by the police to appear in court three weeks later meant that there was no continuous record.

Mr Idris had told the police that he had harmed himself seven years ago but had no current thoughts of self-harm.[116] This information did not appear on the handwritten PER which would accompany Mr Idris to the prison, or the e-PER[117] which states 'no suicide issues now or in past'.

[113] Notes of meeting with Team Manager HMCTS Wales Enforcement Office 31 March 2022.
[114] Current sentencing guidelines note that where an offender's only source of income is state benefit, the relevant weekly income is deemed to be £120. Where the offender has failed to provide information, the assumed weekly income is £440. https://www.sentencingcouncil.org.uk/explanatory-material/magistrates-court/item/fines-and-financial-orders/approach-to-the-assessment-of-fines-2/3-definition-of-relevant-weekly-income/ (accessed 20 July 2022)
[115] Notes of meeting with managing chaplain 7 April 2022
[116] Custody record (police)
[117] PER and ePER

Information retrieved from other police records[118] also identifies that in July 2015 Mr Idris's partner reported that he had attempted self-harm. Why this information was not available to the police custody officer is not clear.

In summary, various agencies held information about his history of reported self-harm.

- During his assessment with AADAS in October 2015 Mr Idris reported that when he was 17 he cut his arm and superficially cut his throat and that he tried to hang himself at the age of 17, when under the influence of drink and drugs. He said that he was stopped by his girlfriend.[119] He also reported accidental overdose 12 months earlier.

- On arrest in October 2015, he told the police that he had tried to harm himself seven years earlier.[120] (This may have referred to the first incident noted above)
- The probation case management system (Delius) shows a flag for Suicide/Self-Harm in 2013.[121] (Again, this may have referred to the first incident above).

- Police records show a report by his girlfriend in July 2015 that he had tried to stab himself.

We have found no record of Mr Idris having received any medical attention following these incidents.

In recording that there were no current or previous issues of self-harm, those completing the PER were reliant on self-report. At that time, in 2015, the relevant case recording systems did not 'talk to each other'. Because of Mr Idris's three weeks on bail, there would have been no way for information to be automatically transferred from the police to the Prisoner Escort and Custody Service at court. As Mr Idris was not causing any undue concern there would have been no reason for the staff in the court cells to seek additional information.

The PER form includes a list of possible sources of information – forms that could have been attached. None were either ticked or marked as not available. This appears to have been an administrative shortcoming. The required warrant for the custodial sentence was attached.[122] According to the PER, the PNC record[123] did not accompany Mr Idris to the prison. (Strangely though, the PNC box is ticked on the scanned version of the same document).[124]

[118] NRR
[119] Notes of meeting with Head of CDAT 16 March 2022. PARIS records - Risk assessment/ risk management plan – CDAT (RPT_SMAT_RISK)
[120] Custody record
[121] Notes of meeting with Senior Probation Officer, 7 April 2022
[122] Warrant for custodial sentence.
[123] Police National Computer record of previous convictions.
[124] Core record 2

A thematic inspection of PER forms (HMI Prisons, 2012) identified issues that are relevant to this investigation.[125] The inspectorate reported that only a small number of prison staff could access the PNC to look for markers about violence or self-harm. The practice of attaching a printout of the PNC to the PER varied, as did the extent to which missing information was chased up by prison staff. 'Some always telephoned court custody officers, some said they never did, and none said they contacted the police'. Assessments of self-harm were sometimes completed with no other information than what the prisoner himself had told staff. The report comments:

> While prisoners themselves are an important source of information, the receipt of historic information should not be left to chance, particularly with the tendency of some prisoners to avoid the stigma of an ACCT being opened.

The report recommended that the flow of information between police, PECS and prisons should be improved.

Since 2015, changes have been put in place. A new 'ePER' – a digital form – follows an individual through from police to court and on to prison.[126] This change should address this specific gap in the transfer of information between criminal justice agencies.

GEOAmey staff[127] told us that sometimes a newly sentenced prisoner would be visited in the court cells by his solicitor or probation officer, who may be able to convey concerns from the family, or from their personal knowledge of the individual. Mr Idris received no visitors after his sentence.

Recommendation

We have focused here on the information that accompanied Mr Idris to the prison and we have noted some shortcomings. We therefore make the following recommendation to HMPPS:

- HMPPS should seek to ensure that where relevant information about an individual is held by criminal justice agencies, this is available to prisons on reception to inform the early assessment of the prisoner.

[125] We do note, however, that the inspection commended South Wales police for the quality of PER forms.
[126] Notes of meeting with Compliance Manager, GEO Amey, 11 April 2022
[127] Notes of meeting with GEOAmey staff 5 April 2022

4.3 Did the prison follow the correct procedures on reception and induction?

Findings

Cell sharing risk assessment (CSRA)

Examination of the records received in Swansea from the court escort service demonstrate that reception staff followed the procedures in *PSI 09/2011 Cell Sharing Risk Assessment* to identify whether Mr Idris posed a risk to or from others with regard to cell sharing. The CSRA shows that staff checked the Person Escort Record (PER) for evidence of risk.

As noted above, at the time of assessment the PNC was not available, although if it had been then the CSRA assessment of 'standard' would still have been reasonable because there was no evidence of assaults on other prisoners and staff or other indications that the person may be violent.

Whether it was wise for Mr Idris to share with this particular cellmate – seemingly another drug user – is a moot point, but not one that the CSRA is expected to address. We note that inspection reports (HMI Prisons, 2015b) at that time described B wing as more akin to a detoxification unit than an induction wing, due to the large number of inmates with substance misuse problems. We can see the logic of putting together two young men who knew each other.

Next of kin

PSI 64/2011 Safer Custody requires that all prisoners must be asked to nominate a next of kin who must be updated regularly. His core record shows that Mr Idris had been asked and had identified a next of kin, namely his mother.

Reception phone call

PSI 49/2011 Prisoner Communications Services requires that local arrangements must be made to allow a call to be made within the first 24 hours of reception. Reception staff must read the PER and the police/Crown Prosecution Service MG6[128] form to identify whether restrictions need to be placed on the prisoner's communications and if a prisoner is subject to, or likely to be subject to, public protection restrictions.

The induction form[129] shows that Mr Idris was identified as subject to *PSO 4400 Public Protection Measures* and that no PIN was issued as a result. We assume this refers to a recorded concern of domestic abuse (dating from 2013).[130] This PSO had, however, been

[128] MG6 – Case file information
[129] Induction form
[130] C-NOMIS and notes of meeting with Senior Probation Officer 7 April, with reference to probation records. NRR.

superseded by *PSI 08/2009 Public Protection Manual* and later by *PSI 07/2015 Early Days In Custody – Reception In, First Night In Custody, And Induction To Custody* which was introduced in February 2015. This instruction states that newly arrived prisoners must be given access to a telephone in reception to address urgent issues or to advise a family member where they are being held. If the prisoner is subject to public protection restrictions, a member of staff should make the call on the prisoner's behalf, checking that the recipient is willing to receive the call in the first instance.

When Mr Idris was asked by the duty chaplain (who has now retired) whether he had been given the opportunity to contact his family, he replied that he had. This is recorded on the induction interview by the chaplain[131] but there is no other record of a call. We had no means of checking whether such a call was made.

Mr Idris's cell mate told the prison manager,[132] who completed the immediate post incident review, that Mr Idris had said that he missed his family. The review recommended that prisoners should have the opportunity to telephone home and that if there are public protection concerns, then a call should be made on their behalf. We would support that recommendation.

Recommendation

To HMP Swansea

- On reception all prisoners should be able to make contact with their next of kin/close contact. If the prisoner is subject to restrictions or other public protection procedures, the call should be completed by reception staff. The case management system should record whether the call has taken place.

4.4 How well were Mr Idris's needs assessed and met on his arrival at the prison and during the short period before the incident?

Findings

We have commented above about the information that was transferred to the prison from the PECS. Prison staff we interviewed said that they normally expect to receive the 'PNC' and that this should contain information about self-harm and any other alerts about the individual. The PNC document provided for the investigation contains only the details of previous convictions and nothing about self-harm. The prison case recording system, P-NOMIS,[133] contained nothing about self-harm.

[131] Interview with managing chaplain 7 April 2022 and the duty chaplain's induction interview.
[132] Background Information on Serious Self Harm – report by Regional Safer Custody Lead.
[133] NOMIS Transfer report

Reception staff made an assessment on the basis of available information. Nothing about Mr Idris's presentation caused concern and the reception staff had no reason to assume that the information they had received on the PER was incorrect. The different systems in operation were not connected, and historical information retrieved by this investigation may not have been easily or quickly accessible by staff in a busy reception area.

Similarly, the electronic record system used by healthcare staff in the first night screening was basic and operated as a standalone system with little access to supplementary community health records. This made it difficult to make a comprehensive review of risk during the early stages of custody.

The PPO in their Annual Report on HMP Swansea for 2014 – 2015 (Prisons & Probation Ombudsman, 2015) comment that although reception, first night and induction processes had all been introduced to help identify and reduce the risk of prisoners harming or killing themselves, they remained concerned about the number of deaths that occurred in the early days in prison. They found that 'on occasions, prison reception staff, in particular, put too much emphasis on the prisoner's presentation, rather than fully taking into account known risk factors.'

