Investigation into the circumstances surrounding the death of a man at HMP Cardiff in April 2010

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

This is the report of an investigation into the circumstances of the death of a man in April 2010 at HMP Cardiff. He was 36 years old when he died.

It is always tragic when a young man takes his own life and I would like to offer my condolences to his family and all those touched by his death. One of my family liaison officers has had contact with various family members during the investigation and continues to assist them to contribute to this process.

I asked my senior investigator to conduct the investigation into the man's death and report on her findings. An investigator employed on a sessional basis by my office assisted my investigator and wrote this report. Healthcare Inspectorate Wales was asked to review the medical treatment he received whilst at HMP Cardiff. I am grateful for this contribution to the investigation.

I want to take this opportunity to thank the Governor of the prison and his staff for their assistance to my investigation. The Safer Custody Manager acted as liaison to the investigators when they visited the prison and they appreciated his attention to detail.

The man had been open with his cellmates, medical and other prison staff about feeling low and how he faced a number of difficult problems. He was, however, never explicit with any one person about how badly he was affected. No-one, staff or other prisoners, believed that he would take his own life and everyone spoken to during the investigation expressed shock at his death. As there was no specific occasion when anyone assessed him as being at risk of suicide, I think that it was reasonable not to put the suicide monitoring systems in place.

I do not make any recommendations of my own but I endorse three in the clinical review. They concern blood pressure monitoring for detoxifying prisoners, record keeping and giving prisoners advance notice of healthcare appointments. I do not think that these matters had any material effect on his wellbeing or his decision to end his life.

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

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **July 2011**

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SUMMARY

The man was first remanded to HMP Cardiff on 9 December 2009. He had been charged with offences following the death of a fellow hostel resident and it was initially suspected that he might have supplied the drugs that had led to the fatal overdose.

The Prisoner Escort Record Form (PER) that accompanied him from court flagged up a history of depression as well as heroin use. However, at the standard health screen interview on reception, he did not disclose any thoughts of suicide or self harm and there were no immediate concerns about his presentation.

A heroin user for several years, he was immediately placed on the prison's detoxification programme for both alcohol and heroin. He completed the required course of treatment and moved to an ordinary remand wing on 4 January 2010.

From early on in his time in prison, he talked about feeling "low in mood" and described symptoms of flashbacks, palpitations and sleeplessness. He requested an increase to the dose of Chlorpromazine, an anti-psychotic drug prescribed by his own doctor in the community. He took it to alleviate the impact of Post Traumatic Stress Disorder (PTSD) that he suffered as a consequence of childhood sexual abuse. His request was granted and he was referred to the prison's consultant psychiatrist. He also asked for counselling, having had a positive experience of abuse counselling during a previous sentence at HMP Parc. No such service was then available at Cardiff, and he was advised to discuss other options with the consultant psychiatrist.

When he first met with the psychiatrist on 2 February, he was again very open about the extent of his problems. It was thought that, although distressing, his anxiety symptoms were manageable and he was not at risk of harming himself. He hoped to be transferred to Parc once he was sentenced where he could again receive counselling which he felt best met his needs.

The psychiatrist did not assess him as mentally ill and agreed with the existing diagnosis of PTSD. He shared with him the possible negative side-effects of long term use of Chlorpromazine and suggested an anti-depressant instead. He agreed to the change in his medication and was referred to a psychotherapist for emotional support while he waited to be sentenced. In the event, he did not like the new medication and stopped taking it after four days. The previous prescription for Chlorpromazine was resumed.

He was eventually convicted of Intent to Supply and Possession of a Controlled Drug, namely heroin, on 15 March. The fear that he would be charged directly with the death at the hostel, which had created much early anxiety for him, had not materialised. He was remanded again until 31 March for sentencing. In the event, he was not sentenced on that day but instead attended the magistrates' court in relation to the earlier drug offences. He was due to be sentenced on 20 April but his solicitor said that he did not think that he would have known this when he died. He was anticipating a lengthy sentence.

On 6 April, he again met the psychiatrist as part of a standard review. He complained that the anti-depressant made him "worse" which was why he had stopped taking it. The doctor confirmed that he could continue taking Chlorpromazine and told him that he would pursue the appointment to see the psychotherapist, which had not yet taken place. The doctor had no concerns about him.

The next day, he moved to B Wing. He moved in with someone he knew and, according to this cellmate, he was distressed the weekend before he died. He had been on B Wing for less than a week when he took his own life. This was not long enough for him to form supportive relationships with wing officers at a busy time on that landing. Neither he nor his cellmate told staff about the emotional "turmoil" he apparently experienced over the weekend before he died.

He was due to appear at the inquest into the death of the resident of the hostel on 16 April which had been postponed from 31 March. His solicitor had not been aware of the impending inquest although he knew that the police wanted to speak to him in relation to the matter. The investigation team could not find any evidence to confirm whether he was aware that he was due to appear as a witness.

At about 9.15am on Monday 12 April, his cellmate went on a legal visit. That was the last time he was seen alive. An officer made a fabric check (the daily security check of the cell to ensure that there is no damage and need of repair) at 10.06am. The officer would have seen him in the course of the check. Some time between 10.06am and 11.30am, when his cellmate returned to the cell and raised the alarm, he tied a ligature made from a bed sheet around his neck and hanged himself from the window frame.

