PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Cardiff in July 2012

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to
safer, fairer custody and offender supervision’

This is the report of the investigation into the death of a man at HMP Cardiff in July 2012. The man was found hanging from the bars of his cell window. He was 45 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local PCT appointed a clinical reviewer to conduct a clinical review. Cardiff cooperated fully with our enquiries.

The man had complex mental health issues. He spent the first two months of his sentence in the prison's healthcare centre because his behaviour was described as bizarre and aggressive. He then moved to the remand wing where he attended education daily and interacted well with staff and prisoners. In the days before his death, he saw the prison doctor about his medication but gave no indication of the action he was about to take.

While I do not consider that his death was foreseeable, this investigation has found a number of areas for improvement at Cardiff. Assessment of risk on reception did not take into account all available information and there is no evidence that a secondary health screen subsequently took place. His discharge from the healthcare centre was not well managed, he was not followed up by the mental health in-reach team as promptly as he should have been and there were record keeping and prescribing deficiencies. It is also of concern that he was not properly reviewed after he had been convicted via video link of a serious offence with a potentially long sentence. Finally, the investigation found that emergency procedures at Cardiff require improvement.

This is a lengthy list of deficiencies and it is particularly disappointing that some of them have been identified in previous investigations into deaths at the prison. I trust that the Governor and Head of Healthcare will take robust action to avoid recurrence.

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 I my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2013**

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SUMMARY

1. The man had received mental health treatment since 1994. Shortly before his remand into HMP Cardiff, he had been arrested, but taken to hospital. He was discharged without further treatment.

2. On 13 April 2012, he appeared at court charged with arson. Court officers opened suicide prevention procedures and he was monitored in a cell with a camera. When he arrived at Cardiff, suicide prevention procedures were not started, but he was admitted to the healthcare centre as an inpatient for further observations and assessment of his unusual behaviour by the mental health team. On 16 April, a psychiatrist prescribed antipsychotic medication. Over the following weeks, his behaviour was still erratic and he continued to be monitored by nurses and the mental health team. On 1 May, his antipsychotic medication was increased.

3. On 18 May, the man was transferred to a remand wing, although there is no record of the decision to discharge him from the healthcare centre. He was discussed at the mental health team meeting on 23 May and was accepted onto their case load. He appeared to settle into wing life and he attended education daily and mixed with other prisoners.

4. He was convicted via video link to court on 18 June, but he was not reviewed or assessed after his change of status. However, on 21 June, he was assessed by the mental health team for the first time since leaving healthcare. The nurse noted that he felt much better, displayed no psychotic behaviour and said he did not feel suicidal.

5. On 4 July, he told a doctor that he had thoughts racing through his mind, but could not be more specific. The doctor noted that he was not distressed and referred him for psychiatric assessment. This was the last time that he was seen by a member of the prison's healthcare team.

6. On 5 July, the man was due to be sentenced but this was adjourned until 12 July. A couple of days later, he was found hanging from the window bars. Resuscitation was started and continued by paramedics. The first defibrillator brought to the scene did not work. He was pronounced dead by the doctor at 9.21am.

7. The clinical reviewer has identified concerns about the lack of secondary health screens, record-keeping, the delivery of mental healthcare and the arrangements to discharge the man from the healthcare centre, with which we agree. He should also have been reviewed once he had been convicted. Finally, we are concerned that emergency equipment had not been regularly checked, and that an ambulance was not called immediately.

THE INVESTIGATION PROCESS

8. The Ombudsman was notified of the man's death on 7 July. The investigator issued notices informing staff and prisoners at Cardiff of the investigation and asking anyone who had relevant information to contact him. No responses were received.

9. Another investigator visited the prison on 12 July on the first investigator's behalf. She met the investigation liaison officer, the prison's family liaison officer and obtained relevant documents.

10. The investigator informed Her Majesty's Coroner for Cardiff and Vale of Glamorgan District about the investigation and provided the results of the post-mortem examination. The Coroner has been sent a copy of this report to assist with her enquiries.

