Investigation into the circumstances surrounding the death of a man at HMP Cardiff on 10 June 2007

Report by the Prisons and Probation Ombudsman for England and Wales

January 2008

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Cardiff on Sunday 10 June 2007. At about 6.00pm that evening, the man was found hanging in his single cell in the prison's First Night Centre. He had been in prison custody for just two days, having been locked out of HMP Swansea for one night under Operation Safeguard. The man was 27 years old.

The post mortem examination concluded that the man' death was caused by pressure to the neck. A toxicology report commented that the man tested positive for benzodiazepines but these were consistent with therapeutic use. The report also commented that:

> "… the observed low concentration (trace amount) of diazepam found in the post mortem blood would be consistent with therapeutic use and does not indicate an overdose of this drug prior to death."

I offer my sincere condolences to the man's family and friends for their tragic loss.

The investigation was conducted by one of my colleagues. My family liaison officer, liaised with the man's family. I also commissioned an independent clinical review of the management of the man's health needs while he was in custody. As on previous occasions, I am most grateful to the clinical reviewer for her contribution to the investigation.

The investigation found that the man gave prison staff no indication he was actively contemplating suicide. While I am critical of some aspects of his care, I conclude that his death could not reasonably have been predicted or prevented.

I make one recommendation. I also commend the Prison Service and paramedic staff for their attempts to revive the man in very harrowing circumstances. The clinical review makes two recommendations, one of which I endorse.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2008**

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SUMMARY

The man was arrested on Thursday 7 June 2007 on suspicion of criminal damage and possessing an offensive weapon. He had apparently damaged premises above his own flat in Swansea. The man appeared before Magistrates' Court that day and was remanded in custody. He would normally have been taken to HMP Swansea. However, as Swansea had no vacancies, the man remained in police custody overnight.

The next day, the man was transferred from police custody to HMP Cardiff. On arrival at Cardiff, he refused to disclose his next of kin as he did not want anyone to know where he was. The man gave his date of birth. His family later confirmed another date of birth. The man said he had been in prison many times before and had last been released in February 2006 from HMP Parc in Bridgend.

During his reception health screen, the man said that 17 years earlier he had received treatment from a psychiatrist in the community, although not as an inpatient. He said he did not currently have a psychiatric care worker and had never received medication for mental health problems. However, the man did disclose that, in May 2006, he had attempted to hang himself but gave no details. The man said that, despite being in prison, he did not feel suicidal. In view of his mental health history, the nurse who carried out the reception health screen decided to refer the man for a mental health assessment. The man was nevertheless considered to be fit for accommodation in a residential wing rather than in the healthcare centre.

During the reception procedures, a cell sharing risk assessment was carried out. The man was judged as presenting a low risk of harming others and was considered suitable to share a cell. He was therefore placed in a shared cell in the First Night Centre.

During that night (Friday/Saturday), there was an altercation between the man and his cell mate. The investigation found that, whilst his cell mate was asleep, the man inflicted upon him a very minor injury to his head. The cell mate did not retaliate as he thought the man was simply behaving strangely rather than maliciously. The next morning, the cell mate reported the incident to wing staff. In liaison with healthcare colleagues, they decided to separate the two prisoners, leaving the man in a cell on his own. The injury received by the cell mate was not examined by anyone from the healthcare department because no one completed a form F213SH (report of an injury to a prisoner).

There were no further events of any significance until the following afternoon (Sunday) when the man began to demonstrate further bizarre behaviour. Officers in the First Night Centre repeatedly called the healthcare centre to see the man, but no one did so. An officer took it upon himself to ask a member of the healthcare department on duty in the wing treatment room on the landing above the First Night Centre to see the man. The officer was told that the man was due for a mental health assessment the following day and felt reassured by that. Meanwhile, a member of staff in the healthcare centre was asked by a manager to see the man that evening. This was due to take place at about 6.00pm. Before this happened, the man was found hanging from the window bars of his cell. Attempts by prison staff and a paramedic

crew to revive him were unsuccessful. The man was pronounced dead at approximately 6.20pm.

I am concerned at the apparent failure by healthcare staff to see the man after repeatedly being asked to do so by wing staff. My investigator was told that this was due to the combination of a shortage of healthcare staff and a heavy workload for those who were on duty. The investigation could not prove conclusively that these factors prevented anyone seeing the man before he died. However, despite my evident concern, I am reluctant to criticise individual members of staff. My reluctance is based on the following factors:

- Although his behaviour was bizarre, the man did not present as suicidal. It was, in my view, reasonable for staff to consider him as non-urgent.

- The man had appropriately been referred for mental health assessment during the reception procedures on Friday 8 June. This assessment was likely to have taken place during the following week. (An entry made in a diary kept in the healthcare centre shows that a request was made for the man to be seen on Monday 11 June.)

The author of the clinical review, suggests that the man's death might have been prevented had his mental health assessment taken place earlier. The clinical reviewer also recommends that the full complement of healthcare staff is present to maintain a safe level of care for prisoners who need it. I accept that staffing levels are a critical factor in ensuring the delivery of the Prison Service's duty of care. However, for reasons explained in detail in the body of this report, I have not endorsed this recommendation.

The investigation found that no urine test was carried out during the man's reception health screen. As a result, it was not clear to healthcare staff whether the man had taken drugs shortly before his arrival at the prison and, therefore, what interventions were necessary. The clinical review makes a recommendation about the management of the man's health needs in which she points to the need for routine urine tests for prisoners who admit to abusing drugs and alcohol.

I am concerned that no one completed a form F213SH (report of an injury to a prisoner) when it became obvious to staff that the man had assaulted his cell mate. I have recommended that the Governor reminds his staff of the importance of doing so.

Finally, I commend the prison staff and paramedics who attempted to revive the man in very harrowing circumstances.

