Investigation into the circumstances surrounding the death of a man at HMP Swansea in May 2009

Report by the Prisons and Probation Ombudsman for England and Wales

September 2010

This is the report of an investigation into the circumstances of the death of a man who died at HMP Swansea in May 2009. The man was found hanging in his cell approximately nine hours after arriving at the prison. He was 21 years old. I would like to offer my personal condolences to the man's family and to all of those touched by his death.

The investigation was undertaken by two of my colleagues. Both they and I would like to thank the management and staff at Swansea prison for their cooperation during the course of our inquiries. I am also grateful to the Healthcare Inspectorate of Wales for the review of the man's medical care whilst he was in prison.

The consultation period was extended to allow the man's family time to consider the draft report and provide their comments. These have been incorporated into this final report. It has taken longer than normal to issue this final report, for which I apologise.

The man who is the subject of this report had been in police custody prior to his arrival at Swansea. Whilst there he had torn strips from a bed sheet, and tried to strangle himself. This information was not passed onto prison staff save for ticks on the PER, and this matter has been subject to a separate investigation by the Independent Police Complaints Commission (IPCC).

Despite his behaviour in the police station, the man did not appear to be at risk of harming himself while at Swansea. I believe that, had staff been aware of the man's actions, his time at Swansea could well have been managed very differently. I am concerned that the first night health screening process was not completed satisfactorily and that the man, in the opinion of the clinical reviewer, should have been offered assistance to manage his withdrawal from drugs during his first night. I make eight recommendations in total.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **September 2010**

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SUMMARY

The man who died was arrested by South Wales Police on Friday 8 May 2009. The man was charged with a number of offences, and was held in police custody over the weekend of 9 and 10 May. He was initially taken to hospital as he was withdrawing from drugs. The man admitted a number of offences, some of which were more serious than those for which he was arrested.

The man attempted to strangle himself whilst he was in the police station and the Independent Police Complaints Commission (IPCC) is investigating the period the man spent in police custody. This act was not noted on the paperwork designed to inform those responsible for the man as he was transferred from police to prison custody. On the eve of the man's death, he was remanded into custody and transferred to Swansea Prison. Staff at the prison were not aware that the man had harmed himself at the police station. The man had been in Swansea prison for a short time earlier in the year.

Reception and first night centre staff at Swansea prison talked to the man. His demeanour, overall behaviour and willingness to talk to both staff and other prisoners led staff to believe that the man was settling in well and did not pose a risk to himself. The man was put into a single cell as he expressed unhappiness to staff at the prospect of sharing a cell with another prisoner. No concerns (other than an enquiry about medication) were raised by the man until he was found hanging in his cell at 1.40am. Staff arrived quickly and cardio pulmonary resuscitation (CPR) was attempted. However, the man was declared dead at 2.12am.

I make eight recommendations. They include the need for staff to ask escort staff for further information, the requirement for documentation to be correctly completed, the need for substance withdrawal to be appropriately managed and for prison and healthcare staff to undertake refresher training in resuscitation techniques.

THE INVESTIGATION PROCESS

1. My colleague led the investigation assisted by a further colleague of mine. On their initial visit to the prison, my colleagues met the Deputy Governor and representatives of the Independent Monitoring Board. My colleagues were shown the induction wing and the man's cell. Notices had already been issued to prisoners and staff to alert them to the investigation. No-one came forward in response to the notices.

2. My colleague wrote to Healthcare Inspectorate Wales to request a clinical review of the care the man received while in prison custody. A clinical reviewer conducted the clinical review. The clinical reviewer was provided with all of the relevant documentation and transcripts of the interviews in order to assist in her report. The clinical reviewer left her post with NHS Wales in September 2009 and responsibility for finishing the man's review was passed to the Inspections Manager at Healthcare Inspectorate Wales.

3. My colleague and one of the Ombudsman's family liaison officers visited the man's family to discuss the investigation and any issues or concerns they had. The family were concerned as to whether the man had been identified as being at risk and, if he had, what monitoring he was subject to. The family also wanted to know why the man had been checked at 1.40am, how he was found and what position he was found in. These points are answered in the report. The man's family's legal representatives later wrote to the office to raise further issues relating to the investigation.

4. The Independent Police Complaints Commission (IPCC) provided a copy of the statement given to them by an officer from Reliance Custody Services (a private company responsible for escorting prisoners) who, in turn, gave permission for his statement to be referred to in this report. The Ombudsman's investigators also reviewed the man's records from his previous sentence at Swansea.

5. The investigators conducted interviews with prison staff and prisoners on 14 and 15 July. Following these interviews, they requested further information from the prison on a number of occasions in order to answer questions raised by the man's family.

6. The draft report took longer to publish than we would have liked, and I regret the delay. Some of this was due to the complexity of the investigation, and some of it was caused by the investigators ensuring that they answered the issues raised by the man's family. The consultation period following the draft report was extended to allow the man's family further time to consider their comments. Their comments have been answered in this report, or replied to separately. There was a further delay in finalising this report and I apologise for any inconvenience.

HMP SWANSEA

7. The prison was built in 1861. It is a category B prison that holds both convicted and unconvicted men aged 21 and over. In the first quarter 2009-10 National Offender Management Service quarterly performance review Swansea prison is assessed as achieving good performance.

8. The prison has an operational capacity of 422 prisoners. Swansea started the Samaritan trained prisoner Listener scheme in the early 1980's, which has gone on to become a national initiative across the prison estate.

9. B wing is the induction wing where prisoners live for the initial period of their custody.

HM Chief Inspector of Prisons

10. HM Chief Inspector of Prisons last conducted a full inspection of Swansea in April 2005. There was also an unannounced follow-up inspection in February 2008. In her 2008 report she considered Swansea to be a generally safe prison which had made noticeable improvements in managing activities despite its limited space.