Both HMI Prisons (2015b) and the Independent Monitoring Board (IMB, 2016) commented on the lack of private interview space on reception or induction. The IMB say 'It is unacceptable for men to be asked personal questions whilst sitting at a table on the wing landing where other men are milling about.' In this situation it may be difficult for a new arrival to show their vulnerability.

HMP Swansea was described to us[134] as 'a very local Local' prison – in other words, one that operates as part of a local community, where some staff and prisoners are known to each other outside of the prison. We speculate that this may have a bearing on how prisoners choose to present themselves on arrival, as well as on the objectivity of the assessment of them. We do not suggest that this happened in this case, but in this sort of culture, it is important to use evidence from different sources to ensure an accurate assessment of risk.

In summary, it is our view that from the information available, including Mr Idris's behaviour and presentation, and from the assessment interviews carried out by experienced healthcare staff and prison officers, the level of risk identified was not enough to raise significant concerns that Mr Idris would attempt to take his own life.

[134] Notes of meeting with chaplain, 7 April 2022

Recommendation

To HMP Swansea

- Prison staff should have both the time and the skills to conduct adequate risk assessments on new arrivals. Historical information about self-harm should be carefully considered, particularly where the individual claims to have no such thoughts at the present time. A private room should be available for interviews with prisoners on reception and induction.

4.5 Was the health care Mr Idris received equitable with what someone could have expected to receive in the community? Was he provided with appropriate medication?

Findings

Shortly before his court appearance, Mr Idris had sought help in the community for his substance misuse problem but had been sentenced before he was able to attend a follow up appointment. Whilst we cannot second guess the outcome of that appointment, he may have received a prescription for an opiate substitute.

This information would not have been available to healthcare staff in the prison because the electronic record system used by healthcare staff in the first night screening was basic and operated as a standalone system. There was little opportunity to review supplementary community health records when assessing new inmates. This made it difficult to make a comprehensive review of risk during the early stages of custody.
Furthermore, once Mr Idris was received into the prison, the treatment options for substance misusing prisoners within a custodial setting were limited by the policy and practice within Wales at the time. This inequality had been highlighted in reviews and reports (Independent Monitoring Board, 2015; HMI Prisons, 2015b). The findings of these reports are summarised in Part 5 of this review.

We have concluded, therefore, that in relation to his treatment for substance misuse, the care Mr Idris received on admission to HMP Swansea was not equitable to that which would have been available in the community.

This inequality in provision was recognised by the thematic report by HMI Prisons *'Changing patterns of substance misuse in adult prisons and service responses*', (HMI Prisons, December 2015), which recommended to Welsh Assembly Ministers and NOMS that:
'Prisoners in England and Wales should have consistent access to equivalent substance misuse treatment.'

The immediate reviews following the incident[135] identified the need for wing staff to be aware of prisoners who have refused PGD medication and may therefore start to develop symptoms of withdrawal. We agree with this recommendation.

It was reported[136] that Mr Idris was checked during the night, but there is no recorded evidence of any check until 06:34 the following morning. His cellmate claimed that they had not slept much since around 03:30.[137]

Although Mr Idris had been prescribed medication that would help with his withdrawal symptoms, the timing of his appointment with the doctor meant that he would not have received this medication until later in the day.

We therefore make the following recommendations:

Recommendations

To HMP Swansea and Swansea Bay/Abertawe Bro Morgannwg University Health Board

- The Governor of HMP Swansea and the healthcare provider should ensure that there are regular checks by prison and healthcare staff on the well-being of all new prisoners, regardless of the level of risk identified.

- Prison and healthcare staff should be made aware of prisoners who have refused medication for relief of withdrawal symptoms. There should be a clear recording system to ensure that all checks are carried out as necessary. Each check should be recorded separately and in a timely fashion.

- The Governor of HMP Swansea and the healthcare provider should continue to implement recommendations (for example those in the thematic inspection report '*Changing patterns of substance misuse in adult prisons and service responses*', HMI Prisons, 2015a) that prisoners in England and Wales should have consistent access to equivalent substance misuse treatment.

To Swansea Bay/Abertawe Bro Morgannwg University Health Board

- The healthcare provider should seek to ensure that where relevant information about an individual is held by community health organisations, this is available to the prison on reception to inform the early assessment of the prisoner.

[135] Background Information on Serious Self Harm – report by Regional Safer Custody Lead. And IR3
[136] IR3
[137] OEL

- All prisoners withdrawing from drugs and alcohol should receive comprehensive monitoring and prescribing according to the updated guidance - *Drug Misuse and Dependence UK Guidelines on Clinical Management (*Department of Health, 2017*).* Prisoners continuing opiate substitution from the community should receive regular prescribing reviews.

4.6 Was the level of care provided to Mr Idris appropriate and timely in response to the incident?

Findings

As part of our investigation, we visited the location of the cell on B wing. It was clear that to get to cell B3-12 an officer would have had to pass cell B3-11. Looking in through the observation hatch, someone in front of the window would have been in silhouette, and we concluded that it was not surprising that Officer A did not immediately see what had happened.

As there were no obvious or known concerns about Mr Idris, there would have been no reason to check him more frequently. He had been seen at some point during the previous hour, when he was collecting his lunch.

When Officer A realised what had happened, they acted swiftly in identifying and correctly communicating to the control room a 'Code Blue' incident[138] - namely one involving breathing or collapse.

Prison staff in the rest room reacted swiftly to the call and ran towards the incident, arriving within seconds. The officer who had been first on scene opened the cell door as they approached.

The prison was in the lunchtime 'patrol state'[139] and we were told by some staff that a cell door would not be opened during an incident when the wing was in a 'patrol state'.

PSI 24/2011 Management and Security of Nights describes action to be taken during the night patrol state when staffing levels are at the minimum and staff should not open cells alone except in an emergency. The PSI states that staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence. The member of staff should make a rapid dynamic risk assessment of the situation and a decision on whether to enter immediately or wait for assistance; and the Communications Room/Control Room must be informed before entering the cell stating the location of the cell and describing the circumstances that require intervention.

[138] *PSI 03/2013 Medical Emergency Response Codes* defines the meaning of Code Red and Code Blue incidents.

[139] A period when prisoners are locked up in their cells and prison staffing is at a minimum level.

This incident occurred during the lunchtime patrol state, when staff frequently remain in the prison and would be able to respond quickly as happened during this incident. We found that the authority to make a personal assessment of the situation and enter a cell in an emergency was not fully understood. However, the prompt arrival of other staff avoided delay.

The staff involved in cutting down Mr Idris and starting resuscitation acted promptly and professionally. Officer B - who was trained as a first responder and was very experienced in emergency first aid - acted promptly and, in the opinion of the clinical reviewer, correctly and effectively.

We have noted that prison staff were aware of problems with radio reception in certain parts of the prison, notably health care. However, the actions taken by Officer D to alert health care staff to the situation meant that health care staff arrived quickly, with the necessary equipment. From the statements of prison and health care staff, and our interviews with them, we formed the impression of a professional group of staff working well together to provide emergency care.

We note, however, that there was a lack of clarity about when and how the ambulance was called.[140] The Code Blue should have triggered a 999 call for an ambulance, and this should have been recorded in the control room log. The only record of this call was in a handwritten paper attached to the logbook. We were unable to ascertain whether anyone on the scene checked whether an ambulance had been called. In comparing the timelines reported by prison staff with the ambulance logs, there would appear to have been a delay of several minutes (possibly ten minutes) before the ambulance was called[141].

The ambulance log records the call at 12:54:27. The control room log (a contemporaneous, handwritten note) records the Code Blue at 12:40 and the ambulance call at 12:50.

We conclude that either there was no clear protocol for calling an ambulance or else that the correct procedures were not followed. This is unacceptable practice. In either event, the poor recording of the incident is unacceptable.

Despite our criticisms, it is important to say that, in the view of the clinical reviewer, staff acted in a timely and professional manner on the discovery of Mr Idris in his cell. They provided a good standard of care to Mr Idris and reacted to his changing needs as necessary. The presence of a trained first responder was significant. Effective CPR was commenced immediately staff gained access to the prisoner. It is evident from the documentation and statements available that the prison officers and healthcare staff acted as a team in delivering effective CPR interventions to Mr Idris and committed to providing

[140] Notes of meeting with Officer E. 6 April 2022

[141] The ambulance log records the call at 12:54:27. The control room log (a contemporaneous, handwritten note) records the Code Blue at 12:40 and the ambulance call at 12:50.

the necessary care until the situation was handed to Welsh Ambulance Trust paramedic staff. The prompt response of the Welsh Ambulance Service was also noteworthy.

Because of the prompt actions of those on the scene, Mr Idris quickly received the necessary treatment. By the time the paramedics arrived, Mr Idris had already been stabilised. We conclude, therefore, that the treatment he received was at least as prompt and effective as the treatment he would have received, had a similar incident occurred in the community.