The response to the discovery was competent and fast. Despite the likelihood that he was already dead, officers tried very hard to resuscitate him. Their efforts and those of the paramedics were unsuccessful and he was pronounced dead at 12.10pm.

My report contains three recommendations concerning healthcare arrangements.

THE INVESTIGATION PROCESS

1. My colleague made a preliminary visit to HMP Cardiff on 15 April to open the investigation. The investigation was then carried out by two investigators. Notices were issued to staff and prisoners telling them about the investigation and offering them the opportunity to speak with my investigators. No one came forward as a result.

2. The investigators visited the prison on 12 and 13 May 2010 and interviewed ten people: two prisoners who shared cells with the man, three prison officers, two nurses, a CARAT worker (Counselling, Assessment, Referral, Advice and Throughcare Services), a psychotherapist and a consultant psychiatrist. The investigation team also visited the wings where he had lived.

3. The investigators met with the Governor at the start of the investigation at and also at the end of their visit to discuss findings. No matters of urgent concern were raised at this stage.

4. The investigator contacted the police officers investigating the offences with which the man was charged, and his solicitor. She also spoke with the probation officer who wrote the pre-sentence report for sentencing and was sent a copy of this report for background information. In addition, she spoke with the coroner's officer with regard the inquest into the hostel resident at which he was due to attend.

5. One of my family liaison officers telephoned the man's mother on 7 May. She followed up her initial telephone call in writing and included a leaflet with information about the work of the Prisons and Probation Ombudsman. This explained that the bereaved family could be involved in the investigation if they wished.

6. Both investigators visited the man's mother on Monday 19 July. The family liaison officer has also spoken on the telephone with two of the man's maternal uncles. The following concerns and questions have been raised by the family. I hope that the findings of my investigation answer these and any other questions they may have and helps them better understand the events leading to his untimely death:

   - The family questioned why the prison did not appropriately address his mental health needs, despite him telling staff about them.

   - He had told his mother that the prison had stopped the medication he had been prescribed by his doctor in the community to manage his mental health problems and she wanted to know why.

   - His mother was aware of her son's mental suffering at the time of his death and she feels there was a possibility that he may have been hearing voices. She wanted to know if any evidence was uncovered by the investigation.

- His uncle asked if there were any concerns about his last cellmate and his behaviour towards his nephew.

7. A copy of the draft report was sent to the Prison Service and their responses to the recommendations are repeated verbatim in the recommendation section.

8. The man’s family received a copy of the draft report as part of the consultation period. Having considered the investigations findings, his family indicated to my family liaison officer that they were unhappy with aspects of the report, including what they felt were a number of inaccuracies and issues that had been overlooked. Despite encouragement from my family liaison officer to share their feedback, his family did not feel able to disclose their further comments ahead of the report being made final.

HMP CARDIFF

9. Cardiff is a local category B prison situated in the centre of the Welsh capital and is the largest state-run prison in Wales. A category B prison is a closed prison where do not need maximum security but where escape is made very difficult.

10. General healthcare is provided by doctors and nurses employed by the Prison Service. The 22 bed healthcare centre is two years old and offers 24 hour nursing and medical cover. The local Health Trust also employs a consultant psychiatrist for seven sessions a week to provide mental health clinical work to the prison. A further session a week of mental health input is provided by a local mental health facility, the Caswell Clinic. The mental health in-reach team at Cardiff consists of five people, including the consultant psychiatrist. Other team members are two community psychiatric nurses (CPNs), an occupational therapist and an administrative worker. At the time of this investigation, three members of the team were off sick, two of them long term. The psychiatrist works across both primary and secondary care towards the longer term aim of integrating the whole team. They provide services for those with severe and enduring mental health needs as well as prisoners who need counselling.

11. There is a detoxification wing where prisoners undergo a Lofexidine detoxification. Wales does not use the Integrated Drug Treatment Service (IDTS) now available in the prison estate in England. The aim of IDTS is to provide a broader range of options for those with problematic drug use. For those arriving at Cardiff without a community prescription of Methadone or Subutex, the only option is to go through a 14 day detoxification. Once this has been completed, and the prisoner is regarded as stable, they are moved to ordinary location. The CARATs team provide longer term support for drug users.

12. Like the rest of the prison estate in England and Wales, the prison is expected to accommodate more prisoners than it was designed for. It has an operational occupancy of 824 as of December 2009. This includes both convicted and non-convicted men on remand and there is also a dedicated wing for prisoners serving life sentences.

Her Majesty's Chief Inspector of Prisons

13. The most recent Her Majesty's Chief Inspector of Prisons (HMCIP) inspection of the prison took place in January 2008. The inspection report noted favourably:

> "It suffers from all the difficulties of an overcrowded and pressurised prison system. It is therefore to the considerable credit of the prison's staff and managers that it was nevertheless found to be performing reasonably well across all of our four key tests: safety, respect, purposeful activity and resettlement."

14. The inspection team felt that detoxification procedures were “sound” and that “overall” there was a good level of healthcare. The report commented, however, that:

> “… it was disappointing that the enthusiasm of the safer custody manager had not communicated itself to those staff responsible on a day- to- day basis for supporting those at risk of self-harm. This required more management attention.”