11. The report described the prison as clean but overcrowded with shared single cells, having unscreened toilets and insufficient showers. It also commented on good prisoner-staff relations and, whilst positive interactions were commented on, the report also noted weaknesses in the oversight of bullying and suicide prevention.

12. Although the prison has no dedicated detoxification wing, drug use was described as relatively low for a local prison. The report also commented on the introduction of courses aimed specifically at drug users such as the Short Duration Programme.

Independent Monitoring Board

13. Each prison in England and Wales has an Independent Monitoring Board (IMB). The Board consists of members of the local community who have full access to prisoners and all areas of the prison. IMB members undertake a variety of activities in prison including the consideration of complaints made by prisoners, visits to individual prisoners, reporting on the condition of the prison and examining the treatment prisoners receive in healthcare. Each IMB produces an annual report. The last available report on Swansea was published in 2008.

14. The report commented on Swansea's "true community feel … where respect for individuals is paramount and relationships between staff and prisoners are at the heart of this".

15. The IMB commented on the healthcare department's objectives which include the delivery of timely comprehensive assessment and evidence based

practice and the promotion of effective links with health related services in the community, to ensure continuity of care as appropriate. Reference is also made to the intention to deliver "more holistic substance misuse services".

Assessment, Care in custody and Teamwork (ACCT)

16. Assessment, Care in Custody and Treatment (ACCT) is a care planning tool used by the Prison Service to help support and monitor those prisoners identified as being at risk of suicide or self harm. The ACCT process encourages staff to work together to provide individual care to prisoners in distress and help to diffuse circumstances where self harm or suicide may occur.

17. The investigators asked prison staff about the training provided in ACCT. They were told by an officer that it is provided yearly to staff. A further officer said that he was a tutor in ACCT procedures. He explained that in the autumn of 2008 he had updated all of the reception and induction unit on ACCT training.

Prisoner Escort Record

18. The Prisoner Escort Record (PER) is a document which is individual to each prisoner held in custody by the police, escort services and the prison service. It is a standard form agreed by all the agencies involved in the management of the transfer of prisoners. It is a record of the external movements of each individual prisoner between these different agencies. In this man's case, the PER recorded his movements between South Wales Police, Reliance custody services and Swansea prison.

Previous deaths at Swansea

19. Since this office assumed responsibility for the investigation of deaths in prisons in 2004, Swansea has experienced four other self-inflicted deaths. A colleague's investigation into the death of a man in 2007, also by hanging, highlighted some similarities to this man's case. He also died shortly after arriving at Swansea. In particular one recommendation from that report is relevant:

The Governor should ensure adequate systems are in place to ensure important information from the PER form is communicated to staff responsible for the prisoner concerned, in particular healthcare staff.

KEY FINDINGS

20. The man who is the subject of this report was born in August 1987. He told a probation officer in 2006 that he had been taking heroin since he was 15 and had continued to use heroin, cocaine and Valium since then. The man's remand in May was his second experience of Swansea prison in 2009. He had served a short prison sentence there between February and March. He did not harm himself during that sentence, and was not subject to ACCT procedures.

21. The man's father said that, although he was involved in drugs, there were times when his son had tried very hard to get well. The investigators were also told that, despite the problems he faced, the man maintained close family contact and was described as having a good sense of humour and "not an ounce of aggression in him". He was a keen Swansea City football supporter.

22. The man's family told the family liaison officer that they would often be relieved when he went into prison because they knew where he was. They felt that he would be safe in prison and would look much better upon release. The man's family said that they had hoped that he would receive treatment for his drug addiction problems, as he had during his previous time at HMP Swansea.

23. The man was arrested by South Wales Police in the afternoon of 8 May 2009. He was taken to Swansea Police Station where officers became concerned for him as he appeared drowsy. The man told officers he had used a "£10 bag" of heroin just before being arrested. This prompted them to seek medical advice and he was taken to hospital. He was kept under observation for approximately six hours, following which he was deemed to be fit for detention and taken back to the police station.

24. The man was charged with Going Equipped for Theft. He also admitted to a number of other offences.

25. Due to the time spent in hospital, it was too late for the man to attend a magistrates' court that day. He was held at Swansea Police Custody suite throughout the weekend of 9 and 10 of May.

26. On the evening of 9 May, the man was recorded on CCTV tearing strips from his bed sheet and wrapping them around his neck. He then attempted to strangle himself. Custody staff entered the cell and intervened. He was prescribed codeine (a pain-killer), amitriptyline (an anti-depressant) and temazepam (to help him sleep).

27. On the front page of the Prisoner Escort Record (PER) it was written that the man was received into the custody of Reliance Custody Services (RCS) at 7.30am on the eve of the man's death. This information is in fact incorrect. Page two of the PER shows that the man was actually received into RCS custody at approximately 10.25am by a different officer. I understand that the

delay in handover was caused by conversations the police were having with the Crown Prosecution Service.

28. No records were provided to RCS that mentioned the man's attempt to strangle himself whilst in police custody, other than a tick in the suicide/self-harm tick-box on the PER. The officer from RCS also noted that he was not told anything about the man's actions. In his statement, the officer commented:

> "The Prisoner Escort Record (PER) form that accompanies the prisoner from police custody to the courts can often be misleading as regards the warning marker tick boxes. If the suicide/self harm or other marker boxes are ticked, these can often refer to incidents that have happened a long time ago. If there had been an incident that had occurred recently … I would expect there to be more information on the PER form."