During the investigation we learned that, with the appointment of additional health care staff, fewer prison staff are trained as first responders. We believe that this is a retrograde step. The value of having an experienced first responder who was on the scene quickly was significant. We also learned that, in light of the reduction in the number of first responders, the defibrillators are now located in a healthcare room rather than on the wing. First responders based on the wings would need swift access to the necessary equipment.[142]

Recommendations

To HMP Swansea

- The Governor of HMP Swansea should ensure that staff are aware that a cell door may be opened by a lone member of staff after following the procedures in PSI *24/2011 Management and security of nights.* This should be reinforced by governors during night visits.

- The Governor of Swansea Prison should continue to ensure that the process for the use of 'Code Blue' and 'Code Red' alerts is updated regularly and to ensure that all relevant staff are clear about the process including healthcare staff, prison officers and administrative staff. In the event of an incident triggering a medical emergency response code, the control room should immediately call for an ambulance and keep a clear record of actions.

To HMP Swansea and Swansea Bay/Abertawe Bro Morgannwg University Health Board

- The Governor of HMP Swansea and the healthcare provider should review the provision of first responders within the prison officer cohort to improve the availability of suitably trained staff to deal with incidents requiring emergency interventions. Furthermore, the necessary emergency equipment should be readily available.

[142] Notes of meeting with Executive Director of Nursing and HMP Swansea Head of Healthcare, 7 April 2022

4.7 What happened after the incident? Did the prison comply with the required procedures?

Incident reporting

PSI 11/2012 Incident Reporting System requires that establishments report all incidents of self-harm. This is defined as 'all forms of deliberate self-harm irrespective of the method, intent or severity of any injury'. Where the prisoner involved required resuscitation and/or transfer to an outside hospital as a result of harming themselves this is defined as serious self-harm and falls under the scope of Group A incidents, which are incidents that require reporting by telephone immediately.

Investigations and learning from serious incidents

The purpose of an investigation is to 'inquire into what has taken place, establish the facts, to learn from them and to establish any accountability'. *PSO 1300 Investigations* distinguishes between simple investigation and formal investigations with the emphasis being on simple investigations wherever possible. However, the PSO requires that a formal investigation will be necessary if 'from the findings of a simple investigation or from the outset, it appears that there was serious harm to any person'. *PSI 15/2014 Investigations and learning following incidents of serious self-harm or serious assaults* mandates governors to ensure that the circumstances of incidents of serious self-harm are investigated at an appropriate level and that any lessons are learned from the incident.

Governors were also required to ensure that when requested by the Equality, Rights and Decency (ERD) Group in NOMS, the serious self-harm questionnaire (annex A to the PSI) was completed and returned to ERD Group within three working days of the incident being reported.

The PSI required that in all cases in which a questionnaire was completed and returned to ERD Group, a copy of the investigation report should be submitted within a week.

Where the ERD Group indicated that an independent investigation may be required, all documentation relating to the prisoner(s) involved in the incident (for example, core record, medical record, and Assessment, Care in Custody and Teamwork or Cell Sharing Risk Assessment) must be retained.

Findings

There is no doubt that the self-harm by Mr Idris was a serious incident as he suffered loss of consciousness and was admitted to outside hospital as an in-patient. Key staff were aware of the requirement for investigation of the incident. The Duty Governor's report[143] for that

[143] Duty Governor report

day records that the National Operations Unit was informed at 14:50 and an Incident Report was completed.

The serious self-harm questionnaire was completed in full,[144] with reference to an update in Mr Idris's condition on 27 October 2015.

The ERG Group informed HMP Swansea that an independent investigation might be required, but as this investigation has found, not all documentation relating to Mr Idris has been retained. Mr Idris was accompanied to hospital by prison officers who maintained a bed watch. This would have been a detailed record of relevant activity, including medical checks and visitors. The prison has attempted unsuccessfully to locate this record. We regard the failure to retain this record as unacceptable.

A fact-finding report was completed by the duty governor on 28 October 2015[145] on the template provided in *PSI 15/2014.* A 'hot debrief' was held but we have seen no record of who attended. During this immediate debrief, staff were asked to provide statements. We have seen statements from some, but not all of those involved. Officer A, for example, played a key role yet we have seen no statement from that officer. There was no consistent format for the statements; some were simple statements, but others were produced as memos or emails.

Some of the staff we interviewed recalled being interviewed on a previous occasion; for others, this was the first time they recalled having spoken about it. We have not seen any records of interviews.

A more detailed investigation was completed by the Regional Safer Custody Lead for Welsh prisons very quickly after the incident and this identified areas for improvement.

The review made two pertinent recommendations:

- All prisoners should be given the opportunity to contact next of kin on reception. If prisoners are subject to restrictions, then this should be completed by reception staff

- Any prisoners who are detoxing and do not accept supporting medication by healthcare on reception should be highlighted to B wing staff (First Night Unit).

[144] Questionnaire Serious Self Harm Incident
[145] Fact Finding Report Dated 28/10/2015 – by (duty governor)

Health Review

An IR3 Concise Investigation Report[146] was completed by the Head of Healthcare in the prison (and dated 24 November 2015).

The review draws on the factors identified in the review completed by the Regional Safer Custody Lead[147] and identifies similar lessons learned: that there should be a record made of all prisoners who declined PGD medication; and staff on B wing should be aware of these prisons so that they can be offered PGD medication prior to the second reception process.

Toxicology report

As part of this investigation, we enquired about the results of toxicology tests conducted by the hospital following Mr Idris's admission. These show just a low level of paracetamol – a normal dose. Mr Idris's kidney function was normal; the only abnormality is a moderately raised liver enzyme of uncertain implication.[148] There were no tests for other drugs or metabolites. We find it surprising and unhelpful that, in the circumstances of Mr Idris's admission to hospital, tests for more substances were not carried out.

Contact with family members

PSI 64/2011 Safer Custody requires that where prisoners have suffered sudden life-threatening harm, the prisoner's wishes on whom they would like to be contacted must be ascertained where possible. In the event that the prisoner is unable to communicate their wishes, the prison must contact the nominated next of kin who must be given an accurate account of what has happened.

As Mr Idris could not communicate his wishes, his mother was contacted by the Chaplain whose statement[149] records that when advised about the incident, she naturally became very distressed.

The PSI notes the importance of engagement with next of kin for prisoners who have suffered a rapid deterioration in their physical health, regardless of whether death is likely to occur as a result of injuries. As early reports from hospital indicated that the prognosis for Mr Idris was very poor, a Family Liaison Officer (FLO) should have been appointed. It is also good practice for communication with the family to be recorded in a FLO log.

When the investigators met with Mr Idris's mother, she said that she was unhappy with the abruptness of the Chaplain. When we interviewed the Chaplain, he accepted that Mr Idris's

[146] IR3
[147] Background Information on Serious Self Harm – report by Regional Safer Custody Lead
[148] Toxicology report and email from current lead GP for HMP Swansea, 17 May 2022
[149] An email from chaplain to the duty governor on 2 November 2015 – his statement

mother did not want to speak to him and that communication with the family ceased three days after the incident.

This was not a satisfactory response. The lack of handover to an FLO appears to mean that the need for the prison to keep in touch with the family was not given sufficient priority.

Staff Care

Prison Service managers have a duty of care in terms of supporting staff when they have been involved in dealing with a violent incident, including self-harm.[150]

The staff we interviewed had varying recollections of what happened after the incident. This may be due to the passage of time, or possibly because they had different experiences. We understand that a 'hot debrief' was held as required, but it appears that not all the staff who had been involved in the incident were involved. This may be because of shift patterns, or it may be because some returned to their normal duties and were not called upon. Whatever the reason, the failure to follow up the incident with all staff involved was not acceptable.

Most of the staff we interviewed had been affected by the incident – particularly where this was one of several incidents that they had experienced in their careers, both within the prison service and in other settings. We note in particular the experience of the first on scene, who had the shock of the unexpected discovery and took the appropriate action but was then on the periphery of the incident,[151] despite their request to 'see it through'.

One interviewee recalled their experience of deaths in custody, including murder, and several incidents of serious self-harm. Some said that they did not feel supported after incidents, reporting that the culture at the time was just to get straight back to work. One commented that if you try to ignore what happened 'you suffer for it later'. Some of the staff we interviewed had arranged their own counselling. Some had taken time off sick or had moved into a non-operational role. We were not able to interview all those involved in the incident as some were no longer employed within the prison.

In summary, there did not appear to have been a robust system in place for supporting staff following the incident. Some prison officers and healthcare staff who have been exposed to disturbing incidents over many years, have experienced continuing anxiety and distress.

Article 2 investigation

This investigation was commissioned in May 2021. It is not clear to us why it took over five years to reach this point, particularly as it was evident soon after the incident that Mr Idris

[150] *PSI 08/2010 Post Incident Care*. This has now been replaced by PSI 02/2018.
[151] Notes of meeting with Officer A and with IMB member.

had suffered a life-threatening injury. Where incidents are serious enough to be reported by telephone to the National Operations Unit, we considered that the appropriate level of scrutiny could be determined at an earlier stage.