INVESTIGATION PROCESS

The investigation commenced on 18 June 2007 when my investigator met the then Governor of HMP Cardiff, together with representatives of the local Independent Monitoring Board and the local branch of the Prison Officers' Association. The prison's investigation liaison officer was also present. My investigator briefed the meeting on the nature and scope of the investigation. The same day, notices were issued to staff and to prisoners announcing the investigation and inviting anyone with information or concerns about the man's death to make themselves known to my investigator.

An independent clinical review of the management of the man's health needs while he was in custody was conducted by the Investigations Manager, Health Inspectorate Wales.

Fifteen members of staff and one prisoner were interviewed during the course of the investigation. In addition, my investigator and family liaison officer visited the man's mother, uncle and former partner on 13 July at their home in Swansea. During the visit, the family raised a number of concerns they wanted my investigator to investigate. The matters they raised have been addressed in this report.

My investigator spoke to the solicitors, who represented the man in court on 7 June. He also spoke to a representative of Reliance, the private security company contracted by the Prison Service to escort prisoners between courts and prisons.

During the course of the investigation, my investigator kept the Governor apprised of the issues that emerged. On 9 August 2007, he wrote his initial observations and findings, emphasising that these were, at the time, subject to further examination.

HMP CARDIFF

Cardiff prison, situated near the town centre, is a local and a training prison. It can hold up to 754 adult male prisoners. The prison has six residential units, one of which is used exclusively to hold life sentenced prisoners. The prison also has a detoxification unit for up to 52 prisoners and a healthcare centre that provides 24 hour nursing and medical cover and beds for up to 16 in-patients.

In February 2005, Cardiff was inspected by HM Chief Inspector of Prisons, Dame Anne Owers. The report of that inspection commented as follows:

> "Two years ago, we described Cardiff prison as being at a crossroads as it struggled with competing pressure, including the inexorable rise in population. This unannounced follow-up inspection records that Cardiff had achieved a great deal despite these unpropitious circumstances. We found that most of our recommendations had been implemented and in some key areas the prison had gone significantly further."

A non-executive member of the then Home Office's Group Executive Board and author of the Report of the Review of the Correctional Services that led to the establishment of the National Offender Management Service, visited HMP Cardiff on 21 December 2005. He commented on his visit as follows:

> "I have been in a large number of prisons both in this country and in other parts of the world and against that background I have to say that Cardiff was one of the best establishments that I have ever visited. From the first moment, the appearance of the building, the friendly attitude of staff and the air of professionalism were manifest."

In their report on Cardiff prison for the period 1 September 2005 to 31 August 2006, the Independent Monitoring Board drew attention to the fact that two prisoners had apparently taken their own lives during the reporting period. The Board commented that my office had investigated both those deaths and that my reports had described the Safer Custody Policy in place at Cardiff as the most comprehensive my investigators had witnessed in the Prison Service. Nothing found in the investigation into the man's death detracts from that observation.

KEY EVENTS

Thursday 7 June: Arrest, appearance in court and remand into custody

At about 12.45am on 7 June 2007, police were called by the occupant of a flat on the floor above the man's flat in Swansea. The occupant told police that the man had shouted at him and had tried to damage the entrance door to the flat. When the police arrived, they arrested the man and took him into custody at a police station in Swansea where they charged him with criminal damage. Later, when they searched him, the police discovered the man had secreted a knife about his person. They therefore also charged him with possessing an offensive weapon. According to his legal adviser, the man admitted both offences.

The man's solicitor told my investigator that, at about 9.30pm, he arrived at the police station and stayed with the man until about 11.30pm. the solicitor explained to my investigator that the man was known to his firm of solicitors in Swansea from previous court appearances. The solicitor knew the man as quite a reserved man. He regarded the man's demeanour when he saw him as normal.

However, the solicitor said the man told him he had fallen out with all his family and had nobody to turn to for support. The solicitor thought the man felt anxious about this but did not appear to be depressed. He did not think the man was suicidal. The solicitor recalled that the police might have been told by the man that he had taken amphetamines. The solicitor thought there had been a long delay before he could see the man at the police station because of this.

Appearance in court and remand into custody

The man appeared at Magistrates' Court, charged with criminal damage and possessing an offensive weapon. The man's solicitor told my investigator he made an application to the magistrates for bail. It was rejected because the man's bail address would have put him back at the scene of his alleged offence. In addition, the charge of possession of an offensive weapon was likely to be dealt with by the Crown Court. The man was therefore remanded in custody and ordered to appear again before magistrates via video link on 13 June.

In ordinary circumstances, the man would have been held at HMP Swansea. This was not possible on 7 June as the prison had reached its maximum capacity. A representative of Reliance, the private security company contracted by the Prison Service to escort prisoners between courts and prisons, confirmed that, for this reason alone, the man was returned to police custody at a police station in Swansea under Operation Safeguard. (This is a Prison Service contingency plan to ensure that prisoners "locked out" of a prison because of overcrowding are placed in secure custody elsewhere.) The man was held at the police station overnight and taken to HMP Cardiff the next day.

Friday 8 June

Reception at Cardiff

The man arrived at Cardiff prison at about 1.00pm on Friday 8 June. The prisoner escort record (PER) for the journey between the police station and the prison carried no notation of any risk of self-harm.

The man told reception staff at Cardiff that his home was in Swansea but gave no details of his next of kin because he did not want anyone to know where he was. The man was offered a free telephone call and a free letter but he refused both, possibly for the same reason. He said his date of birth was 21 July 1979. (His family later confirmed he was born on 22 July that year.) The man also underwent an initial health screen and a cell sharing risk assessment.

Reception health screen

The purpose of the health screen is to gather information about each prisoner's current and past mental and physical health, as well as to ensure that appropriate interventions are made in relation to any immediate and longer term health needs.