11. The local PCT appointed a clinical reviewer to review the clinical care that the man received while he was in prison. She was given copies of his medical records and relevant aspects of his prison records. The clinical review was received on 13 December 2012.

12. The investigator and clinical reviewer reviewed the man's records and conducted interviews with staff at Cardiff. The investigator provided initial feedback to the Governor of Cardiff.

13. One of the Ombudsman's family liaison officers contacted the man's family to tell them about the investigation. They had no specific issues they wished the investigation to consider.

14. The family received a copy of the draft version of the report as part of the consultation period. Having considered the investigation findings, they indicated to the family liaison officer that they had found the report comprehensive, informative and helpful. They confirmed they had attended the inquest hearing and had no further comments or feedback to provide on the report.

HMP CARDIFF

15. HMP Cardiff is a local prison, predominantly serving the Welsh courts and the South West of England. It holds approximately 800 adult convicted and remand prisoners.

16. The local health board commissions healthcare, but all nurses and other healthcare staff are employed by the Prison Service. The general practitioner service is delivered by the local health board, which also employs a consultant psychiatrist for seven sessions a week. A 22 bed inpatient facility in the healthcare centre provides 24-hour nursing and medical cover. A mental health in-reach team provides both primary and secondary mental health services.

Her Majesty's Inspectorate of Prisons (HMIP)

17. The most recent inspection of Cardiff was an unannounced follow up inspection in June 2010. The Inspectorate described the primary mental health provision as fragile, with no designated staffing, although the mental health in-reach team provided a good service to the small number of prisoners on their caseload.

18. In the previous inspection in 2008, the Inspectorate had recommended that secondary screening should be mandatory unless the prisoner refused. This had not been achieved in June 2010. We have commented in previous investigations on the failure to conduct secondary health screening as a matter of routine.

19. The Inspectorate also found a recommendation about the introduction of an electronic patient management system had not been implemented.

Independent Monitoring Board

20. Every prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who monitor standards to help ensure prisoners are treated fairly and decently. In its latest annual report for September 2010 to August 2011, the IMB questioned whether prison was a suitable place for some prisoners with mental health problems. The IMB was satisfied that suicide prevention processes were well used, and reported that most ACCTs were opened in reception, the induction wing or detoxification wing.

Previous deaths at HMP Cardiff

21. Since 2010, there have been two apparent self-inflicted deaths at Cardiff and six natural cause deaths. In this report, we repeat our concern that nurses in reception do not have access to all relevant records. The failure to complete secondary health screens and medical record keeping are also recurrent themes.

KEY EVENTS

The man's previous contact with mental health services

22. The man had received mental health treatment since 1994. He was admitted for mental health treatment on several occasions with the symptoms of depression, visual hallucinations, delusional beliefs and thought disorder. He had previously been detained under the Mental Health Act.

23. On 29 March 2011, after making threats to shoot members of the public, he was taken by police to hospital, to be assessed under section 136 of the Mental Health Act. (Section 136 of the Mental Health Act allows for any person to be removed to a place of safety, if they are found in a public place and appear to a police officer to be suffering from a mental disorder and in immediate need of care or control.) He said he had used drugs and he was "tripping". The doctor noted that he was intimidating, confrontational and manipulative, but he was not distressed and there was no evidence of psychosis. He asked the doctor to be sectioned for 28 days so he could watch television and be cared for. The doctor concluded that he was not suitable for either home treatment or admission to hospital. He was discharged back to the care of the police.

24. The next day, 30 March, the man was again detained under section 136 of the Mental Health Act, after he had set off the hospital's fire alarms and urinated in the car park. He was assessed again by a doctor, who concluded he should not be admitted to hospital and there was no need for follow up. He was hostile and aggressive when he left the hospital and was arrested for breach of the peace.

Arrest and remand to HMP Cardiff

25. In the early hours of 11 April, the man was arrested and taken to hospital under section 136 of the Mental Health Act. The hospital psychiatrist noted that he was aggressive and said that he was "tripping" and coming down from drugs. The psychiatrist found no evidence of serious mental illness and he was discharged again.