29. Once in the custody of RCS, the man was searched and given refreshments. He was checked by RCS staff prior to seeing his solicitor and was taken before the magistrates at 12.33pm. He was remanded into custody to crown court and his next appearance was scheduled for 8 June.

30. The PER shows that the man arrived at HMP Swansea at 4.35pm. While waiting to be formally inducted into the prison, the man was heard by other prisoners to say that he had harmed himself whilst in police custody. He told the prisoners that this was done in an attempt to get more medication. Staff at Swansea were not told of this conversation by prisoners before the man died.

31. The man was allocated his prison number and had a jovial exchange with an Operational Support Grade (OSG) regarding the man's Swansea City football shirt. The OSG recalled the man as being in good spirits.

32. The cell sharing risk assessment (CSRA) was started as part of the normal reception process. An officer told the investigators that the man was in a buoyant mood when interviewed, and raised no concerns other than his drug problem. When the investigators read the CSRA during the investigation it contained notes stating: "PER warning; suicidal and drug and alcohol issues" and "abuse all drugs" although the comments were undated. Section two of the CSRA also confirmed that the man abused drugs and was dependant on drugs or alcohol.

33. The man was seen by a nurse for the medical section of the CSRA and for his initial health screen. The nurse told the investigators that he had met the man before and he remembered him from his previous prison sentence. The nurse remembered asking the man directly if he had any thoughts or intentions of self harm. He confirmed that the man had replied 'no' to this question. The nurse told the investigators that the suicide warning was not on the CSRA when he completed his section. He also said that he had not seen the PER.

34. The nurse said that a drugs test was completed on the man's urine which tested positive for Subutex (a controlled drug prescribed to counter the effects of opiate withdrawal), opiates and benzodiazepines. He said that the man had seemed fine and did not appear to be withdrawing from drugs. The nurse spent "quite a bit of time with him" undertaking the assessment, although the initial health screen form was not fully completed. The disclosure consent form and healthcare medication compact were also not completed.

35. The nurse described the man as:

> "talkative … with good eye contact … good communication was maintained throughout the interview … he was in a good mood; he was, you know … talking properly."

36. The nurse said that the man asked "will I have anything?" referring to medication. The nurse responded by offering metoclopramide (an anti-nausea treatment) and quinine (an anti-cramping medication). In his statement the nurse said that the man declined the offer of this medication stating that he was fine and did not need anything at the time. The nurse went on to say that there were nurses on night duty who could respond to the man if he felt he needed the medication.

37. The nurse also clarified to the investigators that no doctors were available in the prison overnight, however there was an emergency out of hours service. He went to say that there was a GP service available during the day. Although the health screen document is incomplete, the nurse said that the man would have seen the doctor the next day. The doctor would then assess him and consider the need for any further treatment. This could include the prescription of a detoxification regime.

38. Following his health screen interview, the man went to the induction unit on B wing at approximately 6.45pm. The man was provided with a first night pack containing basic toiletries, including a Bic safety razor.

39. Further work on the induction process was carried out by the officer who completed the induction paperwork, who noted that the man was familiar with Swansea prison having served a short custodial sentence there in February and March. He remembered the man from that sentence and told my colleagues that he was "jovial and relaxed" and "we shared a [football] joke about the Swans and Cardiff making play-offs". The officer said that he had not at that point seen the PER but was aware of the self-harm/suicide references on the CSRA. He also confirmed that the CSRA warning would ensure that he would seriously address self harm and suicide with all prisoners whose documentation carried this warning. He said that the man showed him where he had injected into his arms and he had also looked for evidence of self-harm scars but could see none.

40. The officer said that whilst he was completing the induction paperwork he addressed the issue of self-harm directly with the man. The officer said that

he referred to the CSRA form, which had the reference to the PER suicide warning on it. He told the investigators:

> "I asked him about suicide, he said he didn't know anything about it. And I asked him had he attempted self-harm or suicide of any note and he categorically said no and his words to me were 'no boss, never have and I never will."

41. The officer summarised on the form: "has previous experience of Swansea. Has severe drug problem. No self harm issues. Should settle quickly once over his drug issues".

42. The man was initially allocated a double cell with another prisoner. The officer who is a tutor in ACCT procedures told the investigators that, once the man became aware of who he was going to share a cell with, he specifically requested not to share with that particular prisoner. The man had told the officer who had completed the induction paperwork that the prisoner was "a bit of a tramp". The officer replied "that's fine; we will have a look now and see what spaces we've got". My colleagues were told that there were no other double cells available. The officer who had completed the induction paperwork said that he asked the man directly if he would be alright on his own to which he replied "Yes, fine boss". During his interview, the officer who is a tutor in ACCT procedures said that he repeated the same question of the man and the man gave the same response, "Yes that's fine boss". The man was allocated single cell B3-2.

43. The man took part in the association period and was seen playing pool and talking to other prisoners. During association, the officer who had completed the induction paperwork allowed the man to make a telephone call from the wing office to let his partner know that he was in custody. The officer who is a tutor in ACCT procedures told the investigators that, during this telephone call, he heard the man ask his partner to visit him and send in some money. There was nothing in the telephone call that concerned the officer about the man's welfare.

44. The officer who is a tutor in ACCT procedures told the investigators that the man approached him at the end of association, "asking about some medication that the nurse in reception told him he would sort out". The officer telephoned the nurse who saw the man for the medical section of the CSRA to ask about the medication. The nurse told the investigators that the officer asked him if the man was able to have Valium (Diazepam). The nurse said that in his opinion Valium was not required. The nurse confirmed to my colleagues that, had the man asked for the metoclopramide and quinine, this could have been provided.