The man's health screen was carried out by a staff nurse. The man told the staff nurse he had not recently seen a doctor and had no outstanding appointments. However, the staff nurse noticed the knuckles on the man's left hand were bruised and swollen. The man said he received this injury on 2 June but gave no further details. He said he had no concerns about his physical health. However, he admitted to being a "binge drinker" and to indulging in substance abuse. He said he normally took benzodiazepines and amphetamines fortnightly. The man also said he had used both sorts of drugs 18 days earlier. The staff nurse asked the man if he was currently taking any prescribed medication. He said he was taking Valium but later explained that this had not been prescribed. At interview, the staff nurse said this was why he initially wrote in the health screen form that the man was taking Valium on prescription and then crossed his entry out.

When asked about his mental health, the man said he had undergone treatment from a psychiatrist in the community 17 years earlier, although not as an inpatient. He said he did not currently have a psychiatric care worker in the community and had never received medication for mental health problems. However, the man disclosed that he had tried to hang himself in May 2006, but gave no details.

The staff nurse told my investigator that at no stage during the health screen did he think the man was exhibiting any signs of strange behaviour. He said the man did not appear to be suffering from the effects of drugs, or from the effects of withdrawal. In keeping with normal practice, the staff nurse asked the man if he felt suicidal because he was in prison but he said he did not. At interview, the staff nurse said the man was not subdued, depressed, or preoccupied but was vague and would not engage easily. Consequently, the staff nurse decided to refer him for a mental health assessment. In reaching this decision, the staff nurse took into account the man's admission that he had received psychiatric care 17 years earlier and had tried to hang himself in May 2006. The staff nurse made an entry in a diary kept in the healthcare centre asking for the man to be seen on Monday 11 June.

At the end of the health screen, the staff nurse concluded that the man was not at risk of self-harm or suicide and was fit for work and for normal location (in other words in a wing rather than in the healthcare centre or separation unit.)

Cell sharing risk assessment

The cell sharing risk assessment is designed to measure the risk each prisoner presents of harming others. Those who present such a risk are normally placed in single accommodation. Judgements as to risk are based on whatever documentary evidence is available during the reception procedures and on the answers prisoners give to the questions listed on the cell sharing risk assessment form. The risk of harming others has to be balanced with the risk of self-harm if the prisoner is left in a single cell.

A prison officer, who normally worked in the First Night Centre at Cardiff, was deployed to the reception building on the afternoon of 8 June in order to complete cell sharing risk assessments on new prisoners. The man told the risk assessment officer he was not a person who became angry or frustrated easily. He said he did not have any concerns about sharing a cell. He also said he had not formerly been subject to any self-harm monitoring procedures. The risk assessment officer judged that the man presented a low risk of harming others, meant he could be allocated to shared accommodation.

The cell sharing risk assessment process also requires a member of the healthcare team to assess the risk the man presented of harming others. This was done by the staff nurse. He wrote on the form, "No concerns, normal location." In answer to the question at section three of the form, "Following the self-harm assessment have any concerns been raised", the staff nurse wrote that none had been raised.

After the reception procedures had been completed, the man was allocated to the First Night Centre where he was placed in a cell with another prisoner.

Saturday 9 June

Report of altercation with cell mate

A prison officer recorded the following information on a retrospective security information report:

> "At approx 9am on 9.6.07, whilst sitting in the office on F1 landing inmate approached the entrance of the office and said he had received a blow to his right eye. Staff present risk assessment officer, prison officer, and myself. We all questioned the other prisoner on how he received the injury to his face. He said his cellmate the man struck him on the eye through the night. He stated I didn't see the man hit me, but it must have been him because there was no one else in the cell. The other prisoner kept saying the man was very strange and was talking to himself through the night. The prison officer went and spoke with the man and immediately removed the other prisoner from

> cell F1-17 and put the man on as a single cell occupant until assessed by hospital staff."

My investigator interviewed the prisoner, the prison officer that completed the security information report, the other prison officer and the staff nurse about this episode.

The prison officer that completed the security information report, said he was an experienced member of the induction team at Cardiff, having worked on F1 landing for five years. He explained that, because of the amount of other work he had to complete at the time, he did not submit his report straightaway. He could not remember exactly when he did submit the document but confirmed that he did so after the man had died.

The other prisoner said that within ten minutes of being in the same cell together, he knew there was something wrong with the man. The other prisoner said the man kept mumbling about religion and talking to his friend as if he was in the cell with him. According to the other prisoner, the man said he was hearing voices. The man kept mumbling until about midnight when the other prisoner made up his mind to ignore him and to try to go to sleep. He told my investigator he managed to fall asleep, but some time later was woken by the man hitting him on the back of his head. When the other prisoner turned over to see what was happening, the man hit his face. The other prisoner said that he did not retaliate. Instead, he turned over again and went to sleep. In the morning, he reported the incident to staff and was placed in a different cell away from the man. The other prisoner told my investigator the man made him feel uncomfortable. He thought the man might have been hallucinating, possibly because he was experiencing the effects of drugs or was withdrawing from them.

The prison officer that completed the security information report, remembered that the other prisoner bore a slight mark near his right eye. He described the injury as a small bruise. The officer was not aware of whether any anti-bullying measures were taken in the aftermath of the altercation. He said that he and the prison officer made numerous calls to the healthcare centre to ask one of the nursing staff to assess the man. The officer said no one from the healthcare centre did so that day.