26. Later that day police were called to his neighbours' flat, where he was holding a knife to his leg, threatening to self-harm. He was again detained under section 136 of the Mental Health Act. He said that he had been using cannabis and had been given drugs against his will. He was discharged after another psychiatric assessment concluded that he had no mental illness.

27. That evening, he tried to set fire to his home and was taken into police custody charged with arson. He was described as incoherent during the assessment and possibly under the influence of drugs. He claimed his mother and brother had died and that he had recently returned from serving in Afghanistan (there is no evidence that this was true). He was considered fit to be detained in police custody.

28. On 13 April, the man appeared at Magistrates' Court, charged with theft and arson with the intent to danger life. A person escort record form (PER) was completed. (The PER form accompanies prisoners on all journeys from and between prisons. It serves as a communication tool about risks a prisoner poses on escort or transfer.) Police noted that he had tried to hang himself on 30 March (although there is no other evidence of this), and had tried to burn his house down the previous day. It recorded that he used cocaine and suffered from depression and schizophrenia.

29. A community psychiatric nurse (CPN) assessed him and opened a suicide self-harm warning form. The CPN noted on the form that he had made threats to hang and set fire to himself earlier that day, but found no evidence of mental health problems. He was placed in a cell with a camera at court and was observed by staff intermittently, until he was remanded to Cardiff later that morning. An Escort Custody Officer (ECO) noted on the PER form that he was talking "rubbish and gibberish" to himself and banging the sides of the prison van. He arrived at Cardiff prison at 12.05pm.

30. In reception, a Senior Officer (SO) signed his suicide self-harm warning form indicating that he would be kept safe until screened by a member of healthcare staff. In the first reception health screen, a registered mental nurse (RMN) wrongly recorded that he had not tried to harm himself in or out of prison, but had been admitted to a psychiatric hospital in 2009. He told the nurse that he was an occasional cannabis user and used illicit benzodiazepines (prescribed for anxiety and depression) most days. The nurse noted that he was "bizarre" but polite and had no thoughts of harming himself.

31. A nurse noted that the man had arrived at the prison with a suicide self-harm warning form, but that no immediate action was required. The nurse indicated on the form that he did not need to be placed on an ACCT (Assessment, Care in Custody and Teamwork, the prison system used to identify and support prisoners at risk of suicide or self-harm), but referred him for assessment by the mental health in-reach team. He gave details of his General Practitioner (GP), but there is no record that his medical history was obtained.

32. A cell sharing risk assessment (CSRA) was completed by an officer. (A CSRA is used to assess the risk of violence that a prisoner would present to other prisoners when sharing a cell.) The officer noted that he had a history of arson and mental health issues, and had been suicidal earlier that day. The nurse wrote on the CSRA that he was suffering from psychosis and was to be located in a single cell in healthcare for further assessment. He refused to take part in the prison's induction programme.

33. The man's care plan included hourly observation of his mood and behaviour, a psychiatric assessment, and a request for his community psychiatric history (although there is no evidence that this was processed). He was described as elated and excitable and unwilling or unable to participate in admission procedures. A doctor prescribed diazepam (used to treat anxiety and sleeplessness). That evening he was described as abusive, threatening,

disruptive and chaotic. He spat at staff when they opened his observation panel, damaged his cell and attempted to flood it.

34. The next morning, 14 April, a Senior Nurse tried to complete his secondary health screen, but could not because he was too disordered. There is no record of a secondary health screen taking place subsequently.

35. Later that afternoon a doctor assessed him and questioned whether he had drug-induced psychosis. The doctor noted that he was agitated and aggressive and had been referred to the in-reach team for assessment. The doctor prescribed olanzapine 10mg (an antipsychotic). The doctor told the investigator that during the assessment the man's urine was tested for drugs and recalled he was positive for amphetamines (a stimulant). The doctor prescribed 20mg of diazepam which is sometimes used in the treatment of drug and alcohol withdrawal. Over the next couple of days, his behaviour continued to be erratic.