Summary

In summary, following Mr Idris's attempt to take his own life, the prison acted correctly in reporting and investigating the incident. We would, however, have expected to see a more managed approach, with statements from all relevant staff, and records of interviews where these were held. All documentation related to Mr Idris and to any investigation should have been retained.[152]

Support for staff was inadequate. Good support was particularly important at a time when prison staff in general were feeling under pressure. It was clear from our interviews that several of the staff involved had been distressed by the incident and did not always feel able to seek help.

Communication with Mr Idris's family was poor, leaving them with unanswered questions.

Recommendations

To HMP Swansea and Swansea Bay/Abertawe Bro Morgannwg University Health Board.

- The Governor and Head of Healthcare in HMP Swansea should ensure that all staff have appropriate support following exposure to distressing incidents. Specifically:

  - all staff involved should be debriefed as soon as possible;

  - the wellbeing of all staff involved should be considered and they should be offered both immediate and longer-term support;

  - appropriate records should be kept to monitor that all staff have been offered access to support.

- The Governor and Head of Healthcare in HMP Swansea should ensure that records are kept of all post incident debrief sessions and interviews conducted. The prisoner's records should be collated and retained for an appropriate time period pending any investigation. This must include bed watch records.

[152] *PSI 35/2014 Records, Archiving, Retention and Disposal*

To HMP Swansea

- Following an incident of serious self-harm, a Family Liaison Officer should be appointed to ensure timely and sensitive communication with the individual's family.

To HMPPS

- Where an incident is serious enough to be reported immediately by telephone to the National Operations Unit, the appropriate level of scrutiny should be determined at the earliest opportunity.

To NHS Wales

- NHS Wales should ensure that when an individual is admitted to hospital following a serious non-fatal incident, appropriate toxicology tests are conducted.

4.8 Summary of findings regarding the incident

We cannot know why Mr Idris attempted to take his own life. From the point of his sentence at around 13:00 on Friday 23 October, through to 06:30 the following day he was asked several times whether he had any thoughts of self-harm or suicide and each time he answered no. There was nothing in his outward presentation to cause staff any concern. Although there were references to previous self-harm on different case management systems, there was nothing to suggest an imminent risk. He does not appear to have alerted those working with him to his forthcoming court appearance, or to any concerns he may have had about coping with prison. Although he mentioned having harmed himself several years ago, he made no reference to an incident in July 2015.

Mr Idris may have started to experience withdrawal symptoms by the Saturday morning. As a regular drug user, he would have expected this, so his refusal of medication on the Friday evening is unexplained. Possibly he thought that he would use his time in prison to 'get clean'. Certainly, his response to his Community Order and drug treatment showed a pattern of compliance, followed by lapses and relapses. In other words, he often appeared to be trying to tackle his drug addiction but after a while would find it too difficult. Possibly he anticipated coping for a day or so in prison and/or being able to top up with whatever medication or drugs he could acquire.

Although Mr Idris's substance misuse was undoubtedly a problem for him, we have no evidence that it was a factor linked to his attempted suicide. We can speculate that withdrawal may have been difficult for him, but by the time he requested medication, he would have been aware that he would shortly be seeing the doctor and would be able to

obtain symptomatic relief – although not a heroin substitute, which at that time would not have been available to him.

There may have been other factors in his life that caused him distress, but we cannot know to what extent these issues played on his mind. The construction of the ligature suggests a serious attempt to take his life. The speed with which this occurred after the lunchtime lockdown may indicate a degree of precontemplation – but again this is speculation.

The staff who found him acted promptly and we commend their attempts to save his life. We have noted that it was unclear when the ambulance was called, but because of the actions of those on the scene, we conclude that the treatment he received was at least as prompt and effective as the treatment he would have received, had a similar incident occurred in the community.

In the next section of this report, we will examine the context within which this incident occurred.

Part 5. A review of relevant findings about HMP Swansea 2010 – 2017

In this section we summarise the findings from various reports about HMP Swansea in the years between 2010 and 2017 – a period that includes the time of Mr Idris's attempt on his life. We have included this section because we believe that these reports raise relevant broader issues.

HM Inspectorate of Prisons (HMI Prisons) provides independent scrutiny of prison conditions and the treatment of prisoner. Inspection reports include recommendations on how establishments can improve outcomes for prisoners.[153]

The Prisons & Probation Ombudsman (PPO) has a duty to investigate deaths in custody. This supports the UK's compliance with the requirements of Article 2 of the European Convention on Human Rights which ensures the right to life, specifically the need for the independent investigation of all deaths in custody.[154]

Every prison has an Independent Monitoring Board (IMB). Members are independent and unpaid. Their role is to monitor the day-to-day life in their local prison and ensure that prisoners are treated fairly and humanely.[155]

5.1 Her Majesty's Inspectorate of Prisons inspection – 2010

HMI Prisons conducted an inspection of HMP Swansea in February 2010. Overall, the findings were relatively positive (HMI Prisons, 2010).

The prison's suicide and self-harm policy highlighted the particular problems for those entering a local prison. The policy was reflected in practice, with good attention paid to the early days. New arrivals had access to peer supporters and listeners and staff spent time talking to prisoners. Levels of self-harm were relatively low.

Healthcare staff saw all new prisoners, assessed indicators of self-harm, applied the substance use and alcohol screening tools and were able to prescribe first night symptom relief for those suffering withdrawal. The local criminal justice intervention team's clinical service provided weekly clinics to assess prisoners jointly with the substance misuse nurse and initiate Methadone or Suboxone treatment, which was then continued on release. Clinical records were predominantly paper based but there were plans to implement SystmOne in 2010 in line with other prisons in the UK.

[153] https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/ (accessed 19 April 2022)
[154] https://www.ppo.gov.uk/about/vision-and-values/terms-of-reference/ (accessed 19 April 2022)
[155] https://imb.org.uk

Health services were commissioned by Abertawe Bro Morgannwg University (ABMU) Health Board. Core healthcare staff were employed directly by the Prison Service. There was clear shared ownership of healthcare governance between the prison and commissioners.

Subsequent inspections and investigations were less positive about the prison.

5.2 Prisons & Probation Ombudsman investigations 2010 – 2012

During this period three deaths in custody were investigated by the PPO.[156] All these men had died within a few days of arriving in the prison. All said that they had no intention of harming themselves, although all had previously harmed themselves. All had abused drugs and/or alcohol and, although withdrawal symptoms were not always immediately apparent, these developed within the first day. Two reported that they were having difficulty sleeping - a factor considered worthy of note by the authors of an earlier report (Department of Health, 2006)[157] and repeated in 2017 clinical guidelines (Department of Health, 2017).

5.3 Her Majesty's Inspectorate of Prisons inspection – 2012

In December 2012, the inspectorate conducted an unannounced short follow up inspection (HMI Prisons, 2012). They reported that, as they had recommended in the previous inspection, action plans following death in custody investigations had been consolidated into a single action plan and were reviewed regularly, although they noted that the reviews appeared perfunctory.

The inspectorate noted that the introduction of a drug support unit was a positive initiative, but prescribing arrangements for substance misusers were not sufficiently flexible for those who were heroin-dependent prior to reception, who only had the option of a rapid detoxification with a non-opiate. Prescribing continued appropriately for those already on opiate substitution in the community.

5.4 Her Majesty's Inspectorate of Prisons inspection – 2014

In October 2014 HMI Prisons conducted an unannounced inspection of HMP Swansea (HMI Prisons, 2015b). At the time of the inspection there had been four self-inflicted deaths since the previous full inspection in 2010, two of which had taken place in the previous two years. The Chief Inspector concluded that, although the number of self-harm incidents was low for a local prison:

> some incidents were serious and there was evidence of some complacency in the prison's approach to this important issue. We were not assured that enquiries into

[156] The reports can be accessed at https:www.ppo.gov.uk/

[157] 'Insomnia is one of the most striking symptoms of opiate, alcohol and benzodiazepine withdrawal. Protracted sleep loss has a detrimental effect on thought, mood and behaviour. Insomnia should therefore be regarded as a potential risk factor for self-harm and suicide'.

> incidents were thorough, and the prison was not acting on recommendations made by the Prisons & Probation Ombudsman following his investigation into these deaths.

Many of the serious incidents had occurred during prisoners' early days in custody – a pattern which was similar to that of the actual deaths in custody where all four had occurred in the first 20 days of a prisoner's arrival, with the three within the first three days of custody. HMCIP was not assured that the prison was sufficiently sighted on this pattern. The inspectorate also found that the prison was tackling a significant drug problem and lacked a fully integrated strategic approach to tackling the needs of substance misusers. In particular they were concerned about delays in the prison initiating opiate substitution for new arrivals who were drug users.

The report noted that:

> while there was continuity of treatment for prisoners arriving on an existing verified prescription for opiate substitution as none of the Welsh prisons were funded for the Integrated Drug Treatment System (IDTS), those arriving with a street opiate problem or an unverified substitution regime were only given non-opiate symptomatic relief for withdrawal…Prisoners with a record of poor previous engagement with community treatment were sometimes refused initiation on to opiate substitution in the prison. Instead, they were given continued non-opiate symptomatic relief to the point of detoxification (typically five to seven days).