Independent Monitoring Board

15. Every prison has an Independent Monitoring Board (IMB) made up of local people whose job it is to monitor standards to ensure prisoners are being treated fairly and humanely. Each IMB is required to report every year on their findings. The last IMB report on Cardiff concluded that it was “a well-run establishment with good relationships between staff and prisoners”. It noted that a general counsellor had resigned during that reporting year and no replacement had been found.

Assessment, Care in Custody and Teamwork (ACCT)

16. Assessment, Care in Custody and Teamwork (ACCT) is a care planning tool used by the Prison Service to help monitor and support prisoners identified as being at risk of self harm or suicide. Any member of staff can open the ACCT procedures by filling in certain documents detailing their concerns and the process encourages staff to work together to tailor individual care to prisoners in distress. Regular checks and reviews of the prisoner’s situation are built in to the process with the ultimate aim of diffusing circumstances where suicide or self harm can take place.

Previous investigations of deaths in custody

17. There were four apparently self inflicted deaths in 2009. None of these people were subject to the enhanced monitoring of Assessment, Care in Custody and Teamwork (ACCT) procedures at the time of their deaths. There have been no other self inflicted deaths in 2010. The man’s death shares one similarity with two of the deaths in 2009, in that it came as a shock to everyone concerned.

KEY FINDINGS

18. The man was arrested on 8 December 2009 after he had discovered the body of a fellow resident at the YMCA in Cardiff. This man had apparently died from a drug overdose and he was initially suspected of supplying the drugs that killed him. He consistently denied this. He had also been arrested a few days earlier on drug offences and released on bail.

19. He was remanded into custody at Magistrates' Court on 9 December 2009. He arrived at the prison and went through the usual reception procedures including a standard health screen. Drug tests revealed the presence of benzodiazepines (used to treat symptoms including anxiety and insomnia) and morphine (opiate used for pain relief) in his system. He was interviewed by nursing staff and allocated to the detoxification unit on C wing. He started an opiate, benzodiazepine and alcohol detoxification. No immediate concerns were raised about his risk of suicide or self harm although a history of depression was identified in the Prisoner Escort Record (PER) that accompanied him from court.

20. On 10 December, he underwent a standard assessment interview with the CARAT worker on the detoxification wing. He had a visit from one of his legal representatives on 14 December. This meeting was followed up by another legal visit four days later.

21. He started work with members of the CARATs team on both 21 and 23 December. On 27 December, he is recorded in the medical record as complaining of feeling "low in mood". He had been prescribed Chlorpromazine for post traumatic stress disorder (PTSD) in the community which continued in prison. Chlorpromazine is an anti-psychotic drug which has anxiety relieving and sedative properties. He explained that he had been used to a higher dose than he was being prescribed at that time. He was told that he would be referred to a mental health nurse the next day.

22. He was duly assessed by Nurse A on 28 December and discussed abuse he had suffered as a child and flashbacks he was experiencing as a result. In the medical notes it queries whether the level of dosage of his medication should be reviewed. It was also recorded that he had no thoughts of self harm and was advised to speak to staff if he had further concerns.

23. The next day he reported that he had suffered "palpitations" during the night. There is evidence of a further assessment of his situation and the following options were discussed:

   - He should see a community psychiatric nurse (CPN) to "get things off his chest".
   - He was advised that there was no counselling service at Cardiff, so he should consider transferring to HMP Parc where he benefited from counselling during a previous sentence.

24. On 31 December, he was seen by a mental health nurse who increased the dose of Chlorpromazine to 200mg daily to help with his “racing thoughts”. After four days, however, he again saw a nurse to complain that his medication was not working. He was advised by a nurse who saw him on this occasion to persist with this dosage as it had not had long enough to be effective. No other concerns were recorded. Staff noted that he was participating in activity on the wing. He had good eye contact, which was seen as a positive sign, and no thoughts of suicide or self harm.

25. The detoxification treatment was completed the next day and, on 4 January 2010, he moved to F Wing. He was placed in a shared cell and no immediate concerns were recorded in the wing log.

26. He had an appointment with a Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS) worker, in early January 2010. Her role was to help him to focus on his drug use now he was drug free after detoxification. It is clear that he was motivated to make positive use of this opportunity and he appeared committed to working with professionals to achieve a drug free life. He talked about his need for abuse counselling and his wish to transfer to HMP Parc as soon as he was sentenced.

27. She later said in interview with my investigators that she offered to refer him to a member of the chaplaincy who was trained in bereavement counselling, and will speak to prisoners more generally about their problems. However, when she explained to him that there was a waiting list, he said he was “fine” to wait for counselling to be arranged through the mental health team. Following the CARATS session, he was given “homework” to do between meetings. He showed his willingness to address his drug use by completing the written exercises in an enthusiastic and thoughtful way.

28. His problems sleeping and his flashbacks continued and he sought help again from medical staff via “sick parade” (prisoners request to see a doctor on the day of illness) on 15 January. He mentioned that these problems stemmed from previous abuse and coming off heroin. He was told to wait for his psychiatric appointment and there is no record that he made any further complaints before he saw a Consultant Psychiatrist on 2 February.

29. He seems to have been very open with the psychiatrist about the nature of his problems. They had a lengthy discussion about appropriate medication and the psychiatrist persuaded him to switch to Citalopram, an anti-depressant used to treat major depression associated with mood disorders and PTSD in particular. The psychiatrist’s medical advice was that taking Chlorpromazine over time could lead to unpleasant and damaging physical side effects.