45. However, the officer who is a tutor in ACCT procedures remembered the conversation differently. He said that he discussed with the nurse medication the man had been given by a police doctor and that the nurse said he could not offer anything else. Despite this uncertainty, the two members of staff agree that the man was not given any further medication.

46. The officer who is a tutor in ACCT procedures went back to the man who was in his cell and told him that the nurse who saw the man for the medical section of the CSRA was unable to give him anything until he saw the doctor in the morning. The officer told my colleagues that the man's response was "Ok, [officer] that's fine, thank you very much". The man showed no signs of distress at this decision.

47. The officers on night duty were responsible for a roll check at the start and end of their shift. They were required to look in each cell and verify the numbers of prisoners on their wing(s). They were also required to undertake 'pegging' which involved walking to certain pegging points each hour. It should be noted that pegging does not require the staff to look in any cells or check on any prisoners. The man was not receiving Assessment, Care in Custody and Teamwork (ACCT) monitoring checks, and so would not have been checked anymore than any other prisoners. Prisoners on the induction wing do not receive more checks than those on regular wings.

48. At 9.05pm, an officer undertook the roll check. He noticed that the lights were on in the man's cell and, on reaching the cell, saw him writing at his desk.

49. At 9.50pm, staff noticed a discrepancy with the roll check numbers. During interview, the officer who undertook the roll check at 9.05 pm told the investigators that he and a fellow officer immediately checked the cells again. On the wing cell occupancy printout the man's cell had two prisoners recorded as being present and this caused the anomaly in the numbers. Having checked the cells, the officers clarified that the man was the only occupant of cell B3-2. The officer who undertook the roll check at 9.05 pm looked into the cell and told the investigators that, although the lights were off, the television was on and he saw the man moving.

50. At approximately 1.40am the fellow officer noticed a light on in the man's cell. He opened the cell flap and saw the man hanging from the cell window. The officer saw that the man had tied a green sheet to the bars on the window and "made a noose around his neck". He also said that the man's feet were obscured by the toilet seat. It appears that there was some blood on the floor of the cell, apparently caused by cuts the man had made to his arm. Police later removed a broken razor blade from the cell.

51. The officer who had opened the cell flap and saw the man hanging immediately radioed and called for help. He was joined by the Night Orderly Officer, Senior Officer (SO) and a further officer. This happened very quickly as the Night Orderly Officer described himself as "within sort of yards" to the officer who had opened the cell flap and saw the man hanging. He explained the process of opening the cell door to my colleagues:

> "[The officer] was attempting to open his sealed pack to open the door but I said get out of the way because it was quicker, I had the bunch [of keys] in my hand, and I opened the cell straightaway because obviously time is of the essence."

52. Once the cell door was open the Nightly Orderly Officer lifted the man up to take the weight off the ligature. The officer who had opened the cell flap and saw the man hanging cut the ligature using his anti-ligature knife and started cardio pulmonary resuscitation (CPR). A staff nurse arrived at the cell. During interview, the staff nurse said that she moved a chair out the cell and instructed the Night Orderly Officer to call for an ambulance. She then began CPR. (Although there was a defibrillator close by, it was not brought to the cell. A defibrillator is a device that can restart the heart by giving it an electric shock. It cannot always be used and can only provide a shock if there is sufficient electrical activity in the heart.)

53. The paramedics arrived at 1.55am. They took over CPR and used their defibrillator on the man. The staff nurse told the investigators that she thought that it was used to shock the man. Despite these efforts, the man was pronounced dead at 2.12am.

54. Following the man's death, the police attended the prison in accordance with usual protocol. There was some confusion amongst the prison staff about who was to break the news to the man's family. Although the deputy governor was keen for the usual prison contingency plan to be put into action, the news of the man's death was broken to his family by South Wales Police. Swansea prison appointed a principal officer as the Family Liaison Officer. The family were visited by the Governor and the prison chaplain on the day of the man's death.

55. Three letters were found in the man's cell. One was addressed to his mother. The man started the letter referring to his arrest and time at Swansea police station. He wrote "my life is not worth anything … no respect for myself and no one has respect for me". The man also wrote that he was depressed and "I might as well get it over with but I'm afraid you would do the same". Later in the letter, the man started to make some plans for the future by asking his mother for some money and finished the letter by saying he had put his mother's name on the visiting order he had sent to his girlfriend. The remaining letters were written to his girlfriend and to a friend. He asked for some money to be sent in to him as well as some photographs. There was also a note, possibly addressed to his girlfriend, in which the man wrote "its not that I can't cope with jail it's my life" and "I'll watch over you".

56. Prisoners located on the man's wing learned of his death from officers. One prisoner who was situated in an adjacent cell was interviewed by the investigators. This prisoner, who was subject to ACCT monitoring procedures at the time of the man's death, praised Swansea prison staff for their caring approach to him at a time when he was particularly vulnerable. I was pleased to hear of this.

57. The Deputy Governor and Governor both came into the prison immediately following the man's death and supported the staff. Although there was no formal debrief in the hours following the man's death, it is clear that staff who attended to the man were supported as a group and individually. A

notification was placed in the staff entrance to the prison to alert officers to the man's death reporting for duty the next day. On 26 May, the National Offender Management Service (NOMS) employee support team organised a formal debrief at the prison.

ISSUES

Deciding whether to open an ACCT plan

58. Annexe 3B of Prison Service Order 2700 (Suicide Prevention and Self-Harm Management) says:

> "If prisoner has self-harmed whilst under escort supervision, at court, in transit, or while in Police or other custody, then the reception healthcare screener (or nearest reception staff equivalent if no Healthcare presence) will open an ACCT Plan."

59. An ACCT was not opened for this man. It is, therefore, essential to consider why the Swansea prison staff did not undertake this task, and whether this was reasonable. As I have said, the man did harm himself whilst he was in police custody, but regrettably the information was not described on his PER although the self-harm/suicide box was ticked.