The inspectorate recommendations included two that were pertinent to the management of self-harm and substance misuse.

1) The prison should thoroughly investigate all serious incidents of self-harm, and act on learning points and recommendations. It should implement learning points from recommendations in Prisons & Probation Ombudsman death in custody reports, and review them regularly.

2) All new arrivals testing positive for opiates should receive clinical stabilisation in line with the specific guidance (*Clinical Management of Drug Dependence in the Adult Prison Setting 2006*, p14) from their first night to reduce the risk of self-harm, suicide and overdose, and to give clinicians time to discuss future treatment options.

5.5 Action plan – 2014

Following the inspection, HMP Swansea completed the required action plan to address the recommendations. This included reviewing progress against PPO recommendations at Safer Custody meetings and through SMT performance meetings. The plan also notes that the regional self-harm reduction advisor was leading a project involving staff from all Welsh prisons and sharing good practice and lessons learned.

The second of the recommendations cited above was partially accepted. The action plan notes that:

> The measures taken to support new arrivals at HMP Swansea are in line with the current arrangements in place in other Welsh prisons. A move towards stabilisation and the resources and strategic support that will need to be in place to support this will be considered by providers. All new prisoners testing positive for opiates will continue to receive first night monitoring and daily detox checks by nursing staff, with notes being made in clinical records.[158]

5.6 Independent Monitoring Board (Annual Report May 2015 – May 2016)

The IMB's annual report (Independent Monitoring Board, 2015) notes that the prison continues to be one of the most overcrowded prisons in the country. It was designed to hold 219 prisoners, but with a new wing opening in September 2015 this increased to 279; at the time of the report, it held up to 515.

The report comments on the lack of dedicated interview rooms on the first night unit – B wing. This meant that there was little privacy for interviews, but the IMB also remarked that officers spent time settling new prisoners. A considerable number arrived with substance misuse problems. Although the IMB commended the prison's work to tackle the drug problem, they noted that it remained a significant issue.

5.7 Her Majesty's Inspectorate of Prisons inspection – 2017

A further inspection took place in August 2017. On this occasion HMCIP reported that standards had slipped in three of the four healthy prison tests. Since the previous inspection, there had been four more self-inflicted deaths, all within a few days of arrival. The report by the chief inspector noted that:

> Significant and highly relevant PPO recommendations had not been implemented. This was inexcusable, particularly in view of the fact that in the previous six months there had been 134 incidents of self-harm – three times the rate that was recorded at the last inspection…. Much more needed to be done to analyse and understand what sat behind the suicides and self-harm in the prison. The response to the 2014 inspection of HMP Swansea was inadequate (HMI Prisons, 2018).

The inspection found that neither of the 2014 recommendations (those quoted above) had been achieved.

---

[158] Accessed through https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2015/02/Swansea-action-plan-2015.pdf

The inspectorate made a number of recommendations relevant to the experience of new arrivals and to those with substance misuse problems.

- All newly arrived prisoners should have a private interview to help identify vulnerability and risk, followed by systematic support during their early days in prison. There should be rigorous support for prisoners identified as being at risk of self-harm and PPO recommendations should be implemented in full.
- All new prisoners should be located in a calm and supportive environment, where they can assimilate information and receive help to settle into the prison.

- The strategy to prevent self-harm should be based on the analysis of information about the nature of incidents, patterns and trends and overseen by Safer Custody.

- All prisoners with substance misuse issues should have prompt and sustained access to a comprehensive range of psychosocial support which meets their identified needs.

- All prisoners withdrawing from drugs and alcohol should receive comprehensive monitoring and prescribing according to the Drug Misuse and Dependence UK Guidelines on Clinical Management 2017. Prisoners continuing opiate substitution from the community should receive regular prescribing reviews.

5.8 Action plan 2017

An action plan in response to this inspection was submitted in March 2018.[159]

With regard to new arrivals the plan included: ensuring that all new prisoners have a stable and supportive experience, including sufficient access to Listeners and other forms of support; and increasing the levels of observation during the night patrol state for the first 72 hours, so that checks take place hourly until midnight, then three further times before 06.00.

To tackle self-harm, the plan included: analysing long term data to better understand and address the underlying causes of self-harm; bringing together a multi-disciplinary team to develop a self-harm reduction strategy and monitoring progress through the Safer Custody meetings.

[159] Accessed through https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/01/HMIP-Action-Plan-HMP-Swansea-Updated.pdf

With regard to substance misuse the plan proposed that:

> HMPPS in Wales will work with ABMU to ensure that the Welsh Govt clinical substance misuse policy is operationally effective both clinically and in a custodial setting. HMP Swansea will follow the drug misuse and dependence UK Guidelines on Clinical Management 2017. Prisoners who are maintained on opiate substitution from the community will have three monthly reviews.

5.9 Summary of relevant findings about HMP Swansea

In this section we have examined issues that are relevant to the way HMP Swansea was operating in 2015. Despite a negative inspection report in 2014, and the findings of the PPO following deaths in custody, HMI Prisons made it clear in the subsequent inspection report (2017) that HMP Swansea had made insufficient progress in addressing the recommendation.

During our investigation we were told that the period around 2014 – 2015 was a difficult time in the prison service.[160] Nevertheless, the current prison governor accepted that by 2017 not enough had been done to address the actions from 2014. HMP Swansea was not alone in facing challenges. The public sector benchmarking programme had been introduced in the male prison estate from late 2013 as a way of reducing expenditure, predominantly through a smaller work force[161] with the result that many experienced prison staff had left the service.

During the period from 2010 to 2014 annual rates of self-harm (by males in custodial settings) increased from 14,346 to 19,048, and again to just under 24,977 in 2015. The vulnerability of prisoners during the early part of their sentence cannot be underestimated. In 2014 the PPO reported that 10% of self-inflicted deaths in prison happened within the first three days (Prisons & Probation Ombudsman, 2014).

It is beyond the scope of this investigation to explore the reasons for the increase in self-harm. It may reflect, for example: issues in the wider population; changes in the prison population; new challenges facing prisons (including the availability of drugs); or the impact of staffing changes; or indeed any combination of these and other factors.

Nevertheless, we have concluded that, in failing to respond adequately to inspection reports and investigations by the PPO, HMP Swansea was failing in its duty to protect the life and wellbeing of those in its care. It is within this context that Mr Idris attempted to take his own life, with catastrophic consequences.

---

[160] Notes of meeting with Governor, 5 April 2022

[161] https://publications.parliament.uk/pa/cm201415/cmselect/cmjust/309/30906.htm (accessed 19 April 2022)

Part 6. What has changed since 2015? What actions have been taken by HMP Swansea in relation to managing self-harm and suicide, and dealing with individuals who have substance misuse problems?

At the time of our investigation, it is over six years since the incident, and it has become evident during this review that many findings from reports and investigations carried out during the period in question have been actioned and much progress has been made.

The healthcare department at HMP Swansea has received significant investment over the period and has expanded to include a crisis team, who manage lower level presentations of mental health issues. Increased pharmacy services and a new primary care model, which functions like a GP service are in place. [162]

It is clear that the healthcare services in the prison are valued and supported by the local Abertawe Bro Morgannwg Health Board. The Executive Director of Nursing and the Head of Healthcare at HMP Swansea work closely together. Recently senior health board personnel have reinstated monthly meetings with the prison governor and regular meetings with community treatment services are scheduled.

The management team for prison health services recognise that there remain areas of service delivery that require further attention and development. It is acknowledged that more work needs to be put into improving the IT interface, particularly in respect of access to external information. There is an ongoing challenge in meeting the changing demands on the service due to fluctuating case numbers and not being able to 'flex' staffing resources to match demand, specifically around seven-day working, and the 'pinch points' that occur out of hours.

The prison healthcare service now has agreement from the Home Office to hold controlled drug licences, which will further increase the range of treatments available to prisoners.

Following the death of a prisoner in 2016, the report by the PPO (Prisons & Probation Ombudsman, 2020), the Director of NOMS in Wales and the Welsh Government stated that they would 'work closely with Health Inspectorate Wales, Public Health Wales and key stakeholders in substance misuse services in Wales to review the effectiveness of the current drug detoxification treatment provided in prisons from reception to release'. [163]

In 2020 HMI Prisons reported that, at the time of their scrutiny visit, ninety prisoners were receiving opiate substitution treatment, but this was not available for the first night (HMI Prisons, 2020). A high number of prisoners had mental health concerns and the primary care and crisis teams worked closely with the safer custody team. Few individuals refuse to

[162] Notes of meeting with Executive Director of Nursing and HMP Swansea Head of Healthcare, 7 April 2022
[163] Action plan – Dean George at HMP Swansea on 10/04/2016

commence opiate substitution or deny addiction problems. For those who do refuse, a new form is completed to inform prison staff. [164]

With regard to wider issues, we were shown the arrangements now in place to reduce prisoners' access to illegal drugs, including body scanning all new arrivals. We understand that these measures have had considerable success.