30. Although self confessedly “low in mood”, he did not strike the psychiatrist as suicidal or at risk of self harm. The psychiatrist made a note to this effect in the clinical record. Whilst acknowledging that there was no specific counselling service at Cardiff, the psychiatrist decided to refer him to a psychotherapist who attends the prison for one morning session a week. The psychiatrist recognised that he had benefited previously from counselling and

responded to this type of psychological support. The doctor sent a comprehensive letter outlining his needs to the psychotherapist dated the next day, 3 February. As a result of the consultation, Chlorpromazine was reduced from 3 February and the new drug Citalopram issued from 4 February.

31. From the time of his arrival on F Wing, no problems were noted about his behaviour. In the three entries from early January he was described as quiet and spending a lot of time in his cell sleeping. On 4 February, however, he was recorded as being "verbally aggressive" to nursing staff about his medication.

32. He then refused to take Citalopram on 8 February and the psychiatrist agreed to resume the prescription of Chlorpromazine of 100mgs twice a day on 9 February. He did not see him in connection with this decision but recalled that he agreed to this change to help calm his "agitated state". He had a visit from his solicitor on 12 February. The next entry in the wing record on 14 February comments on "further signs of non-compliance" after returning from getting his medication. The entry goes on to say "a poor week from him".

33. The disruptive behaviour appears to have been short lived, however, and the rest of his time on F Wing seems to have passed much more peacefully. Wing records throughout March say that he was calmer and there were no concerns, although one entry described him as a "Jekyll and Hyde". Two police officers from two police stations both in Cardiff visited him on 8 March in relation to the drug offences for which he had been bailed in early December.

34. He was convicted of possession of a controlled drug with intent to supply and possession of a controlled drug at Crown Court on 15 March. He was remanded back to HMP Cardiff to await sentencing on 31 March.

35. He was due to be visited by a Detective from the police station on 19 March. The police officer went to see him at the request of the coroner to obtain a statement regarding the death of the YMCA resident. The Detective told my investigator on the telephone that he had refused to see him.

36. On 22 March, he received a visit from his legal team. The next day, a probation officer visited him in connection with the preparation of a pre-sentence report for court. She did not deem him to be at risk of self-harm or suicide, although he was open about the personal difficulties he was facing. When he appeared at Crown Court on 31 March, sentencing did not take place and instead he appeared at the Magistrates' Court in relation to the older drug charges. His solicitor said that he was fine on that day, although preoccupied with wanting to know the length of sentence he might receive. By this time, he knew he was not facing charges in relation to supplying drugs to the hostel resident who died.

37. For his last few weeks on F wing, he shared a cell with Prisoner A. During interview for this investigation, the prisoner said that he had known him outside the prison but they had also had shared a cell for about five months at

Parc in 2008 on a previous sentence. He felt he knew him well and spoke warmly about him. Although he shared a lot about his problems with the prisoner, his death came as a complete shock. He had never believed that his friend was at risk of self harm and said that he would have alerted staff if he had felt that he was in danger of taking his own life.

38. As a convicted prisoner, the man could no longer remain on F Wing. He left F Wing on 1 April and was placed on A Wing until a place became available on B Wing.

39. On 6 April, he was again seen by the psychiatrist for a routine follow up review. He said he was "still the same really". There had been no contact yet from the psychotherapist and the psychiatrist recorded that he would follow this up. He also said that Citalopram had made his anxiety and panic attacks "worse". They agreed that he would continue taking Chlorpromazine as much for its sedative properties which helped him sleep.

40. The psychiatrist explained to the investigation team that he did not think that Chlorpromazine was the right medication for his specific needs in the long term. Nevertheless, he agreed to go along with his patient's preference. During his interview for this investigation, the psychiatrist was adamant that he was not suicidal at this appointment.

41. On 7 April, he was allocated to cell 5 on B4, the top landing on B wing, to share with Prisoner B. Again, the cellmates knew one another from their acquaintance outside the prison and they had also been on F wing at the same time. The prisoner says that they had not spent much time together on the previous wing but he had noticed from a distance that he appeared "very isolated" and "depressed".

42. In his statement to the police and also in interview with my investigators, the prisoner described him as very open about his emotional distress, once they had started to share a cell. As well as talking about the abuse he had suffered as a child, the prisoner said that his cell mate was also "in a turmoil" about his sexuality. By his own account, the prisoner was sympathetic and tolerant towards him when he shared his thoughts with him. He at no time, however, thought he was suicidal or at risk of self harm and he too said he would have told staff about any concerns. Although h did share with the prisoner that he had been implicated in the death of someone who had overdosed, he did not go into much detail or say that he would have to attend an inquest. The prisoner commented that he had had a restless night on 10 April and did not sleep well generally.

43. The only one officer on B Wing who appears to have had any memorable contact with him, who remembered him taking part in a sweepstake the officer had organised for the Grand National on 10 April. He remembered him coming to get his ticket. He also noticed that he shaved his head sometime during Friday 9 and Saturday 10 April, although he did not think this was unusual. This lack of contact with him is reflected in the recollections of two

officers who, whilst knowing who he was, only recall him as a quiet person who spent most of his time in his cell.