The prison officer confirmed the other officer's account. He told my investigator he was on duty in F Wing during the morning of Saturday 9 June. At about 9.00am, the other prisoner approached the wing office and told him he had been hit by the man during the night. The prison officer said he went to have a word with the man who denied that he had hit the other prisoner. The prison officer became concerned about the man. At interview, he said:

> "The reason that I was concerned at that point was because he was a slight, small bloke, certainly smaller than the other prisoner. But the reason I was concerned was that he was quite vacant in his expression and his words were very monotone, very flat …"

The prison officer said he rang the healthcare centre to ask someone to assess the man. He said he spoke to a healthcare manager. The prison officer told my investigator that he was on duty until 5.00pm that day, and during that period no one from the healthcare centre came to see the man. My investigator was unable to interview the healthcare manager as he was on long term sick leave.

The staff nurse told my investigator he took a call about the man during the morning of 9 June. He said he was told that there had been an altercation between the man and the other prisoner. The staff nurse said he advised that the man should be separated from the other prisoner and placed in a single cell until such time as his mental health could be assessed.

The prison officer found another cell for the other prisoner and kept the man on his own. He wrote in the man's prison record:

> "Complaint by cell mate of altercation with the man. Subsequent interview revealed strange behaviour. Single cell until review by mental health nurse."

The prison officer said that as far as he could tell, the altercation between the man and the other prisoner was not related to bullying. He told my investigator he did not think the man appeared suicidal

No officers completed a form F213SH (report of an injury to a prisoner) after it became obvious that the other prisoner had been assaulted. The staff nurse said he was not made aware of any injury to the other prisoner. Had the form F213SH been completed, the other prisoner would have been examined by a healthcare professional, which might have led to an assessment.

Resettlement planning

As part of the resettlement planning process, the prison officer completed what is known as a passport form with the man. This contains a series of questions about such subjects as housing, employment, health, education, finance, relationships, attitudes, behaviour and institutional skills. The man told the prison officer he had never worked and would have no job available on release. He was entirely dependent on benefits. The man said his income would be about £155 per fortnight. He admitted he had taken drugs since he was 11 years old, at a cost of £30 a day. The man told the prison officer he had never tried to seek help for his drug addiction and did not want any help from the CARATs (Counselling Advice, Referral, Assessment and Throughcare service) now that he was in prison. The man told the prison officer there was nothing about himself he wanted to change and he had no plans to stop re-offending. He said most of his friends were in trouble with the police. He had been in prison on 14 occasions and had been last released in February 2006. Finally, the man told the prison officer he had nobody to turn to in the community.

Seen by chaplain

After seeing the man as part of the induction procedures, the chaplain, noted in the man's record that he thought he was a "strange character".

Sunday 10 June

Nothing of note seems to have occurred during the morning of Sunday 10 June. However, at 3.15 pm, an officer who was on duty on F2 landing, noticed the man walking up the stairs from the landing below. The man said to the officer, “Do I have to go to heaven tonight?” At interview, the officer on F2 landing explained that 3.15pm was the usual time at which prisoners on F1 landing were allowed to go to the treatment room on the landing above to collect their medication. Thus, it was in order for the man to move out of the First Night Centre to F2 landing above. The officer asked the man what he meant by that question and whether he needed any medication. The man did not answer, but walked back down the stairs towards the First Night Centre. The officer told his colleagues in the centre what the man had said. The officer told my investigator that, a little later, he saw a member of staff on duty in the First Night Centre, take the man to the treatment room.

At interview, the officer from the first night centre explained that at about 3.30pm the man had approached the office in the First Night Centre and started mumbling. The officer from the first night centre was in the office. He heard the man say, “When will I go?” the officer said to him, “Where?” The man replied, “To Guys Marsh.” The officer then said to him, “If you are convicted and sentenced, you may go to Guys Marsh if you meet the criteria for that prison.” The officer told my investigator the man then started talking about religion. The officer was aware that other staff had earlier asked someone from the healthcare centre to see the man. He knew that no one had yet seen him. The officer thought it wise to take the man to the treatment room on the landing above where he knew there would be a member of the healthcare staff on duty. The officer wanted to know whether the man needed any medication. A healthcare officer was on duty in the treatment room. At interview, the healthcare officer said he could remember the officer from the first night centre bringing the man to the room. He said he rang the healthcare centre and spoke to a healthcare manager. The healthcare officer told my investigator that the healthcare manager advised him that someone would go and see the man that evening. The man was then taken back to F1 landing. According to the officer from the first night centre, the man stayed outside his cell for the remainder of the association period. This ended at about 4.00pm with the serving of the tea meal.

According to the prison officer that completed the security information report, further calls to the healthcare centre were made that day. He said he spoke to the healthcare manager who arranged for a nurse to see the man after the tea meal had been served. The prison officer that completed the security information report saw the man take his tea meal at about 4.00pm and noticed he was quiet. However, he did not think there was anything particularly wrong with him. At no stage did the man give the prison officer that completed the security information report, any reason to believe he was contemplating suicide. the prison officer that completed the security information report, who went off duty that day at 5.00pm, said the nurse did not see the man that evening.

The officer from the first night centre was on duty that evening. He was responsible for supervising F1 landing where the man was located. At about 6.00pm, when all prisoners were locked in their cells, the officer was patrolling the landing. After checking several prisoners, he arrived at the man’s cell.

The officer opened the observation hatch in the cell door and saw the man hanging. He was suspended from the window bars by a ligature made from his sheets and a belt.

The officer from the first night centre sent a message over the radio to the control room. He said there was a "code blue" in cell F1-17. ("Code blue" is a term used to alert key staff to a hanging without giving any details that might distress other prisoners who are within earshot.) The officer repeated his message. He then entered the cell and took the man's weight. He was soon joined by an officer who cut the ligature, using a special knife issued to staff for that purpose. Three other prison officers had also arrived by this time. They helped take the man's weight so that he could be lowered and carried out onto the landing where there was more space available. An other prison officer checked to see whether the man had a pulse and if he was breathing. He could detect no signs of life. Between them, they started to apply cardio-pulmonary resuscitation (CPR). At this point, the healthcare officer arrived and gave his assistance.