As we have noted earlier in this report, we also understand that the transfer of information via the PER form has improved through digitalisation; we have not tested this out.

We were told that health IT systems are now more joined up, although some issues remain at the weekend. We note, however, that as recently as 2021 this issue was picked up by the Welsh Parliament's Health, Social Care and Sport Committee in their report on the adult prison estate in Wales. [165] The committee noted that in Wales there was a lack of connectivity between the prison SystmOne and community ICT systems, including those in community substance misuse services. This meant that clinicians did not have quick and easy access to records, which may delay treatment. They reported that the government planned to take forward discussions regarding ICT access and compatibility between systems.

The Operational System Assurance Group (OSAG)[166] carried out a safety audit of HMP Swansea in February 2022. They reported[167] that violence and self-harm figures are low and in recent months have consistently been lower than those in similar prisons. ACCT case reviews were good and robust quality assurances processes quickly identified any deficiencies. Peer support is good, and the 'insiders' in the first night centre are passionate about their role in supporting new prisoners. The prison received a 'green' rating on the criteria of 'Managing and reducing the risk of suicide and self-harm'.

[164] Notes of meeting with Executive Director of Nursing and HMP Swansea Head of Healthcare, 7 April 2022

[165] Welsh Parliament (2021) Health, Social Care and Sport Committee. *Health and social care provision in the adult prison estate in Wales*. Cardiff: Welsh Parliament

[166] A department in HMPPS that provides operational audit and quality assurance to HMPPS and MoJ stakeholders.

[167] OSAG Safety Audit, February 2022 and OSAG Safety Audit Report Update April 2022

Part 7. Concerns raised by the family of Mr Idris

7.1 Issues Raised

At an early stage in the investigation Louise Taylor and I met with members of Mr Idris's family. They described Mr Idris as an outgoing but private person who loved his family, of whom his mother and his children were a significant part. He hid his drug use because he knew that his mother would disapprove. He was always well dressed and groomed and worked at various jobs. Mrs X said that if she had known he was shoplifting she would have marched him round to the shop to apologise.

Mrs X queried why he had not been on a watch, having heard from hospital staff that he had attempted self-harm around three weeks earlier, in the court or police cell. She was aware of another incident that occurred when he was around 16 years old.

She said that he had wanted to be on a prescription for an opiate substitute and she had understood that he had been prescribed Subutex (by AADAS) but that this had not been written down.

In the initial aftermath of the incident, the family queried why Mr Idris's cell mate did not raise the alarm.[168] A source at the prison had told Mrs X that Mr Idris's cell mate was 'off his face' on drugs, and this comment is also recorded in the post incident report.

Mrs X raised concerns about the way the incident was reported to her, saying that the chaplain was very blunt. There had been no ongoing contact with the prison and the family had not received Mr Idris's property, including a mobile phone and passport.

Mrs X reported that she understood that when in hospital in a coma, Mr Idris was handcuffed to the bed. The officers were on the other side of the room.

7.2 Review of the issues raised

We have reported on the history of Mr Idris's self-harm attempts. We have found no evidence of any attempt shortly before his court appearance in October, although a document from the police does contain reference to an incident in July, which appears to have occurred at his home. It is not clear why there is no reference to this incident in the log of Mr Idris's time in police custody on 2 October 2015. We found no evidence of any self-harm attempt at the court or in the police station.

We have noted that Mr Idris attended an appointment at AADAS the week before his court appearance, but his appointment for possible prescribing was not due until the week after his court appearance.

[168] Statement by chaplain

We understand the family's question about why Mr Idris's cell mate did not wake during the incident and raise the alarm. We have noted the reports about the behaviour of Mr Idris and his cellmate and regret that we have not been able to interview the cellmate. Unfortunately, the inconclusive toxicology tests are unhelpful.

We agree that, after the incident, the prison's contact with the family was inadequate. We note Mr Idris's mother's perception about the way the incident was reported. A Family Liaison Officer should have been appointed to maintain contact with the family.
The prison has confirmed that they do not have any of Mr Idris's property. Mr Idris had signed the usual disclaimer confirming that he had been made aware that the prison would dispose of any unclaimed property twelve months after his permanent release.[169] We agree with the family that his property should have been returned.

We asked several interviewees about the way in which Mr Idris was managed when he was in hospital. All reported that handcuffs were not used, commenting that there would have been no point as he was in a coma. We were convinced by the consistency of their responses, but without the bed watch record, we cannot confirm the position. The failure to retain the constant watch record is poor practice.

[169] Property card

Part 8. The Inquiry Process

The Appropriate Level of Public Scrutiny

The State's investigative obligation under Article 2 of the European Convention on Human Rights (ECHR) includes an element of public scrutiny. We have considered carefully whether the publication of the final version of this report will be sufficient to satisfy the requirement for public scrutiny or whether some further stage in the investigation is needed, such as a public hearing. We have reached the view that the publication will suffice some of the elements involved in this case, but with regard to other aspects, further public scrutiny may be warranted.

In reaching this view we have considered four questions. The first is whether there are serious conflicts in the evidence, which would require further questioning of witnesses to test the credibility of what they say. We have concluded that there are no such concerns. Written statements produced shortly after the incident are broadly consistent and are supported by the comments of those whom we interviewed. Any inconsistencies are minor and are understandable given the passage of time.

Secondly, we have considered the management of Mr Idris from his arrival at HMP Swansea, including the response to the incident in which he sustained a life-threatening injury. We have concluded that when the incident occurred, the response by prison and health care staff was prompt and appropriate. It was at least equivalent to the response he would have received had the same incident occurred in the community.

Thirdly, we have considered whether HMP Swansea should have managed Mr Idris as someone who was at risk of self-harm. Healthcare records included information about the self-harm incident that reportedly occurred around seven years earlier. Information known to the police about an incident of self-harm that apparently occurred three months earlier was not available to those dealing with Mr Idris at court or on arrival at prison. Even this relatively recent incident, however, would not necessarily mean that an individual would be considered vulnerable at the present time, unless they showed current signs of distress. We have concluded that, on the evidence available to the prison – including the way Mr Idris presented to those who assessed him on arrival - there was little to suggest that he was at risk of self-harm.

Nevertheless, the gaps in information sharing between agencies point to wider systemic issues that may benefit from further examination.

Which leads us to the fourth question we have considered. Why was it that a number of men were able to take their own lives, or seriously harm themselves, particularly during the period 2012 – 2017?

Mr Idris suffered his life-threatening injury a year after HMP Swansea had received a critical report from HM Inspectorate of Prisons – a report which highlighted the importance of focusing on findings from the PPO following their investigations into deaths in custody.

In this report we have summarised some of the key findings of those reports, notably those that resonate with this investigation. In particular we note that Her Majesty's Chief Inspector of Prisons was concerned that the prison was not sufficiently sighted on the pattern of self-harm occurring during the early days in prison; also that HMP Swansea, in common with other prisons in Wales, was not following the clinical guidelines for the clinical stabilisation of those testing positive for opiates.

Whilst we can speculate that these issues may be relevant to the management of Mr Idris, it is not possible – and perhaps would rarely be possible - to make a direct causal link. Nevertheless, we have concluded that, in failing to respond adequately to the inspection report, and to the reports of the PPO, the prison was failing in its duty to protect the individuals in its care.

In this report we have noted that the post incident actions were patchy. Whilst the report prepared immediately after the incident was succinct but to the point, the debriefing of staff and the subsequent follow up seems to have been ad hoc. This, combined with the poor response to inspection reports and investigations, suggests a culture in which the approach to learning from serious incidents was inadequate.

We believe that the issues we have identified point to wider systemic failures. We have heard that many of the issues have been resolved in the intervening years, but it is beyond the scope of this investigation to seek evidence to confirm this. As such, we believe that further scrutiny of the issues we have raised, and whether these have now been resolved, may be warranted in order to maintain public confidence.

Annex A – Glossary

AADAS	Abertawe Alcohol and Drug Assessment Service
Abertawe Bro Morgannwg University Health Board (ABMU)	Swansea Bay/ Abertawe Bro Morgannwg University Health Board – the current provider of health care services to HMP Swansea
ACCT	Assessment, Care in Custody and Teamwork Plan: Care planning system used to help to identify and care for prisoners at risk of suicide or self-harm (replaced F2052SH Self-harm at Risk Form)
Ambu bag	Artificial Manual Breathing Unit. A self-inflating bag used to give air to a patient who has stopped breathing.
Arrest referral	A scheme designed to engage at the point of arrest with someone whose offending is linked to drug or alcohol misuse, to provide early advice, information and referral.
AUDIT	Alcohol Use Disorder Identification Test: AUDIT is a comprehensive 10 question alcohol harm screening tool. It was developed by the World Health Organisation (WHO) and modified for use in the UK and has been used in a variety of health and social care settings.
Benzodiazepine/ Diazepam	Diazepam is a drug from a group of drugs called Benzodiazepines – it has sedative and anxiolytic properties and can be used for withdrawal in alcohol
Breach	When someone does not comply with a Community Order they can be returned to court for breach of the requirements.
Buprenorphine	An opioid used to treat opioid use disorder, acute pain, and chronic pain. It can be used under the tongue, in the cheek, by injection, as a skin patch, or as an implant.
CDAT	Community Drug and Alcohol Team
Community Order (CO)	A community sentence that includes one or more requirements
CPR	Cardiopulmonary Resuscitation – an emergency procedure which is performed in an effort to return life to a person in cardiac arrest
CRC	Community Rehabilitation Company. Private companies who, from 2014 to 2021 ran probation organisations responsible for low and medium risk of harm offenders.