44. Prisoner B described him as being “very manic” on 11 April. They spent much of the day talking through his issues. None of this appears to have been conveyed to either discipline or medical staff. He remembered that he received a letter from his mother with some money that day.

Events of 12 April

45. Prisoner B explained in his police statement that he awoke later than usual at about 8.30am on Monday 12 April and the man was awake before him which was also unusual. By the time he came to be interviewed by my investigators on May 2010, his memory had dimmed but he could not remember having any concerns about him that morning. He left the cell at about 9.15am to be escorted to a legal visit. He did not return until after exercise had finished as he went to see a friend on another landing after his visit and then went straight to exercise from there.

46. Although Officer A initially remembered collecting him to go for exercise at about 10.00am that day, he later acknowledged that he was confused with another occasion. The officer has no memory of seeing him at all when he asked prisoners if they wanted to go for exercise at about 10.00am that morning.

47. The officer decided to combine unlocking the cells and making the accommodation fabric check at the same time. This was not his usual practice. In interview, he could not explain why he did so on this occasion. The wing was described as very busy that day so he told the investigation team that he might have wanted to speed things up by combining two tasks.

48. An accommodation fabric check involves staff physically checking cells for damage and need of repair, in particular for security reasons. This must be done once a day. Part of the overall check is a cell bell check when the bells in each cell are pressed inside and then switched off by the officer on the wall outside. The cell bell check for cell B-05 is recorded as taking place at 10.06am which is consistent with the officer’s original assertion that he started to work his way round the landing to ask about exercise at the same time as doing the accommodation checks at about 10.00am.

49. Although officers are not required to communicate with prisoners during accommodation checks, the officer would have opened each cell door to and reach inside to ring the bell. He said that he would definitely have seen him if he had been hanging at that time, as he was eventually found directly in front of the door. Although he could not specifically recall, he assumes that he was in the cell but in bed at the time of the check.

50. There is no record or recollection by the wing officers of any other contact with him or visit to his cell until his cell mate returned from exercise. Prisoner B remembered eventually arriving back at the door outside the cell at about

11.30am (although it could have been a few minutes earlier when other timings are taken into account). He looked through the observation flap to see him hanging from the window frame. He immediately shouted for help and Officer B came running from the end of the landing where he had been talking to another prisoner.

51. The officer unlocked the cell and immediately tried to support his weight. He was helped by the prisoner who followed him inside. Officer C was next to arrive and he cut the ligature around his neck with his anti-ligature knife. (This knife is colloquially known as a "fish knife" or "fish hook" in the Prison Service because it is shaped like a fish. Anti-ligature knives are issued to all prison staff who are required to carry them at all times.) The ligature was made from a green bed sheet.

52. The prisoner was asked to leave the cell by Officer D who had arrived at the cell immediately behind Officer C. Officer A had also arrived from helping a colleague on B3 landing with a collapsed prisoner. He helped Officer B and Officer C to lay him on the floor to check for breathing. They could find no sign of breathing and Officer B started cardiopulmonary resuscitation (CPR) at a rate of 30 compressions to two breaths, without pausing to use his mask. Officer C left the cell at this point.

53. Officer A took over compressions and Officer B continued mouth to mouth resuscitation. A Senior Officer arrived and called the Code Blue emergency call which signals to staff that someone has been found hanging. Various incident logs time this as happening at 11.28am.

54. Nurse C responded to the Code Blue call and arrived to find his colleagues giving CPR. He judged that they were doing a good job and he prepared the defibrillator when it arrived. The defibrillator had been called for by the prison doctor, who had also responded to the Code Blue. Officer A left the cell at about this time because he thought there were enough people in the room.

55. Although Officer B said at the "hot debrief " meeting that he thought Nurse C had problems getting" the kit out", this was refuted by the nurse when he was interviewed by my investigators. When the defibrillator pads were placed on the man no heart rhythm was detected and it instructed not to proceed with CPR. However, CPR was continued as Mr B took over full CPR when Officer A left the cell.

56. According to the Controller's Death in Custody Check List the first call to the Ambulance Service was made at 11.30am. A single crewed first responder was on mobile patrol close to the prison and the paramedic logged that he received a radio message at 11.36am and arrived at the prison a minute later at 11.37am. This differs slightly from the check list which records that the ambulance arrived at 11.33am. When the paramedic arrived at the cell he found three people carrying out CPR and he took over CPR with the help of prison staff until two other paramedics arrived at about 11.45am. Officer B handed over to them and left the cell. The man was pronounced dead at 12.10pm.

57. The clinical reviewer commented favourably on the “exhaustive attempts by the emergency team” to revive the man. She concluded that the medical response to the discovery of him was “quick” and that CPR was “appropriately” undertaken.

Events after the man’s death

58. The Governor, chaplain and prison family liaison officer visited the man’s mother at about 1.45pm that afternoon to break the news of his death.

59. It should be noted that this was the first day of the Governor’s appointment as Governor of Cardiff. The fact that he responded so responsibly to the task of breaking news of a death to a family in person when still so new in post is impressive. Experience from other investigations conducted by my office tells that families appreciate direct contact from Governors and we encourage this wherever possible.