The healthcare officer said he was on the healthcare landing when the code blue message was broadcast on his radio. He said he picked up the resuscitation bag and proceeded to F1 landing by the shortest possible route. He said it probably took him about 60 seconds to reach the man's cell. The healthcare officer said that, as he was not designated as a "first responder", he did not take the defibrillator. He told my investigator he was not sure who took it but remembered that it arrived within minutes of his arrival at the cell. The healthcare officer assisted in applying CPR. He also gave an instruction for an ambulance to be called. By this time, two senior officers arrived. The first senior officer used her radio to ask the officer in the control room to call for an ambulance. The log of events kept by the prison shows that this was done at 6.02pm.

Despite the fact that the healthcare officer thought the man might have been dead for some time, he applied the defibrillator. However, the man did not respond. CPR was maintained until a paramedic crew arrived at approximately 6.06pm. They continued to administer CPR until approximately 6.20pm when they pronounced the man's death.

Informing the next of kin

The chaplain together with a principal officer, took it upon themselves to inform the man's next of kin of his death. Although the man had refused to declare his next of kin during the reception procedures, he did give details of what he said was his own address in Swansea. The chaplain and the principal officer drove there, expecting to meet the man's mother. As they approached, they realised there was an incident in the vicinity that the police were handling. They therefore called in to a nearby police station to seek advice. The police, who knew the man well, agreed to accompany them. However, when they arrived, they discovered that nobody was in.

The police suggested another address. On arrival at that address, they once again found nobody at home. They therefore returned to the police station where they were given a third address to try. When they arrived they were told that the man's mother had moved. Upon arrival at that next address, the principal officer was told by the occupant that she had never heard of the man's mother. The principal officer then approached the next door neighbour who said she knew the man's mother well and had her mobile telephone number which she disclosed to the principal officer. He rang the number. The call was answered not by the man's mother but by the man's former partner. The principal officer explained who he was, then told the man's former partner that he and the chaplain needed to visit to speak to her about the man. The man's former partner gave him her address. They arrived at about 10.00pm and stayed with

her for about an hour. During that time, the man's former partner phoned other members of her family and tried to track down the man's mother but was unable to do so. (The man's former partner broke the news of the man's death to his mother later that day.) With the man's former partner's agreement, the principal officer and the chaplain then left.

The principal officer told my investigator he later arranged for the man's belongings to be returned to his family. He said the funeral costs were paid in full by the Governor. The principal officer also confirmed that the Governor was keen for a representative of the prison to attend the funeral but the man's mother did not want this. The principal officer extended an invitation to the man's mother and the man's former partner to view the man's cell if they wished. This too was declined.

ISSUES

Here I examine:

- Whether the man's health needs were properly met while he was in custody at Cardiff.
- Whether his risk of suicide was properly assessed, monitored and managed.
- Whether the response by staff when the man was found hanging was prompt and effective.
- Whether appropriate courtesies were offered to the man's family in the aftermath of his death.

Were the man's health needs properly met while he was in custody at Cardiff?

Physical health needs

I repeat here extracts from the clinical review of the management of the man's health needs conducted by the Healthcare Inspectorate Wales:

> "The First Reception Health Screen form was completed on 8 June 2007. No significant physical illnesses were mentioned. The man was noted as appearing 'spare but muscular'. It was also noted that the man was receiving prescribed medication, but Reception Nurse mentioned at interview that the medication was Valium and not prescribed by The man's GP. Therefore, this was not continued in the prison. The reception nurse noted that the man had bruised and swollen knuckles on his left hand. The man mentioned that he 'binge drank cider fortnightly' but showed no signs of withdrawal to the reception nurse. The man also mentioned that he had taken benzodiazepines and amphetamine but had not taken any for the past 18 days. No test was performed on the man's urine to verify this statement."

The clinical review goes on to make the following recommendation:

> "Prison authorities should give consideration for routine urine testing for drugs in prisoners who admit taking drugs and alcohol to excess in the past."

I endorse this recommendation.

Mental health needs

I quote again from the clinical review:

> "In the mental health section of the First Reception Health Screen form, it noted that the man had received psychiatric treatment outside prison 17 years ago, for abuse. The man also mentioned that he had attempted hanging in May 2006, but there is no record of why he did this. This shows he had the ability to harm himself. At interview, the reception nurse said that the man 'had wanted to die'

> in 2006, but the man refused to expand on the event to the reception nurse.
>
> The reception nurse… recommended a Mental Health Assessment and also entered this on the 8th June in the Continuous Medical Record. It states, 'Slightly vague and difficult to engage. For MHA (Mental Health Assessment) please.' At interview, the reception nurse told us that the man said he was not considering suicide and did not appear to be mentally unwell at that time and so the reception nurse did not open a self-harm at risk (ACCT) form."

In this regard, the clinical reviewer summarises her views as follows:

> "The man's behaviour was unusual and worrying for wing staff, who tried to get him assessed by an RMN. However, he was not overtly aggressive or expressing a wish to kill himself and was, therefore, not deemed a mental healthcare emergency. Low health care staffing levels and a high emergency workload on the Saturday (i.e. 9 June) did not allow the man to receive a routine mental health assessment before he died. It could be hypothesised that if the man had received a mental health assessment on Saturday or Sunday morning, he might have been diagnosed with a mental illness or drug withdrawal and been admitted to healthcare for observation, thus preventing his suicide later on Sunday "

(I agree with the clinical reviewer's conclusion that the man might have been diagnosed with a mental illness or a drug related condition had he received a mental health assessment - I note particularly the indication that he had been hearing voices. Whether this might have prevented his death is necessarily a matter of speculation for which there is no direct supporting evidence.)