CSRA	Cell Sharing Risk Assessment
Defibrillator	A device that gives an electric shock to the heart of someone who is in cardiac arrest.
Delius/n-Delius	The case recording system used by the probation service.
DRR	Drug Rehabilitation Requirement: a condition that can be included in a Community Order
Dyfodol	A specialist substance misuse service for people involved with criminal justice services (formerly known as IOIS). The service has been delivered by WCADA since 2001. It was originally commissioned directly by MoJ with NOMS Cymru. In 2016 the Dyfodol service was funded by South Wales Police and Crime Commissioner and HMPPS.
ECG	Electrocardiogram – a test to check the heart's rhythm and electrical activity.
ECHR	European Convention on Human Rights
ERG	Equality, Rights and Decency – a department in NOMS
FLO	Family Liaison Officer
GEOAmey	A private company that provides prison escort and custody services
GP	General Practitioner
Guedel	A Guedel is a rigid plastic tube which sits along top of mouth and ends at base of tongue (an adjunct to help keep airway open)
HMCIP	Her Majesty's Chief Inspector of Prisons
HMCTS	Her Majesty's Courts & Tribunals Service
HMI Prisons	Her Majesty's Inspectorate of Prisons
HMPPS	Her Majesty's Prison and Probation Service
IMB	Independent Monitoring Board (formerly Board of Visitors)
IOIS	Integrated Offender Interventions Service

Lofexidine	A drug used to reduce the physical symptoms of opiate withdrawal
Loperamide	A drug used to control and relieve the symptoms of acute diarrhoea
Mebeverine	A drug whose major therapeutic role is in the treatment of irritable bowel syndrome (IBS) and the associated abdominal cramping
Methadone	An opioid used to treat pain and as maintenance therapy or to help with detoxification in people with opioid dependence
Metoclopramide	A drug also known as Maxalon used for nausea or vomiting associated with opiate withdrawal
MoJ	Ministry of Justice
NCES	National Compliance and Enforcement Service. Part of HMCTS
NHS	National Health Service
NRR	Nominal Research Report – a police document
NOMIS/ P-NOMIS/ C-NOMIS	Computerised National Offender Management Information System, now known as Prison-NOMIS. It is a single national database of offender information and provides a single and consistent source of information for enquiries and reporting
NOMS	National Offender Management Service
NPS	National Probation Service. From 2014 to 2021 the NPS was responsible for preparing court reports and for the management of certain offenders (predominantly those assessed as high risk of harm, and those subject to Multi-Agency Public Protection Arrangements), whilst the CRCs managed those assessed as low and medium risk. In 2021 probation services were unified, forming a new National Probation Service
OEL	Occurrence Enquiry Log – a police document
OMU	Offender Management Unit
Opiate	Opiates and opioids include controlled prescription substances that are derived from Opium, which is a chemical that occurs naturally in poppy seeds and plants. These drugs are used clinically for treating mild to severe pain in patients. Opioids have tremendously high rates of abuse which can lead to addiction

OSCAR 1	The most senior operational manager on duty during Patrol and Night state. During the core day the Duty Governor is the most senior operational manager on duty.
Paracetamol	Paracetamol a common painkiller used to treat aches and pains
PARIS	PARIS is the CDAT record system. It is a Local Authority/Social Care system that is used by health in some areas
PCT	Primary Care Trust
PECS	Prisoner Escort and Custody Service. PECS provides the safe and secure transport of prisoners and has been managed by private sector providers since 1994
PER/e-PER	Person Escort Record: the documents that accompany the prisoner from court to prison
PGD	Patient Group Directions (PGDs) provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber
PNC	Police National Computer
PPO	Prisons & Probation Ombudsman: carries out independent investigations of complaints and deaths of people in detention or recently released
Promethazine hydrochloride	A neuroleptic medication and first-generation antihistamine of the phenothiazine family. The drug has strong sedative and weak antipsychotic effects
PSO/ PSI	Operational policies – from 2010 Prison Service Orders were issued as Prison Service Instructions
PSR/ Pre-Sentence Report	An assessment of the nature and causes of an individual's behaviour and the risks they pose. It is prepared by probation staff at the request of sentencers
Quinine Sulphate	A medication used for cramps or sweats associated with opiate withdrawal symptoms
SASH	Suicide and Self Harm
SLED	Sentence and Licence Expiry Date

SOCO	Scene of Crime Officer
SystmOne	A clinical computer system used in the UK by healthcare professionals
Subutex	An opiate substitute
WIISMAT	WIISMAT (Wales Integrated In-depth Substance Misuse Assessment Tool)

Annex B - Disclosures

DOCUMENTS RELATED TO THE INCIDENT
Fact Finding Report Mr Idris Dated 28/10/2015 – by Duty Governor
Questionnaire Serious Self-Harm
ACCT Plan, Part 1
C-Nomis
Core Record 2 – redacted. Includes: - licence 10/11/2015 – 27/12/2015 - OMU allocation – to Swansea CRC/NPS. RSR score 3.82. 16 weeks + 20 days consecutive - F2050 Prisoner Personal Record System containing: - early release decision from PPCS; licence; - reception forms; - sentence calculation; - warrant of commitment 23/10/2015 (5 days concurrent); - warrant of commitment 23/10/2015 (20 days consecutive); - Personal Escort Record Form (risk indicator); - warrant for custodial sentence of 16 weeks; - cell sharing risk assessment; - release date notification slip – establishment copy and offender copy - dated 4/11/2015; - notification to Clerk to the Justices (dated 4/11/2015) that received into custody on 18/12/2015 and ceased to be held on 27/12/2015 *(the date on which the non-payment days would be applied);* - notification to Clerk to the Justices (dated 4/11/2015) that received into custody on 18/12/2015 and ceased to be held on 20/12/2015 *(the date on which the non-payment days would be applied);*
Cell sharing risk assessment (CSRA) 1 reception date 23.10.15
Mr Idris's Incident Log - handwritten notes
Duty Governor Report and stability audit return
Induction
Person Escort Record (PER)
Property Card
Statements – some not dated - IMB member who attended the scene - Officer D – Custodial Manager Residential, dated 2/11/2016 (may be a typo – should be 2015) - Officer B - Email Officer C to Duty Governor 28/10/2015 - Email chaplain to Duty Governor 2/11/2015 - Nurse E - Nurse F - Officer E to Duty Governor 24/10/2015 - Letter to governor from hospital consultant, Hospital A 4/11/2015
Chaplain's induction interview
Background Information Serious Self Harm – Report by Regional Safer Custody Lead
Control room log – with handwritten record of the incident
NOMIS – TX report
COURTS AND FINES RECORDS
Mr Idris – case no. 1400731011 Register 16/12/2014 (dropping litter)

Mr Idris - Fines account 16.01.14
Mr Idris – Fines account 24.07.15
Mr Idris – 1500731277 – non-payment of fines 23.10.15
Extract from register of West Glamorgan Magistrates Court: Swansea 23.10.2015 Mr Idris 1500683868 – Court Extract 23.10.15
Warrant for custodial sentence.pdf
PROBATION DOCUMENTS
Community Order (pdf)
Statement of Fact, Breach of Community Order
NPS pre-sentence report (oral) for SMC 8/8/2014
Delius entry 23 Oct 2015 screenshot
HEALTH RECORDS – RELATED TO THE INCIDENT AND PATIENT RECORDS
Ambulance summary (incident details)
Sequence of Events
Patient Clinical Record (post incident)
Patient Records (prison) 2013 – 2015
NHS Wales incident report IR1 Appendix 3
IR3 Concise Investigation Report
Mr Idris toxicology report 24/10/2015
Email from the Clinical Lead for Secure Environments and Substance Misuse, Lead GP HMP Swansea
RECORDS FROM SUBSTANCE MISUSE SERVICES
PARIS - Initial and review Assessment/Care Plan – from CDAT (RPT_SMAT_INTRV)
PARIS - Risk assessment/ risk management plan – from CDAT (RPT_SMAT_RISK)
INFORMATION FROM THE POLICE
Custody record 1500344341
OEL – attempt hanging 1500394467 (Occurrence/ intelligence enquiry log)
NRR
PNC – Court defence probation print
Email exchange with South Wales Police Disclosure Officer, 15th and 30th May 2022
RECORDS FROM PRISONER ESCORT SERVICE
Mr Idris ePER
Vehicle Operational Record: Consists of: - vehicle operational record, - VOR – subject movement record - PER
GEOAmey SOP 063 Self harm and suicide prevention v11 Oct- Nov 2015 - OBSOLETE
HMPPS
Operational and System Assurance Group (OSAG) Safety Audit; HMP Swansea, February 2022
OSAG Safety Audit Report Update - NTS 55.2022 SUMMARY
RECORDS OF INTERVIEWS
Notes of meeting with head of healthcare, HMP Swansea 18 March 2022