60. A full “hot debrief” meeting of the staff who responded to the emergency was held that afternoon to establish what had happened and the sequence of events. Staff who had direct contact with the man and who attempted to resuscitate him were thanked and told where they could get support.

61. The family liaison officer continued to have contact with family members in the weeks immediately after the death and visited to return the man’s belongings. I understand that the prison complied fully with Prison Service guidance and offered the family financial help with funeral expenses

ISSUES

Clinical care

62. A clinical review was prepared by the Healthcare Inspectorate Wales. In total, five recommendations were made, three of which are endorsed in my report (the third recommendation is repeated further in this section). One of these concerns blood pressure monitoring as the man's was not taken every day for the first three days whilst undergoing detoxification which was not in line with policy.

    The frequency of blood pressure monitoring should be clearly stated within the plan of care to ensure that prisoners are monitored correctly, whilst undergoing detoxification.

63. The quality of the healthcare record keeping was variable and there were many instances of the records being incomplete and/or inconsistent, and in a number of cases both the information recorded, and the names of signatories detailing the information was illegible.

    The Head of Healthcare should ensure that all records containing information relevant to prisoners' health are maintained in accordance with professional standards, e.g. as stated in the Nursing and Midwifery Council Record Keeping: Guidance for Nurses and Midwives (2009).

64. The other two recommendations made by the clinical review are discussed below and concern the man's access to health professionals and obtaining medical records from other prisons.

Assessment of the man's risk of harm

65. A key question whenever someone apparently takes their own life is whether there was any opportunity to intervene and prevent it. It was known that the man had a history of alcohol and drug abuse and he underwent detoxification on his arrival. He talked openly to medical staff and others about childhood experiences of abuse which left him anxious and distressed. He had been previously diagnosed with Post Traumatic Stress Disorder and had been prescribed a drug, Chlorpromazine, by his own doctor in the community. In prison, he described symptoms of depression, panic attacks, flashbacks and palpitations to a range of health professionals and received medication to address some of these.

66. On most occasions when he presented with these symptoms he was asked if he felt suicidal or at risk of self harm. On no occasion did any professional feel sufficiently worried to record immediate concerns or open the ACCT procedures. He was not unusual in the general prison population as someone who had been through damaging early experiences. In his case, this had led to self medication through alcohol and heroin. He was struggling to some extent after detoxification in prison as he was now faced with the re-emergence of painful memories leading to flashbacks and interrupted nights.

67. The psychiatrist was aware of the difficulties facing him and assessed him as needing treatment by agreeing to resume the prescription for Chlorpromazine. His clinical opinion was that his condition was better served by different medication but because he asked specifically for a drug he felt more comfortable with, the doctor thought it was important to adhere to his request. The problems that he had sleeping were a key factor as Chlorpromazine has a sedative effect. The psychiatrist did not think that he was clinically depressed and did not, therefore, refer him for further assessment or treatment. He asked him on both occasions when they met whether he had suicidal thoughts and was convinced by his replies that he was not thinking in this way.

68. He also had significant contact with his CARATS worker. Again, she never felt that he was at risk of taking his life. She has been trained to open the ACCT procedures and has done so in the past when concerned about a prisoner. He, although clearly troubled, did not cause her this level of concern. She felt he was focused on the future and was able to manage his anxiety.

69. Although it seems that he shared some of his personal and intimate worries with a number of people in the prison, it does not seem that he shared everything with any one person. His friend and cellmate knew about his early abuse, that someone had died recently and that he was concerned about being convicted. He did not seem to know about his dilemma about his sexuality. Similarly, this was an aspect of his distress that he chose not to share with the psychiatrist or his CARATS worker, the professionals he confided in most. It seems that the only recipient of this last piece of information was Prisoner B in the final week of his life.

70. He also shared some of his distress with people outside prison. He wrote regularly to his mother and was candid about his frustrations about not getting the in-depth counselling he felt he needed for his problems. Although she worried about her son, his letters to his mother were quite varied in tone. In some, he came over as quite upbeat and almost optimistic about his future and at other times he appeared very down in mood. It was hard, therefore, for her to form a clear picture of what was happening. His death was a terrible shock for her as she had no indication that he intended to act in this way.

71. He discussed his symptoms of PTSD and anxiety with the probation officer who interviewed him on 23 March for a pre-sentence report for court. He disclosed, however, that he was receiving medication for anxiety and saw the anticipated custodial sentence as an opportunity to get the therapy he needed. Indeed, he thought he would have a better chance of receiving the right intervention in prison rather than in the community where resources were less accessible. She was clear in her assessment of risk of serious harm in her report that:

> "Probation records indicate that he has suffered depression in the past but he disclosed no such feelings now. He discloses no history of self-harm or

suicide attempts. He is therefore not considered to pose a risk of harm to himself."

72. He was also visited by police officers and his solicitors on various occasions. Again, none of these professionals passed on any concerns about him to prison staff.

73. A number of professionals identified that he was suffering with depression and struggling with the after effects of withdrawing from drugs. However, he was not assessed as at risk of suicide which, without the benefit if hindsight, I am satisfied was a reasonable assessment given his denial that he was thinking about harming himself.