The clinical reviewer makes the following recommendation:

> "Healthcare management must give regard to ensure that the recommended full complement of staff is present to maintain a safe level of care for prisoners who need it."

Although I too am concerned at the apparent failure by healthcare staff to see the man after repeatedly being asked to do so by officers on the First Night Centre, I do not endorse this recommendation for the reasons I set out below.

My investigator interviewed staff all of whom were on duty at various times during the weekend. The staff nurse said that on Saturday 9 June, there was a staff shortage in the healthcare centre. He said there should have been five members of staff on duty but that day there were only three, possibly four on duty. The staff nurse told my investigator he remembered taking a call from someone that day about the man's altercation with the other prisoner during the previous night. The staff nurse said he advised that the man and the other prisoner should be placed in separate cells and that the man should remain single cell status until his mental health assessment was completed. When my investigator suggested to the staff nurse that thereafter staff in

the First Night Centre were still sufficiently concerned about the man to ring the healthcare centre again to ask for someone to see him, he said:

> "… it couldn't happen again because there was a staff shortage and because there were all sorts of incidents going on in the prison. There was a code red (i.e. a life threatening situation) and a number of other things that were happening that took them away from the ability to see the man".

The staff nurse claimed that the combination of the staff shortage and the fact that numerous incidents occurred in the prison that day meant that no one could be made available to see the man.

The duty manager told my investigator that during the preceding week, they were aware that there would be a shortage of healthcare staff over the weekend. The duty manager explained that on Saturdays there should be a minimum of five healthcare staff on duty in the morning and afternoon and two during the evening. On Sundays, there should be five staff on duty in the morning, four in the afternoon and two in the evening. The duty manager explained that the higher staffing level on Saturdays was necessary because there were newly received prisoners to be seen on those days, whereas on Sundays there were no new receptions. He went on to say that on both Saturday 9 June and Sunday 10 June there was a shortage of two members of staff: a qualified nurse and a healthcare officer.

The duty manager said he asked the healthcare manager to sanction overtime for the period during which the staff shortages were expected. The duty manager said that the healthcare manager refused to do so because the overtime budget was overspent. He also said that at about 11.30am on Sunday another healthcare manager, voluntarily came in to the prison to make up the shortfall of staff. The deputy manager said this meant that the correct staffing levels were achieved for the rest of the day.

The healthcare officer confirmed he was on duty in the treatments room on F2 landing on Sunday 10 June. He could remember the officer from F1 landing approaching him at about 3.30pm to tell him that he had concerns about the man who was behaving in a bizarre fashion. The healthcare officer said he rang the healthcare centre and told the duty manager that the staff on F1 landing wanted someone from the healthcare centre to see the man. The healthcare officer was concerned that he personally could not see the man because he was a Registered General Nurse rather than a Registered Mental Nurse. The healthcare officer said he was also restricted because he was working with an unqualified Grade B Nurse and so he could not leave the treatments room. According to the healthcare officer, the duty manager said he would ask someone to see the man during the evening.

The healthcare officer told my investigator he was aware of staffing difficulties that weekend but explained that this was not unusual. He said:

> "Staffing at weekends is always just enough to do the job. There is never any spare capacity to go and see if there is a fight or an incident for those to be taken away from their existing jobs. There is no one left in the wings as such, so yes we were thin but that has been the case many times. So it wasn't exceptional to be short that weekend because we have been thin at other weekends but nothing has

> happened so therefore the powers that be won't provide the funds to have more staff."

When asked by my investigator if he knew anything about attempts by managers to make up the staff shortages, the healthcare officer said,

> "Well yes. In fact I was one of those staff. I was on overtime that day."

The nurse told my investigator that, at about 5.00pm on Sunday 10 June, he was asked by both the healthcare managers to go to F1 landing to see the man. The nurse said he checked with them how urgently he should see the man. He said he was told it was not urgent and it was alright to see the man during the evening as soon as he had time. The nurse said he knew a phone call had been made to the healthcare centre at about 3.15pm from F1 landing. However, the managers who took the call had waited until he and the healthcare officer returned to the healthcare centre before they asked him to see the man. The nurse explained that as soon as he arrived at the healthcare centre he was due his 30-minute meal break. He then had to issue medication to the inpatients in the healthcare centre until 6.00pm. The nurse said he told the healthcare officer he would therefore see the man at about 6.30pm. Unfortunately, the man died before the nurse was due to see him.

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On 3 September, my investigator returned to Cardiff to discuss the question of healthcare staffing levels with the deputy governor and the principal officer, the Safer Custody Manager. They explained the agreed staffing levels for the healthcare centre and confirmed that there were no staff shortages on 9 and 10 June. The principal officer also showed my investigator details of the events that occurred in the prison on 9 and 10 June. These showed there was only one event of any significance over that weekend for the healthcare staff to deal with. This was a minor self-harm that took place at 7.30pm on 9 June. The principal officer stressed that his examination of the agreed staffing levels for healthcare staff, and the number of staff on duty over the weekend of 9/10 June, was discussed with two healthcare managers as well as a healthcare trade union representative. The principal officer's findings showed no evidence of any shortfall in the agreed staffing levels for the material time.

As noted above, those healthcare staff interviewed felt strongly that the number of staff on duty on 9 and 10 June was insufficient to enable them to cope with the demands placed on them. Some of them shared a perception that overtime was not sanctioned to make up for shortfalls. However, the healthcare officer confirmed that he was in fact working overtime on 10 June for that very reason. Both healthcare officers were adamant that the number of healthcare staff on duty over the weekend was in keeping with agreed staffing levels. They also showed my investigator evidence to suggest that that the only incident that occurred on 10 June prior to 6.00pm was what they described as a relatively minor act of self-harm.