The response to the ticked box on the PER

60. PSO 2700 states:

> "When receiving a prisoner with a Suicide/Self-Harm Warning Form, an open ACCT Plan, or a Prisoner Escort Record with the suicide/self-harm warning box ticked, if the reasons for the concern are not clearly documented the Reception Officer should be asking for a verbal handover (i.e. a further explanation)."

61. It is not clear if any of the reception staff asked the RCS escort staff about the tick on the PER. However, as has become clear, even if they had done so they would not have received any information from the RCS staff about the man's actions in police custody. Since the escort staff had not been given any information (written or verbal) from the police, they would not have had any to pass to reception staff. An officer from RCS who received the man into custody explained in his statement that, as he was not given any information from the police, he deemed the tick to relate to historical information. PSO 2700 says:

> "When receiving a prisoner with a Suicide/Self-Harm Warning Form, an open ACCT Plan, or a Prisoner Escort Record with the suicide/self-harm warning box ticked, if the reasons for the concern are not clearly documented the Reception Officer should be asking for a verbal handover (i.e. a further explanation)."

62. It requires staff to request a verbal handover from the escorting staff but does not mention asking the other services involved, such as the police, for such information. It is the responsibility of the police to share such information, and their failure to do so is subject to a separate investigation. However, it would clearly be good practice for staff to contact other agencies in such situations, and should be encouraged where possible. Therefore, with reference to PSO 2700, I recommend:

The Governor should remind reception staff of the requirement to ask escort staff about any ticks relating to risks on the Prisoner Escort Record.

63. Although, it is clear that RCS gave Swansea no further information, reception staff still had a responsibility to further consider the implication of the tick. Prison Service Order 1025 (Communicating information about risks on escort or transfer - The prisoner escort record) instructs escort and prison staff:

> "If a prisoner is received from the police with this box [suicide/self-harm] ticked staff must establish whether the risk is current or past."

64. The PER that arrived at Swansea prison did have the 'suicide/self-harm' box ticked, but no further information was provided. The investigators were told by prison staff that a tick by the self-harm/suicide box with no additional information would not necessarily be assumed to be a current risk. The officer who completed the man's induction paperwork said that such warnings can be "old markers … sometimes they [prisoners] don't know anything about it". However, as the PSO makes clear, staff had to ascertain whether the risk was current.

65. Swansea staff did explore self harm and suicide issues with the man as a result of the information on the PER. His presentation and demeanour in interview with prison staff was such that he was assessed not to be at risk of suicide or self-harm. The officer who completed the man's induction paperwork stated to the investigator:

> "I asked him about the suicide [tick], he said he didn't know anything about it. And I asked him had he attempted self-harm or suicide of any note and he categorically said no and his words to me were 'no boss, never have and I never will'."

66. Swansea staff attempted to find out from the man whether the risk was current or past, he assured them that he had never thought of suicide or self harm and never would. As noted earlier, it would have been good practice for staff to have sought further information on this tick from the police.

Other information omitted from the PER

67. Another factor related to the judgment about the risk is the lack of further information provided on the PER. PSO 1025 states that those ticking the boxes on the PER are required to provide further information:

> *"Any warning boxes that are ticked in Section 4 must be supported by further information in this section unless an additional report is attached.* This box should also be used to indicate any special care to be taken by receiving authorities, including the need for further attention by professional medical staff."

68. No further information was written on the PER by the police and no verbal information was passed to the escort service. When the man arrived at Swansea, the tick was the only reference to suicide and self-harm on the form.

69. The Ombudsman's investigators were told that when the suicide/self harm box is ticked and no further explanation is recorded, this will often be interpreted as historical information. Staff told the investigators consistently that, if a serious attempt at self-harm had recently occurred in police custody, they would have expected further information on the PER. The officer who is a tutor in ACCT procedures stated:

> "I'd definitely expected that to be explaining more than a tick box on the PER from the escorting staff that had brought him in … If something happens whilst he's in custody, and he's made an attempt in custody, that should definitely be highlighted in Section 5 of the PER."

70. The lack of any further information, and the responses and attitude of the man, meant that the tick was deemed not to refer to a current risk.

71. PSO 1025 also states:

> "Staff should note that it is now a requirement to indicate both a current risk of suicide or self-harm and any known past risk. It is now however only a requirement that an F2052SH[1] is opened if there is a current risk."

72. The responses given by the man, and the lack of other information, show why staff did not deem the tick to be related to a current risk, and therefore explain why ACCT procedures were not begun. It is clearly highly regrettable that the police did not pass on specific information related to the self-harm the man committed while in their custody. However, it is not in the Ombudsman's remit to investigate the actions of the police, and I understand that the IPCC have conducted their own investigation into this.

73. I believe that prison staff took the tick seriously. Although some of the staff recalled the man from his previous sentence, it does not appear that their actions were overtly influenced by their memories of him. A note referring to the tick was written on the Cell Sharing Risk Assessment and all staff who came into contact with the man sought to establish the relevance of the tick. The man was consistently denied any knowledge of the reason for the tick,

[1] The F2052SH system was formerly the Prison Service's procedures for dealing with prisoners at risk of self-harm or suicide. It has now been replaced by the ACCT process.

and appeared to be stable, in relatively good spirits and not visibly suffering from drug withdrawal. He had a conversation on the telephone to his girlfriend which included reference to events and issues in the forthcoming days. If staff had been aware of such a recent and serious self harm had occurred so recently, it is reasonable to have expected the likely outcome to be that the man be placed under the ACCT monitoring procedures. The officer who completed the man's induction paperwork told the investigators:

> " … if it was marked up that he'd attempted suicide or self-harmed then an ACCT would have been opened."