Opportunities to meet mental health staff

74. The psychiatrist did not refer him to the mental health in-reach team mainly because he did not think he had a severe mental illness and that he would not have benefited from such a referral. It is clear that there were plans for a new integrated team of healthcare staff at Cardiff although these seem to have stalled partly by the illness of key personnel. It is likely that he would probably have been referred to the team if it had been in existence. In interview with my investigators, the psychiatrist acknowledged the problems for mental health interventions caused by long term staff sickness. How effective such a referral would have been in preventing his death, however, cannot be known. Even though the doctor referred him to a psychotherapist, he would have still had to spend much of his time in his cell without access to appropriate counselling.

Counselling at Cardiff

75. He had found counselling received in 2008 on a previous sentence and at another prison (Parc) a great help and was actively seeking this route to tackle his problems again. Unfortunately, there was no specific service of this kind at Cardiff at this time. He appeared to have accepted this with good grace and patience. The clinical review draws the conclusion that his medical records should have been accessed from Parc. However, obtaining medical notes from previous prison sentences is not routinely carried out across the prison estate and therefore not a criticism which can fairly be lodged at Cardiff.

76. He knew that he had been referred to a psychotherapist by the psychiatrist but also understood that she only had a limited appointment capacity and there was a long waiting list.

77. Sadly, the psychotherapist told my investigators that she would first have been able to offer him an appointment on Tuesday 13 April when a vacancy occurred. It is not her usual practice to let prisoners know in advance of an appointment as disappointments can arise if, for any reason, it is not possible to go ahead. He would not have known, therefore, that an appointment for

counselling was so close. The psychiatrist would also not have known of this appointment when he met him on 6 April.

78. The clinical review made the following recommendation with regard informing prisoners about appointments.

The Head of Healthcare should ensure that prisoners and relevant staff (including other healthcare professionals) are given reasonable advance notice of forthcoming appointments with healthcare professionals.

79. He was also meeting with his CARATS worker and it is clear from her record of the meetings and her interview with investigators that, whilst anxious to have counselling, he appreciated that there would be a wait before he could begin. She offered to refer him to a bereavement counsellor who would speak to him more generally but he said he was happy to wait for his referral through the mental health team.

80. Provision for counselling at Cardiff had apparently been reduced in the year prior to his death. The psychiatrist showed my investigators a paper for internal circulation which he prepared in May 2009 and outlined gaps in mental health provision, including counselling to support distressed prisoners. He emphasised in interview, however, that he could not say if earlier contact with a trained counsellor could have prevented him from taking his life. The chance to share some of the burden of his distressing thoughts, however, may have given him more peace of mind as he waited to transfer to Parc.

81. Across the prison estate, access to counselling is highly varied. Clear referral processes and support operate for those with enduring mental health problems via the mental health in-reach team. However, for a prisoner presenting with difficulties like his, the opportunities are patchy. Therefore, I am not minded to make a recommendation but urge the Governor to assure himself that the provision of counselling is the best that it can be with the staff and resources available.

82. The clinical review has reached a different conclusion assessing that the delays he encountered in accessing appropriate healthcare professionals cannot be regarded as good practice. I do not share this view and believe that his access to professionals compares favourably to that which is expected in the community.

The impact of appearing at an inquest

83. When he was first remanded into custody, it was under the shadow of being investigated for supplying the death of a fellow resident at the YMCA. That this weighed heavily on his mind in the early months of his time in prison is confirmed by letters to his mother, the testimony of his friend Prisoner A and various remarks to prison staff. The possibility that he would be criminally charged in connection with this death, however, had receded by the time of his own death.

84. In his interview with the probation officer, he did not appear to be unduly affected by guilt about the overdose. He had denied direct involvement and apparently saw his own activities supplying heroin to other users as a pragmatic way of funding his own use.

85. My investigators were informed that he would have been called to the inquest into the death of the hostel resident which was to be held on 16 April. (The date had been changed from 31 March as this coincided with his original sentencing date at the Crown Court.) It could not be established whether he knew this as no official documentation was found in his cell. Prison staff would not have known either for security reasons as they would normally only have been told to produce him on the day of the hearing. He did not mention that he was worried about attending the inquest in the days before he died. It is not possible, therefore, to conclude one way or the other if his state of mind was influenced by the prospect of attending the inquest.

Personal officer scheme

86. The success of the personal officer scheme (each prisoner has a named officer who they see on a regular basis) at Cardiff depends on staff having time to develop positive connections with the prisoners in their care. When he was on F wing it would seem that he appreciated the support from the working relationship forged with his personal officer there. He was not able to stay on this wing once he was convicted and had to transfer to B wing. Unfortunately, he had not been on this wing long enough to form supportive relationships with staff before his last weekend when he was apparently very troubled.

87. I do not believe that any fault should be directed to the officers on B4 landing. Both officers on duty when he died were highly experienced with many years service between them. Officer A spoke eloquently in interview about the hectic demands of dealing with the 46 to 48 prisoners on B4 around that time, which is typical of the pressures in all local prisons. Although he was aware later that he was designated as his personal officer, there had been no time for him to get to know him and build up a professional rapport. Similarly, Officer B described the morning of his death as extremely busy with many competing demands on the two officers. Apart from the usual duties, another prisoner had collapsed and needed medical attention and a particularly difficult individual was demanding attention from officers.