Notes of meeting with Head of CDAT 16th March 2022	
Notes of meeting with Doctor 2 – prison GP, 16 March 2022	
Notes of meeting with Team Manager HMCTS Wales Enforcement Office March 31st 2022	
Notes of meeting with current Governor 5 April 2022	
Notes of meeting with GEOAmey staff 5 April 2022	
Notes of meeting with Officer A 5 April 2022	
Notes of meeting with Officer B 5 April 2022	
Notes of meeting with Officer C 17 March 2022	
Notes of meeting with Officer D 5 April 2022	
Notes of meeting with Officer E 6 April 2022	
Notes of meeting with Officer F 6 April 2022	
Notes of meeting with Nurse A 6 April 2022	
Notes of meeting with Nurse B 16 March 2022	
Notes of meeting with Nurse C 6 April 2022	
Notes of meeting with Senior Probation Officer, 7 April 2022	
Notes of meeting with Regional Safer Custody Lead 7 April 2022	
Notes of meeting with member of IMB 12 April 2022	
Notes of meeting with managing chaplain 7 April 2022	
Notes of meeting with Executive Director of Nursing, Swansea Bay University Health Board and Head of Healthcare HMP Swansea 7th April 2022'	
Notes of meeting with Doctor 1 – community GP 8 April 2022	
Notes of meeting with Compliance Manager, GEOAmey, 11 April 2022	
Notes of meeting with Service Manager, Dyfodol, 11 April 2022	
POLICY DOCUMENTS	
PSO 1300	Investigations. Issue no 175; Issued 19/06/2003. Updated 25/07/2005
PSO 4400	Prisoner Communications: Prison Service Order *This was replaced by the Public Protection Manual (2009)*
PSI 08/2010	Post Incident Care
PSI 45/2010	Integrated Drug Treatment System PSI 45/2010 NOMS
PSI 24/2011	Management and security of nights https://www.gov.uk/government/publications/management-and-security-of-prisons-at-night-psi-242011
PSI 49/2011	Prisoner Communication Services https://www.gov.uk/government/publications/prisoner-communications-policy-psi-492011
PSI 64/2011 (was revised July 2021)	Management of prisoners at risk of harm to self, to others and from others (Safer Custody) https://www.gov.uk/government/publications/managing-prisoner-safety-in-custody-psi-642011
PSI 11/2012	Management and Security of the Incident Reporting System Disclosure
PSI 03/2013	Medical Emergency Response Codes PSI 03/2013

	https://www.gov.uk/government/publications/medical-emergency-response-codes-psi-032013
PSI 15/2014	Investigations And Learning Following Incidents Of Serious Self-Harm Or Serious Assaults https://www.gov.uk/government/publications/investigating-incidents-of-serious-self-harm-or-assault-psi-152014
PSI 35/2014	Records, Archiving, Retention And Disposal Disclosure
PSI 03/2015	Sentence Calculation – Determinate Sentenced Prisoners Disclosure
PSI 07/2015 and PI06/2015	Early Days In Custody – Reception In, First Night In Custody, And Induction To Custody https://www.gov.uk/government/publications/early-days-in-custody-psi-072015-pi-062015
PSI 20/2015	The Cell Sharing Risk Assessment https://www.gov.uk/government/publications/cell-sharing-risk-assessments-psi-202015

Annex C – Interviews conducted

Meeting with Mr Idris's family	1 December 2021
Current Governor of HMP Swansea – focus on healthcare	17 March 2022
Current Governor of HMP Swansea	5 April 2022
Head of Healthcare, HMP Swansea	18 March 2022
Head of Community Drugs and Alcohol Team	16 March 2022
Community GP – Doctor 1	8 April 2022
Prison GP – Doctor 2	16 March 2022
Officer A	5 April 2022
Officer B	5 April 2022
Officer C	17 March 2022
Officer D	5 April 2022
Officer E	6 April 2022
Officer F	6 April 2022
Nurse A	6 April 2022
Nurse B	16 March 2022
Nurse C	6 April 2022
Managing chaplain (involved at the time of the incident)	7 April 2022
Member of IMB (involved at the time of the incident)	12 April 2022
Team manager HMCTS Wales Enforcement Office	31 March 2022
GEOAmey PECS staff	5 April 2022
Senior Probation Officer, Swansea	7 April 2022
Regional Safer Custody lead (who completed the post incident report)	7 April 2022
Current Director of Nursing, Swansea Bay University Health Board	7 April 2022
Current Compliance Manager, GEOAmey	11 April 2022
Current Service Manager, Dyfodol	11 April 2022

Annex D – References

Department of Health (2006) *Clinical Management of Drug Dependence in the Adult Prison Setting.* London: Department of Health
Department of Health (2017) Independent Expert Working Group. *Drug misuse and dependence: UK guidelines on clinical management*. London: Department of Health
Healthcare Inspectorate of Wales and Care Inspectorate of Wales (2018) *Review of Substance Misuse Services in Wales.*
Her Majesty's Inspectorate of Prisons (2010) *Report on an announced inspection of HMP Swansea 8 – 12 February 2010*. London: Her Majesty's Inspectorate of Prisons.
Her Majesty's Inspectorate of Prisons (2012) *Report on an unannounced short follow up inspection of HMP Swansea 17–19 December 2012*. London: Her Majesty's Inspectorate of Prisons.
Her Majesty's Inspectorate of Prisons (2012) *Thematic report: The use of the person escort record with detainees at risk of self-harm*. London: Her Majesty's Inspectorate of Prisons.
Her Majesty's Inspectorate of Prisons (2015a) *Thematic report: Changing patterns of substance misuse in adult prisons and service responses*. London: Her Majesty's Inspectorate of Prisons.
Her Majesty's Inspectorate of Prisons (2015b) *Report on an unannounced inspection of HMP Swansea 6 –10 October 2014* London: Her Majesty's Inspectorate of Prisons. Action Plan HMCIP report (2015) https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2015/02/Swansea-action-plan-2015.pdf
Her Majesty's Inspectorate of Prisons (2018) *Report on an unannounced inspection of HMP Swansea 7, 8, 14–17 August 2017.* London: Her Majesty's Inspectorate of Prisons. Action Plan HMCIP report (2018) https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/01/HMIP-Action-Plan-HMP-Swansea-Updated.pdf
Her Majesty's Inspectorate of Prisons (2020) *Report on a scrutiny visit to HMP Swansea, 25th August and 2nd – 3rd September 2020.* London: Her Majesty's Inspectorate of Prisons.
Independent Monitoring Board: *Her Majesty's Prison Swansea Annual Report 2014 – 2015* (covering the period end May 2014 – end May 2015). Published 2015.
Independent Monitoring Board: *Her Majesty's Prison Swansea Annual Report 2015 – 2016* (covering the period end May 2015 – end May 2016). Published October 2016.
Livingston, W., Perkins, A., McCarthy, T., Madoc-Jones, I., Wighton, S., Wilson, F. & Nicholas, D. (2018). *Review of Working Together to Reduce Harm: Final Report.* Cardiff: Welsh Government GSR report number 21/2018

Prisons & Probation Ombudsman (April 2011) Investigation into the circumstances surrounding the death of a man at HMP Swansea in July 2010
Prisons & Probation Ombudsman (October 2011) Investigation into the death of a man whilst in the custody of HMP Swansea in September 2010
Prisons & Probation Ombudsman (April 2013) Investigation into the death of a man at HMP Swansea in June 2012
Prisons & Probation Ombudsman (April 2014) *Learning from PPO investigations: Risk factors in self-inflicted deaths in prison.*
Prisons & Probation Ombudsman (January 2015) Investigation into the circumstances surrounding the death of a man at HMP Swansea in March 2014
Prisons & Probation Ombudsman (2015) Annual Report 2014 – 2015. (presented to Parliament by the S of S for Justice by Command of Her Majesty September 2015) https://www.ppo.gov.uk/document/annual-reports/ (accessed 22nd April 2022)
Prisons & Probation Ombudsman (2020) *Investigation into the death of Mr Dean George, a prisoner at HMP Swansea on 10 April 2016.* Action plan: https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2020/03/F2751-16-Death-of-Mr-Dean-George-Swansea-10-04-2016-SI-31-40-40-AP.pdf
Tamlyn Cairns Partnership (2020) *HMP Swansea Health and Social Care Needs Assessment*. Commissioned by Swansea Bay University Health Board.
Welsh Assembly Government (2018) *Working Together to Reduce Harm: The Substance Misuse Strategy for Wales (2008 – 2018).*
Welsh Parliament (2021) Health, Social Care and Sport Committee *Health and social care provision in the adult prison estate in Wales*. Cardiff: Welsh Parliament