74. However, the nurse who saw the man for the medical section of the CSRA said that, had he seen the PER when undertaking his conversation with the man,

> "I would have opened an ACCT straightaway."

75. This opinion of the nurse reflects the importance the judgement of staff plays in the protection of prisoners. Had the nurse seen the PER, he may have asked further questions of the man, and he might have decided to begin ACCT procedures. In a previous report on the death of a prisoner at Swansea, a recommendation was made regarding the importance of healthcare staff seeing information on the PER prior to the initial healthscreen interview. As this is the second time information sharing has been involved in a death in custody at Swansea, I would encourage the Governor to review their response to that recommendation.

76. While in hindsight, his stated decision to begin ACCT procedures would have been appropriate, I do not think that his colleagues acted unreasonably on the basis of the information they had at that time. An Annexe to PSO 2700 (Suicide Prevention and Self-Harm Management) includes the sentence:

> "In the event of any incident of self-harm, or whenever a member of staff believes a prisoner is at risk of suicide or self-harm, they must (where there is not one open already) open an ACCT Plan."

77. If ACCT monitoring procedures had been started staff would have decided how often he should be checked which could range from constant observation to three in 24 hours. The assessment interview which provides much of the information for the ACCT is required to be carried out within 24 hours. It should also be remembered that, unfortunately, although ACCT procedures are a huge asset in the effort to safeguard prisoners, they are not a guarantee of safety. The Ombudsman's office has, sadly, investigated the deaths of many prisoners who killed themselves while subject to ACCT monitoring procedures.

78. It is clear to me that the staff involved with this man's care did not believe him to be, at that time, at risk of suicide or self-harm. The limits of my remit prevent me from making a recommendation, but I would expect all of the agencies involved to ensure that crucial information such as this is always

shared in a timely and appropriate manner. The Governor will wish to discuss the report with the Chief Constable of Police.

The initial health screen

79. The man had a lengthy interview with the nurse who saw the man for the medical section of the CSRA, during reception. During his interview with the investigators, the nurse confirmed he had met the man before and remembered him from his previous sentence served in February and March.

80. When asked about why the health screen document was only half-completed, the nurse said that he began to interview the man with a new document but also requested the man's medical notes from his previous sentence. When they arrived, the nurse used the previous file as the basis for his interview. In doing so the nurse believed he had completed the right documents. When asked if it was possible that he had mixed the two sets of medical notes up he said:

> "That could be possible. I could have turned back to his old notes, gone through the questions and thought I'd ticked them … that's a possibility. I'll be honest with you; that could be a possibility. When I've opened up his notes … carried on with the interview process and thought I'd ticked the boxes."

81. The clinical reviewer commented that the result of the document being incomplete was that "we are not clear about his mental state or any risk assessments that might have been needed". It is clearly not acceptable for the initial health screen document to be partially completed. The initial health screen meeting is vital in ascertaining the immediate and ongoing health needs of a new prisoner. It was good practice that the nurse remembered the man, and requested the former documents from the healthcare unit. However, this was undermined by his apparent inability to complete the health screen document or the disclosure consent form and healthcare medication compact. This lapse is frustrating as the nurse appeared to have a useful and open conversation with the man. By not recording it in its entirety, he lost much of the intelligence gained from it. I therefore endorse the recommendation made by the clinical reviewer:

Healthcare staff must complete the First Reception Health Screen Form completely, in case a prisoners' circumstances have changed and new risk assessments are indicated.

82. The actions put in place following the first reception health screen are vital for all prisoners entering prison with a substance misuse problem.

83. PSI 46/2005 states:

> "Prisoners identified via the first reception healthcare screen to have a current substance misuse problem are referred on for a clinical substance misuse assessment. This assessment informs any need for

medicated management of withdrawal symptoms on the first night of custody."

84. The nurse's failure to complete the health screen meant that these referrals were not made. Therefore, had the man been alive the following morning, it is not clear that he would have been referred to the doctor and for a substance misuse assessment.

85. I therefore endorse the recommendation made by the Inspections Manager at Healthcare Inspectorate Wales:

Healthcare staff should refer prisoners who admit or are suspected of being substance misusers for a full substance misuse assessment.

Treating the man's drug problem

86. PSO 2700 states:

"There is a significant relationship between drug and/or alcohol withdrawal and suicide, the risk of which may be significantly reduced if people are assessed on reception and provided with effective needs based treatment commenced on the day of reception."

87. Prison Service Instruction (PSI) 46/2005 (Drug Treatment and Self-Harm) explains the reasons why the link is significant:

"Drug treatment is by nature demanding. Participants often feel under great pressure, especially early on:

- Coming off drugs can be an emotional roller coaster – emotions dulled for many years by drug misuse may be unblocked;
- Facing the underlying causes of addiction can be traumatic; and
- Facing the damage caused by addiction, for example, to loved ones, can be stressful."

88. During the health screen interview, the man was assessed by the nurse who saw the man for the medical section of the CSRA who did not consider him to be showing signs of drug withdrawal symptoms. He described him as:

"And like I say he maintained good eye contact, good communication, he was sat back in the chair, quite relaxed and in a good mood. Obviously talking about you know when he'd come back in and he'd been silly again and what he'd been brought back in for. But from that point of view no and then from my observations obviously through that as well I deemed he didn't require any further medication."

89. On the basis of how he presented and spoke the nurse did not believe that the man warranted Diazepam. Information from the man's time in police custody was not available to the nurse, and he would not have been aware of any medication provided to the man. The nurse did offer the man some

medication, which the man refused, namely quinine for leg cramps and metoclopramide, an anti-sickness treatment.