36. On 16 April, the man was discussed at a ward round. (A consultant psychiatrist explained that during a ward round patients would not necessarily be seen in person, but their care plans would be discussed with other healthcare professionals including members of the mental health in-reach team.) The psychiatrist assessed him after the ward round and noted that the "feeling from community team is that the patient is not mentally ill". He considered that he should remain in healthcare for assessment and planned to review him again later that week. It was noted in his on-going medical record that he remained euphoric and inappropriate at times over the next few days.

37. On 18 April, the man was described as "psychotic and thought disordered. Agitated with shouting and banging throughout the day". That evening, he was observed wrapping a sheet around his head and drawing a face on it. A Registered General Nurse (RGN) and a nurse told the investigator that they did not consider him at risk of self-harm.

38. At an in-reach referral meeting on 18 April, it was agreed that as he was located in the healthcare centre, the psychiatrist would review him again before the team took him onto their caseload. (This was not added to his record until 2 May.)

39. On 19 April, the man was moved to a cell with a television. He was said to have been quieter after the move but became more and more demanding as the evening went on. On 20 April at approximately 3.30am, the electricity to his cell was switched off as he had turned his television volume up to full and would not turn it down. He then smashed his television and was moved back to his previous cell. He continued to display volatile behaviour the following day, tearing his mattress and clothes. A doctor prescribed him 10mg of diazepam that evening in order to assist with his agitation.

40. The doctor told the investigator:

> "He didn't know where he was, who he was, he was very agitated and he was not self-harming or showing any signs of that. But you couldn't have a rational conversation with him to assess his, we obviously made sure he was safe, he was in a camera cell and being obviously closely observed, but you couldn't have had a conversation with him to assess his self-harm risk."

41. Entries made by healthcare staff on 21, 22 and 23 April noted that the man continued to display "bizarre" behaviour. He was reported to be shredding anything he could in his cell, wrapping paper around his head, making parcels of faeces and occasionally drinking the toilet water. He remained abusive to staff.

42. At a ward round on 23 April, the psychiatrist discussed the difference between the man's constant demands in his cell, and his calmer presentation when out of his cell. There was still a question whether he had a mental illness and the consultant psychiatrist agreed that he should remain in healthcare for further observation.

43. At a ward round on 30 April, there was considered to be increasing evidence that his behavioural disturbance was not related to an underlying mental illness, but some of the team disagreed. He continued to be observed on healthcare and take olanzapine. On 1 May, his olanzapine was increased to 20mg, and the diazepam was discontinued.

44. The psychiatrist assessed him for the second time on 2 May. He noted that he continued to exhibit disturbed behaviour, was overactive, not sleeping and pacing around his cell. The psychiatrist noted that the olanzapine had increased to 20mg a day and that this had coincided with an improvement in his behaviour. He told the doctor that he felt better and that his medication had calmed him down. However, he said his thoughts were racing and that his "… head was just gone crazy".

45. Over the next couple of weeks, the man became more settled, less irritable and less confrontational. At a ward round on 14 May, the psychiatrist advised that he should continue taking olanzapine and that he was to remain in healthcare for further observation to inform his diagnosis. However, he was discharged from the healthcare centre on 18 May and transferred to a wing for remand prisoners. There is no record as to who agreed to discharge him and for what reason.

46. The man made an application to see a Counselling Assessment Referral Advice Throughcare Service (CARATS) worker to address his cocaine and LSD addictions, which he said had led to his offending behaviour and mental health issues. (CARATS provide support to prisoners with substance misuse needs.) His CARATS worker met him on 22 May. He told him that he had no thoughts of harming himself, but wanted support with his recreational use of cocaine when he was released. The CARATS worker advised him that he had to wait until he was sentenced for a referral to community services. He

had no further contact with the CARATS worker or the CARAT service.

47. At a mental health in-reach referral meeting on 23 May, it was agreed that the man would be accepted on the in-reach caseload following his discharge from healthcare. Although the psychiatrist did not review him again, he saw him on a couple of occasions informally on the wing. He said that the man told him that he was feeling well and had no particular problems.