88. The last HMCIP report encouraged more attention to be given to the personal officer scheme. That this has happened to some extent is perhaps illustrated by the quality of the relationship apparently established between him and his personal officer on F wing. Prisoners on B wing told the investigation team that staff were approachable and they would have spoken to them about any concerns relating to him. It is regrettable that he did not have enough time on B wing to establish a similarly positive relationship with his personal officer on that wing.

Concerns raised by the man's family

The family questioned why the prison did not appropriately address his mental health needs despite making staff aware of them

89. It is clear that he disclosed the nature of his problems to a number of prison and medical staff. After his arrival at Cardiff, he was referred to a consultant psychiatrist and seen within five weeks of this referral. As a non-urgent referral, the time between the referral and assessment is in line with community mental health services.

90. Following his mental health assessment, he was not considered to be mentally ill and his symptoms of PTSD were addressed through medication and a referral for non-specific counselling from a part time psychotherapist with a long waiting list. He himself put much of his faith in the prospect of counselling when he transferred to Parc after sentencing. It is unfortunate that this facility was not available at Cardiff. It is not possible to know that whether the intervention would have prevented his death.

He had told his mother that the prison had stopped the medication he had been prescribed by his doctor in the community to manage his mental health problems. She questioned the reasons for this

91. The decision to stop prescribing Chlorpromazine to him, as had been the case in the community, was made after a mental health assessment by a consultant psychiatrist. He explained to my investigation team that he was concerned about the long term physical side effects of the medication. The man agreed to this medical advice and Citalopram, an anti-depressant, was prescribed instead. When he complained that he felt worse taking this drug, the doctor agreed to resume the Chlorpromazine.

His mother was aware of her son's mental suffering at the time of his death and she felt there was a possibility that he may have been hearing voices. She wanted to know if there is any evidence of this uncovered by the investigation

92. There is no evidence that he was hearing voices at the time of his death. He never described this symptom to anyone else although he had a number of opportunities to do so. His mental health was assessed and reviewed by a psychiatrist, who did not record the symptom. The last time he saw him was six days before he died and there was no mention at all of voices. He had not been reluctant to share his symptoms previously and there is no reason to think he would have done on this occasion.

93. Similarly, although Prisoner B had a lot to say about matters discussed between himself and the man during the time they shared a cell, he did not mention hearing voices.

His uncle asked if there had been any concerns about the relationship with his cellmate

94. The investigation has found no evidence of worrying behaviour towards the man from his last cellmate. Staff had assessed both men as suitable to share a cell and there were no concerns expressed either before or after his death. The prisoner appears to have listened to and comforted him when he disclosed intimate details about his problems. His response to finding him was swift and appropriate, as were his actions in helping officers to release the ligature.

CONCLUSION

95. Regrettably, it is not always possible to prevent someone taking their own life. Although the man shared his emotional distress with a number of people during his time in prison, he never disclosed that he felt so bad that he would harm himself. There was no occasion, therefore, when staff or other prisoner was sufficiently concerned about his welfare to open the suicide monitoring procedures or alert anyone else to his vulnerability.

96. When asked specifically by medical and other prison staff, he always denied that he was at risk. Crucially, he expressed his distress in a mostly rational and reasonable way. He was rarely disruptive or demanding and it was only too easy for him to be seen as quiet and unproblematic. He had only recently arrived on a busy wing and there had been no time for staff to get to know him enough to gauge whether his behaviour was unusual or worrying.

97. His cellmate's account of his last weekend and his emotionally fraught state suggests that he was struggling. Prisoner A, however, did not recognise that he was so vulnerable. He chose not to disclose the intensity of his feelings to anyone else at that time and certainly did not signal that he intended to take his own life.

98. Although I recommend improvements to blood pressure monitoring, arrangements for healthcare appointments and record keeping, I do not believe that they had a bearing on his decision to end his life.

RECOMMENDATIONS

1. The frequency of blood pressure monitoring should be clearly stated within the plan of care to ensure that prisoners are monitored correctly, and according to assessed need whilst undergoing detoxification.

The recommendation was partially accepted.

The man's blood pressure is documented within the clinical record as follows:

- *9 December 2010 in Reception (110/64)*
- *10 December 2010 on the Clinical Detoxification Prescription Sheet (123/79)*
- *11 December 2010 (119/84)*
- *14 December 2010 (117/73)*

It is accepted that the frequency of blood pressure monitoring should be clearly stated in the care plan.

2. The Head of Healthcare should ensure that all records containing information relevant to prisoners' health are maintained in accordance with professional standards, e.g. as stated in the NMC Record Keeping: Guidance for Nurses and Midwives (2009).

The recommendation was accepted.

Management checks will take place at frequent intervals with feedback to individuals to ensure standards are maintained.

3. The Head of Healthcare should ensure that prisoners and relevant staff (including other healthcare professionals) are given reasonable advance notice of forthcoming appointments with healthcare professionals.

The recommendation was partially accepted.

This would be very difficult to achieve as the Head of Healthcare does not manage all the healthcare agencies within the prison. In the case of the man the counselling clinic list is kept by a Clinical Psychotherapist employed by Cardiff and Vale NHS Trust. It is not her usual practice to let prisoners know in advance of an appointment as she is of the view that disappointment can arise. There are also some security reasons why it is sometimes not appropriate to inform a prisoner of appointments with a healthcare professional. The decision will be made on individual risk assessment.