90. The officers who later saw the man also remarked that he did not appear to be suffering from withdrawal symptoms. Later, the man did ask wing staff to contact the nurse who saw the man for the medical section of the CSRA regarding his medication. The nurse told the investigators:

> "I remember the phone call asking whether he could have anything and I remember asking the officer what does he want and he asked for Valium. And my opinion was that he didn't require it at the time because he showed no forms or signs of withdrawing from any medication."

91. The nurse who saw the man for the medical section of the CSRA also told my investigators that, had the man asked for the symptomatic relief, this could have been provided for him. There was no doctor in the prison at the time of the man's health assessment. The GP system at Swansea was described to the investigators by the nurse as:

> "I have to go through an emergency doctor which would be then contacted in the out of hours services. … It's an SOS doctor which we can contact. We phone up an out of hours service, give the relevant information over the phone, the doctor then can come back to us."

92. The nurse did not contact the on-call GP to discuss further treatment for the man as he did not consider him to be withdrawing from drugs. However, the clinical reviewer commented:

> "However, we do not consider staff to have appropriately managed [the man's] withdrawal from drugs and alcohol when he was readmitted in May 2009. It is clear from the initial health screen that he [(the man)] reported to [the nurse] that he had been taking heroin daily, benzodiazepine daily and cocaine daily. As [the man] confirmed that he last took cocaine, heroin and benzodiazepine on 7 May 2009, he should have been prescribed Diazepam."

93. The oversight identified by the clinical reviewer is a serious one, due to the reasons outlined at the start of the section. It is clear that the timely and appropriate care for prisoners suffering from substance misuse problems is a vital part of the prison's responsibility to care for the person in custody. In light of the findings of the clinical reviewer, I would suggest that this part of the man's time in custody is closely reviewed by the PCT and Head of Healthcare.

Location in a single cell

94. The man was initially allocated a double cell sharing with another prisoner. He approached the wing officers and asked not to share with the other prisoner, to which officers replied that they would see what spaces they had. The officer who is a tutor in ACCT procedures and the officer who completed

the man's induction paperwork said in interview that they both asked the man if he would be alright on his own and he replied that he would be fine. The man was then allocated his own cell. This decision was underpinned by the induction assessments which judged that the man presented no risk to himself or others.

95. PSO 2700 discusses the potential location for prisoners deemed to be at risk.

> "The type of accommodation required for at-risk prisoners cannot be prescriptive, as much will depend on the facilities available in establishments. … The doubling-up of an at-risk prisoner with a cellmate can help to reduce feelings of loneliness and provide both with someone to talk to."

96. Although the man may well have benefited from sharing a double cell, the decision where to locate him was predicated on the assessments of his risk. As these assessments concluded that the man was not at risk of harming himself staff sought to meet his request and I do not think it unreasonable for them to take this step. It should also be noted that 'doubling-up' prisoners is not a fail-safe. I have, unfortunately, investigated many deaths where the deceased shared a cell.

Giving the man a razor

97. The man had attempted to cut his arms while in his cell at Swansea. The post-mortem report makes reference to two cuts on the left arm and a slight cut on the right arm. Following the man's death, the police removed a broken razor blade from the cell. Staff would not routinely remove objects from prisoners unless they had a specific reason to do so. Despite the tick on the PER form, the man was not deemed to be at risk of harming himself by staff who had interacted with him and so he was allowed to have the razor.

98. However, even if staff had considered the man to be at risk of harming himself the razor may still have been provided to him. PSO 2700 states:

> "However, removing personal belongings from a person who is feeling hopeless and depressed … can increase feelings of distress and therefore increase the risk of suicide, self-harm or a higher risk method of self-harm. Where possible, prisoners at risk should be allowed to retain their belongings unless it is clearly unsafe to do so."

Discovering the man hanging

99. The man was discovered hanging by a ligature by an officer at 1.40am. Staff and paramedics responded quickly but the man was declared dead at 2.12am.

100. The clinical reviewer commented:

> "From the information made available to us it would appear that staff acted quickly to resuscitate [the man] upon finding him in his cell on

> 12 May. However our review has highlighted that staff used a resuscitation rate of 15:1. The Resuscitation Council (UK) Resuscitation Guidelines 2005 state that "a ratio of compressions to Ventilations of 30:2 is to be used for all adult victims of sudden cardiac arrest and for a victim the initial two rescue breaths are omitted and 30 compressions given immediately after cardiac arrest is established."

101. The clinical reviewer recommended:

All staff should undertake update training in CPR as a matter of priority to ensure compliance with the Resuscitation Council (UK) Resuscitation Guidelines 2005.

102. A defibrillator was not taken to the man's cell by the nurse although one was located nearby. Swansea prison operates a "first responders" system regarding the defibrillator. Staff on the first responder list are trained to use the defibrillator, and they are the ones designated to use it in the event of an emergency. On the night of the man's death there were no first responders on duty. The staff interviewed implied to the investigators that, in such a situation, the nurses on duty would not be expected to use a defibrillator. The clinical reviewer referred the investigators to the Resuscitation Council (UK) view that it is inappropriate to display notices to the effect that only trained personnel should use the devices and that it is against the interests of victims of cardiac arrest to restrict the use of defibrillators. She provided the investigators with the views of the Resuscitation Council (UK):

> "While it is highly desirable that those who may be called upon to use an AED [automated external defibrillator] should be trained in their use, and keep their skills up to date, circumstances can dictate that no trained operator (or a trained operator whose certificate of training has expired) is present at the site of an emergency. Under these circumstances no inhibitions should be placed on any person willing to use an AED. It is the view of the Resuscitation Council (UK) that the use of AEDs should NOT be restricted to trained personnel. Furthermore, the Resuscitation Council (UK) considers that it is inappropriate to display notices to the effect that only trained personnel should use the devices, or to restrict their use in other ways. Such restrictions are against the interests of victims of cardiac arrest, and discourage the greater use of AEDs by members of the public who may be able to preserve life and assist victims of cardiac arrest."