48. On 27 May, the man's personal officer recorded that he complied with the wing's regime. (Each prisoner should be allocated a personal officer to support them and be their first point of contact.) On 29 May, he was interviewed by a psychiatrist for a psychiatric report requested by his solicitor. He said that he felt okay and had no thoughts of self-harm.

49. On 30 May, a doctor continued his prescription of olanzapine 20mg. She did not see or review him in person.

50. On 18 June, he was convicted of arson, via video link, at Crown Court. He was remanded in custody to await sentencing. There is no evidence that he was reviewed at that time, despite his change of status. However, on 21 June, a nurse assessed his mental health. (This was the first mental health assessment since 2 May). The nurse had never met him before, but noted that he felt much better and appeared to be coping fairly well. They discussed his upcoming sentencing. The nurse noted that there was no evidence of psychotic symptoms or "odd behaviour". The nurse planned to monitor his mental health needs for potential risk of self-harm and for him to be reviewed further by the psychiatrist. The nurse told the investigator that he did not express any suicidal intent on 21 June and he did not see him again before his death because he was on leave. This was the last time that he was assessed by a member of the prison's mental health in-reach team.

51. On 25 June, a doctor continued his prescription of 20 mg olanzapine. Again, she did not see him to review his medication.

52. On 26 June, the man appeared at Magistrates' Court. He returned to the prison from court having been given technical bail for further charges of theft and harassment.

53. On 4 July, a Healthcare Assistant (HCA) saw him while he waited to see the doctor. The HCA said he seemed okay and looked better, although he told her his olanzapine was making him "trip out". He told the doctor that his mind had been racing, he had trouble sleeping and his medication was not working. She noted that he had good eye contact and was not agitated. He said that his thoughts were not upsetting him, so she suggested sleeping pills, but he said he did not want more medication. She told the investigator that he just wanted to see the psychiatrist, so she booked an appointment for 10 July, after his next court appearance. The doctor said she could not remember whether he discussed thoughts of self-harm or suicide and did not mention it in her entry.

54. The day before the man's death, the psychiatrist said that a doctor sought his views on his presentation. He explained that he had changed his mind several times about his diagnosis, but that he had decided to treat his symptoms. The doctor said that she did not think he had a psychotic illness. The psychiatrist concluded that he had no concerns about him and said he was due to see him the next week.

55. During the investigation the investigator spoke to a prisoner at Cardiff, who knew the man well. He said the man suffered from mental health problems, but was not the type to be bullied and could stand up for himself. He said that he gave no indication about what he was going to do and seemed resigned to the fact that he would spend some time in prison. He told the prisoner that he was to be charged with further offences. The prisoner remembered that he appeared quite down about the new charges the day before he died, but said he was often "up one day and down the next".

56. The prisoner said that he last saw him shortly before they were locked in their cells. He said he appeared depressed but did not talk about suicide or self-harm.

Day of the incident

57. One morning in July, Officer A completed the morning roll check with another officer. He said that the man appeared fine and was sleeping in his bed. When he had finished the check he returned to the wing office where he made himself a cup of tea and waited for the arrival of the day shift at 8.00am.

58. At about 8.15am Officer B went to the cell adjacent to the man's to make a list of what needed to be put back in the cell, as it had recently been refurbished. At about the same time, the wing cleaners were let out of their cells to collect their breakfast.

59. At about 8.40am, Officer B began to unlock the rest of the landing for breakfast. She started at cell four and made her way along to cell number 27, the man's cell. When she looked through the observation panel, she saw that he was suspended from the window bars. He had tied a sheet across the window from one hinge to the other, similar to a washing line, and used this to suffocate himself.

60. She called for help. Officer A, who was a short distance from the cell, called a code blue over the radio. (A code blue is an emergency code which indicates that someone has stopped breathing and requires urgent medical assistance.) They both entered the cell. (The investigator was unable to establish an exact time when the man was discovered. Timings varied between 8.45am on statements by staff to 8.53am, when the control room log recorded that the code blue was called.)