In all these circumstances, I do not think it can be conclusively said that the number of healthcare staff available on 9 and 10 June, or the workload they faced that weekend, were the reasons that the man was not seen before he died. However, while with the benefit of hindsight it is easy to judge that the man should have been seen more promptly, I am equally reluctant to criticise staff for not doing so. My reluctance is based on the following factors:

- Although his behaviour was bizarre, the man did not present as suicidal. It was reasonable for staff to consider him as non-urgent.

- The man had appropriately been referred for a mental health assessment during the reception procedures on 8 June. This assessment was likely to have taken place on Monday 11 June. Given his presentation, I consider this timing to have been reasonable.

Completion of form F213SHSH

The investigation found that form F213SHSH was not completed after the other prisoner had sustained an injury following an assault by the man during the night of 8/9 June. Had this been done, the other prisoner would have been examined by a healthcare professional. This, in turn, might possibly have led to an examination or assessment of the man.

The Governor should remind his staff that, whenever a prisoner sustains an injury not caused by self-harm, a form F213SH (report of an injury to a prisoner) must be completed and the prisoner must be examined by a healthcare professional as soon as possible afterwards.

Was the man's risk of suicide properly assessed, monitored and managed?

When the man entered Cardiff prison, he told reception staff he had undergone psychiatric treatment in the community 17 years earlier and had tried to hang himself in May 2006. However, he gave no indications that he was currently at risk of suicide. Consequently, no formal self-harm monitoring procedures were initiated. Nevertheless, the member of staff who completed the reception health screen, taking account of the man's pyschiatric history, decided to refer him for a mental health assessment.

Thereafter, as I have said above, although the man's behaviour was at times bizarre, at no stage did he give any obvious indications that he was contemplating suicide. The only remark he did make that could have been interpreted as an indicator of the presence of suicidal thoughts was his question to an officer, "Do I have to go to heaven tonight?" But this remark was, to say the least, oblique. I make no criticism of the fact that it did not trigger the opening of an ACCT form.

The clinical reviewer comments as follows:

> "One hypothesis for the man's withdrawn and unusual behaviour over the weekend, culminating in suicide, was that he was withdrawing from drugs and/or alcohol. A simple urine test could have verified his (the man's) statement that he had not taken drugs for 18 days. If found positive on entry to prison, he might have been treated on the detoxification unit for his withdrawal."

Whilst I am concerned that no urine test was carried out on the man, and that it was therefore possible that his death may have been linked to his abuse of drugs, there is no direct evidence to prove this. As I have said in my foreword to this report, the toxicology report that followed the man's post mortem examination established:

> "… the observed low concentration (trace amount) of diazepam found in the post mortem blood would be consistent with therapeutic use and does not indicate an overdose of this drug prior to death."

I am satisfied that the decision only to refer the man for a mental health assessment, following his disclosure of his psychiatric history and his apparent attempt to hang himself in May 2006, was justified. In reaching that conclusion, I have taken into account the fact that during the reception health screening process the man said that he was not feeling suicidal.

Was the response by staff to the discovery of the man hanging prompt and effective?

As soon as the officer from the first night centre saw the man hanging in his cell, he called for emergency assistance over the radio. He then entered the cell and, with the assistance of a colleague, cut the ligature away from the man's neck. They lowered the man so that he could be carried out onto the landing where there was more space in which to apply emergency first aid procedures. Checks were made promptly to ascertain whether the man had a pulse or if he was breathing. Having found no signs of life, the staff started to apply CPR. After about a minute, a Healthcare Officer arrived and gave his assistance. The full range of emergency first aid equipment was taken to the cell. An ambulance was called at 6.02pm. A paramedic crew arrived at 6.06pm. The crew continued to administer CPR until approximately 6.20pm when they pronounced the man dead.

I am satisfied that the response to the discovery of the man hanging was prompt. Although it was apparent that the man was beyond the point where his life could be saved, prison staff and paramedics made determined attempts to revive him in very harrowing circumstances. I commend them for doing so.

Were appropriate courtesies offered to the man's family in the aftermath of his death?

The ability of staff at Cardiff to inform the man's family of his death promptly was significantly impaired by the absence of any next of kin details. It is unfortunate that the man did not disclose such details when he was admitted to Cardiff on 8 June. However, the investigation found that the principal officer and the chaplain, with help from Swansea police, did their best to ascertain who was the man's next of kin and to break the news of his death as quickly as was reasonably possible under the circumstances.

The man's belongings were returned to his family. The Governor met the funeral costs in full. He was also keen for a representative of the prison to attend the funeral but the man's mother, as was her right, did not want this.

Family concerns

The family asked for the following questions/concerns to be answered during my investigation:

What were the man's legal representative's thoughts on the man's mental health when they saw him? What did the man say to his legal representative and how did he seem? Has he represented the man before and did the man seem the same?

I have covered this matter on page 9 above.

Did the man leave a note?

No note of any kind was found in the man's cell after he was found hanging.

Were there any writing implements in his cell? (I.e. could he have written a note if he wanted to?)

My investigator asked to see a copy of the cell clearance certificate in respect of the man. The cell clearance certificate completed after the man's body had been removed shows that he had no writing implements in his possession. My investigator was told that, if a prisoner arrives at Cardiff without any writing implements, staff will provide what he needs on request.

Why did CID take the man's watch and necklace off his bunk after the man was found? Shouldn't they have been left as evidence because of the severity of the situation? The man didn't normally take his jewellery off. Were they on him or were they as CID said taken off his bunk?

My investigator attempted on a number of occasions to contact this police officer but was unsuccessful. He was therefore unable to investigate this matter.

The man was referred for a full psychiatric assessment (on Monday because the psychiatric nurses only work Monday to Friday). Why wasn't he put on a 'suicide watch'? If there was an inkling that something was wrong, which obviously there was because of the referral, why wasn't he put on a watch?