103. Therefore I recommend that:

The Governor should ensure that a defibrillator is taken to all identified or possible cardiac arrests.

The Governor should ensure that there are sufficient staff trained in defibrillator use to cover the prison 24 hours a day.

Liaison with the man's family

104. Contrary to the prison's wishes, the police informed the man's family of his death. It also took over two hours for the news to be broken. This was unfortunate as, in most circumstances, the prison is better placed to advise the family of the circumstances of a prisoner's death and is a symbol of how seriously the prison regards the matter and the feelings of the family. An annexe to PSO 2710 (Follow-up to deaths in custody) says:

> "There are opposing views across the Prison Service and outside consultees but the vast majority believe that the first contact must be made directly by the establishment so that the family recognise that the death is a matter of great concern to the establishment."

105. The prison had detailed knowledge of the man's time at prison and would have been able to answer more of the family's questions. The prison also has a system of family liaison officers when liaising with newly bereaved families that could have undertaken the role. I was pleased to hear that the prison Governor and chaplain visited the family the following day.

The Governor should ensure that a suitable protocol concerning informing relatives of prisoners who die at Swansea prison is agreed with the Chief Constable of South Wales Police.

106. I understand that the man's father has written to the prison chaplain thanking him for his compassion and kindness in dealing with the family during a visit to the family home. The man's father also thanked the chaplain for holding services in the chapel in memory of his son.

Support for staff and prisoners

107. The prison management's response to the man's death was quick and well organised. The Governor and Deputy Governor arrived at the prison following the man's death and supported the staff. I understand that staff were appreciative of this, and am glad to highlight their efforts. The prison held a critical incident debrief on 26 May organised by the National Offender Management Service employee support office. Feedback from the staff who could attend was generally positive. However it was noted that some staff were unable to attend for various reasons such as distance from their home to the prison, or absent from work due to sickness. It is unfortunate that some staff were unable to attend.

The Governor should ensure that all staff involved in fatal incidents are offered the opportunity to attend critical incident debriefing.

CONCLUSION

108. The man entered police custody with a significant substance misuse problem, and faced a number of charges. While there he harmed himself. It is very disappointing that this information was not passed to either the escort or prison staff beyond a tick in a box. Prison staff at Swansea did not contact the police directly for further information, but they did ask the man repeatedly about the indication of suicide and self harm. I believe that his care in prison custody would have been substantially different had staff been aware of his earlier behaviour.

109. There were problems relating to the medical care received by the man at Swansea. The PER was not provided to the nurse, and the healthcare documents were not correctly completed. He was not provided with medication for drug withdrawal, as he should have been.

110. Although ACCT procedures could have been opened without knowing that he had harmed himself at the police station, his denial of suicidal ideas and his positive attitude meant that staff judged that he was not at risk. With the available information they had, I do not think that this was an unreasonable judgment. However, I have reminded staff of the need to seek as much information as possible and hope that improved procedures from all relevant agencies prevent a repetition of these circumstances.

RECOMMENDATIONS

1. The Governor should remind reception staff of the requirement to ask escort staff about any ticks relating to risks on the Prisoner Escort Record.

   The National Offender Management Service accepted this recommendation and said:

   > "With the introduction of the redesigned PER all information regarding risks should have remarks to support. A notice to staff with relevance to reception staff highlighting this requirement has been published."

2. Healthcare staff must complete the First Reception Health Screen Form completely as prisoners circumstances from any previous reception may have changed and new risk assessment may be required.

   The National Offender Management Service accepted this recommendation and said:

   > "This requirement has been reinforced by the Head of Healthcare and is now carried out for every new reception."

3. Healthcare staff should refer prisoners who admit or are suspected of being substance misusers for a full substance misuse assessment.

   The National Offender Management Service accepted this recommendation and said:

   > "This is now fully compliant - prisoners who fit this criteria are referred."

4. The Governor should ensure staff undertake update training in CPR as a matter of priority to ensure compliance with the Resuscitation Council (UK) Resuscitation Guidelines 2005.

   The National Offender Management Service accepted this recommendation and said:

   > "This recommendation has been accepted but will involve a rolling training programme - all staff who have been trained since 2005 undertake the resuscitation requirements."

5. The Governor should ensure that a defibrillator is taken to all identified or possible cardiac arrests.

   The National Offender Management Service accepted this recommendation and said:

   > "Achieved and in place - The establishment has a team of trained first responders who are immediately called to any identified situation - the resuscitation equipment is taken with them at all times. There are two

full resuscitation units paced at strategic points within the establishment.

6. The Governor should ensure that there are sufficient staff trained in defibrillator use to cover the prison 24 hours a day.

   The National Offender Management Service accepted this recommendation and said:

   > "Achieved and in place - the two dedicated night staff are now fully trained in resuscitation and the equipment."

7. The Governor should ensure that a suitable protocol concerning informing the relatives of prisoners who die at Swansea prison should be agreed with the Chief Constable of South Wales.

   The National Offender Management Service accepted this recommendation and said:

   > "The protocol will be explored with the relevant personnel."

8. The Governor should ensure that all staff involved in fatal incidents are offered the opportunity to attend critical incident briefing.

   The National Offender Management Service accepted this recommendation and said:

   > "In place - this is already custom and practice - the Prison Chaplain takes the lead in this area."