61. Officer A supported the man's body, while Officer B used her anti-ligature knife to cut the ligature and he was laid onto the cell floor. A SO was nearby and was followed closely by a nurse and a HCA. Officer C, a first responder,

brought a defibrillator. The nurses had also been on the wing when the alarm was raised and brought with them the emergency response bag, which included resuscitation equipment.

62. The nurse said that she could not find a pulse, so started mouth to mouth resuscitation assisted by Officer C, who did chest compressions. She said that the man appeared blue in colour and was cold to the touch. The defibrillator was attached to him, but the battery was flat, so would not work, and there was no spare battery in the pack. Another defibrillator was obtained but reported that there was no heartbeat and that no "shock was required". Resuscitation continued.

63. The SO radioed for a doctor (the incident log shows this call was made at 8.54am). A few moments later, he was told that there was no doctor in the prison, so he asked for an ambulance to be called. The death in custody checklist and control room log record that an ambulance was called at 8.57am, although this appears to have been overwritten with 8.53am on the checklist. Paramedics arrived at the prison at 9.05am and at the cell at 9.10am. Despite further attempts to resuscitate him the paramedics advised that resuscitation should stop. By this time, a doctor had arrived and pronounced him dead at 9.21am.

64. Later that morning the family liaison officer (FLO), the Governor and a chaplain visited the man's brother to break the news of his death. The FLO returned the next day to support the family. The prison paid for the funeral and, as requested by his family, the prison's chaplain officiated.

Support for prisoners

65. A notice to prisoners was issued by the Governor the same day which informed them of the man's death and expressed condolences. The notice reminded them of the support available from wing staff, the prison chaplaincy and Listeners. Prisoners subject to ACCT were reviewed.

Support for staff

66. The duty governor held a hot debrief with staff who were directly involved with the incident (a hot debrief is a meeting immediately after an incident, designed to reassure staff, and provide them with support). During interview, officers said that they were aware of the care team and that, if they chose to, they could contact them at any point for ongoing support.

ISSUES

Reception at HMP Cardiff

67. Officers at the Magistrates' Court opened a suicide self-harm warning form because the man made threats to set fire to himself. His records also showed he had tried to hang himself. At HMP Cardiff, the SO confirmed that he would be kept safe until he was assessed by the nurse.

68. The man arrived at the prison at 12.05pm, but he was not assessed by the reception nurse until 1.40pm. A single nurse works in reception from 1.30pm and prisoners who arrive in the morning have to wait until the afternoon to be assessed. At interview, the nurse said that staff in reception did not prioritise those prisoners who arrived on suicide self-harm warning forms. He said that the prisoners who arrive in reception "… just come through in order".

69. Prison Service Instruction (PSI) 74/2011, Early Days In Custody – Reception In, First Night In Custody and Induction to Custody, section 2.33, states:

> *"The reception procedure can be a stressful experience for prisoners, who must not be held in escort vehicles or holding rooms any longer than is necessary while waiting to complete the procedures, before moving on to their first night location."*

70. Although the man was subject to a suicide self-harm warning form, he was not assessed by a member of healthcare staff for over an hour and a half after his arrival at the prison. We are concerned that there is no system to prioritise prisoners who have been assessed as at risk and make the following recommendation:

The Governor should ensure reception officers prioritise the assessment of prisoners who arrive at the prison with suicide self-harm warning forms from the police and other agencies.

71. The nurse said he did not see the PER form when assessing the man. The PER contained additional information about his risk of self-harm. The reception nurse should have access to and consider all the relevant paperwork, to make an informed decision about whether a prisoner is at risk of self-harm. Had the nurse seen the PER, it is possible he might have altered his assessment.

72. We note that a previous investigation of a death in June 2012 highlighted the fact that relevant information was not being shared with the reception nurse.

The Governor and Head of Healthcare should ensure that healthcare staff have access to and consider relevant documentation, including PER forms and suicide self-harm warning forms in order that they can carry out an informed assessment of a prisoner's risk.