I have considered this important issue at various points in my report. The man was not made subject to any formal self-harm monitoring procedures because he gave no indications that he was currently at risk of self-harm or suicide. He was referred for a mental health assessment because of his strange behaviour. (See pages 11, 12, 13, 17-25.)

A suicide prevention officer was appointed. What was his involvement? Did he see the man.

The role of the Safer Custody Manager is to quality control the suicide and self-harm policies and procedures in place in the prison. At Cardiff this role falls to the principal officer. However, the role does not require him to undertake the personal management of individual prisoners.

The chaplain spoke to the man on Saturday morning and his words were "saw no cause for concern." The health worker saw the man the same day because of an altercation with his cell mate on the Friday evening and stated that they wanted to see the man again on the Sunday. Despite the fact that he was having a full assessment on the Monday – obviously saw concern again – why wasn't he put on suicide watch? What

was the concern to see him again on the Sunday? The health worker was due on the man's block at 7.00pm (estimated) and he was found at 5.55pm.

These matters are covered on pages 17 - 25.

If the man wasn't on 'suicide watch' why was he checked again at 5.00pm then again at 5.55pm? Where are the logs stating the checks? Who was the last person to see the man alive? What was the last thing the man said to a guard or prisoner?

The man was seen by the same prison officer that completed the security information report at 4.00pm on Sunday 10 June while he was taking his tea meal. The prison officer noticed nothing amiss at that time. There was no requirement for the prison officer to make a record of what he saw. At about 5.00pm, the prison officer from the first night centre checked the man in his cell as a matter of routine. The officer from the first night centre told my investigator he saw the man lying on his bed. The officer from the first night centre said he tapped the glass window in the cell door and asked the man if he was alright. The man waved at the officer from the first night centre. Again, there was no requirement for the officer to make a record of this check. It is highly likely that this officer was the last person to see the man alive.

The officer from the first night centre checked the man again at 6.00pm. It was at this time that he found the man hanging. The officer's check of the man at that time was part of a routine check of all prisoners in the first night centre, and not part of any assessment of a risk of self-harm (because the man was not thought to be at risk).

Why was the man pronounced dead almost an hour later? What took so long? Was he actually alive when they found him?

The man was found at 6.00pm. The ambulance crew arrived at 6.06pm. The man was pronounced dead at 6.20pm.

What was the fight about? What was said? Why was the man moved and not the cell mate?

These matters are dealt with in the main body of the report. See pages 12 and 13.

Why didn't they have his records? Isn't it compulsory to obtain a prisoner's file on remand? If not, why not? Especially as the man was not known to the Cardiff Prison staff?

My investigator was told that it is not current practice to call for previous prison records. However, my investigator asked to see records kept at HMP Swansea and HMP Parc. Two records were sent from Swansea: one for the period 28 April to 27 July 2004, and the other for the period 6 June to 1 August 2003. My investigator later received a copy of the record relating to the man's time at Parc prison. None of these files contained any evidence of previous attempts at self-harm.

When was the last time the man was at Cardiff Prison?

There is no evidence that the man had been at HMP Cardiff before.

Why didn't the representatives from Cardiff go to the man's mother's home? Where did they go? Why didn't they get her address from the police in Swansea?

These matters are dealt with in the main body of the report. See pages 16 and 23.

The man's family are certain that this was a cry for help. The man had ample opportunity to do this in his flat where people wouldn't visit for days at a time. Why in jail and not at home? The man had two beautiful children and he would not leave them.

The investigation found evidence that the man was in poor mental health immediately before his death. Moreover, the experience of being locked in a cell is very different from that of living alone in a flat. We cannot know if his death might have resulted from a cry for help.

Why was the man's mother told by the principal officer that it was determined effort? What did he mean by that?

I understand that the principal officer's remark was said in the context of explaining to the man's mother how the man was found. The principal officer told my investigator he meant that the man's method of hanging himself was such that he seemed to have made a determined attempt to kill himself.

The family were also told that sometimes these things are premeditated i.e. the man initiated the fight in the cell to be alone so he could do this. Do they think this was the case? If so why?

I have found no evidence that the man deliberately manipulated his being placed in a single cell.

How many offers of making a phone call was the man given? Why did he refuse? What were his reasons for refusing?

It is known that the man was offered a free telephone call and a free letter during the reception procedures at Cardiff on 8 June. He refused both. It is possible that the man did so because he did not want his family to know he was in prison.

The man's death certificate shows the wrong birth date. Why?

This is probably because the man gave the wrong date on reception.

Why was the man remanded in the first instance? Apparently they were not serious offences.

This too is covered on page 9 of this report.

Conclusion

I have the sad duty of investigating the deaths of many young men in prison. Very often those deaths can be related to mental health problems. It is clear that the man was one such young man, but my investigation found that he gave prison staff no

indication he was actively contemplating suicide. While I am critical of some aspects of his care, I conclude that his death could not reasonably have been predicted.

RECOMMENDATIONS

1. The Governor should remind his staff that, whenever a prisoner sustains an injury other than by self-harm, a form F213SH must be completed and the prisoner must be examined by a healthcare professional as soon as possible afterwards.

I also repeat here the recommendations made in the clinical review of Health Inspectorate Wales. As noted, I have endorsed only the first recommendation.

2. Prison authorities should give consideration for routine urine testing for drugs in prisoners who admit taking drugs and alcohol to excess in the past.

3. Healthcare management must give regard to ensure that the recommended full complement of staff is present to maintain a safe level of care for prisoners who need it.

Commendation

I am satisfied that the response to the discovery of the man hanging was prompt. Although it was apparent that the man was beyond the point where his life could be saved, prison staff and paramedics made determined attempts to revive him in very harrowing circumstances. I commend them for doing so.