73. The nurse said that he did not open an ACCT as the man did not present to him as someone at risk of self-harm. We are concerned that an ACCT was not opened in light of the information on his PER and his suicide self-harm warning form. PSI 64/2011 – Safer Custody - requires "Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide and self-harm must open an ACCT..." The PCT concludes an ACCT would have focused on his recent self-harm and suicidal ideation and provided a more systematic assessment and monitoring process.

74. It is the responsibility of all staff, including officers working in reception, to assess the risk that a prisoner may pose to themselves with regard to self-harm, not just the reception nurse, and to take fully into account information from agencies such as the police. We agree with the PCT that an ACCT would have allowed more systematic assessment and consider it would have been prudent to open one in the light of the warning from the police. We make the following recommendation:

The Governor should ensure that all reception staff are aware of their responsibility to open an ACCT if there is information that a prisoner has self-harmed or threatened to do so.

Community medical records

75. Although the nurse said he requested the man's previous health records from his GP, there is no evidence of the request. Records from his GP were never retrieved.

76. PSI 74/2011 Early Days in Custody – Reception In, First Night In Custody, and Induction to Custody, Annex D says:

> *"Efforts should be made to retrieve any information required from the prisoner's GP, or other relevant service the prisoner has recently been in contact with…"*

77. We make the following recommendation.

The Head of Healthcare should ensure that community GP records are routinely requested for all prisoners to ensure continuity of healthcare.

Secondary health screen

78. A nurse tried to complete a secondary health screen the day after the man's admission to healthcare. He was too agitated and refused to cooperate. There is no record that the health screen ever took place.

79. In an interim report into the man's death, the Clinical Director at Cardiff reported that, "If a secondary health screen is not completed for any reason it needs to be rebooked in the appointment ledger. GPs should also be vigilant and complete secondary health screening opportunistically, if not already

done." Similarly the PCT comments on this matter in its review.

80. This office has raised this issue in four of the eight deaths that it has investigated at Cardiff since 2010, the most recent being the report into the death of a man in January 2011. We repeat our recommendation:

The Head of Healthcare should ensure that secondary health screens are completed in a timely manner.

Returns from court and change of status

81. On 18 June, the man appeared at Crown Court via video link from the prison's video suite. He was convicted of arson with intent to endanger life, which carries a maximum sentence of life imprisonment. There was no evidence that his risk was reassessed by officers or a nurse after his video link appearance.

82. PSI 74/2011, Early Days In Custody – Reception In, First Night In Custody and Induction to Custody, section 2.18 says:

> "Assessments must also be made of prisoners who by-pass some reception processes owing to their late arrival or disruptive behaviour, and those whose status and demeanour may change after a court appearance via video link."

83. The Clinical Director said that no nurses were on duty in the video link suite, so healthcare staff were reliant on officers to contact them. An officer working in the video link suite told the investigator that prisoners who had had a change of status would not always be reviewed by a nurse after appearing via video link. The man's personal officer said that personal officers are not told about changes in status.

84. PSI 64/2011 Management of Prisoners at Risk of Harm to Self, to Others and from Others (Safer Custody) also recognises change of status as a factor that could increase an individual's risk to self-harm. Additional charges can increase a prisoner's risk of self-harm or suicide. Prison Service Order (PSO) 3050 requires that a protocol is in place to screen prisoners passing through reception for any potential healthcare, suicide or self-harm issues. After the man was technically bailed for further theft and harassment offences on 26 June, he was not reviewed.

The Governor and Head of Healthcare should ensure prisoners who may experience a change of status either on their return from court or after appearance via video link receive a screening for any potential healthcare or suicide and self-harm issues and that wing staff are notified.

Healthcare records

85. During our investigation, it became apparent that healthcare staff used three separate systems to record the man's clinical care, SystmOne, PARIS (NHS electronic records), and handwritten logs. The local PCT comments that this was confusing for healthcare staff and equally problematic for any investigation, review or audit. The PCT reports that handwritten records were not always accurate, contemporaneous, clear or legible and some signatures were impossible to read.

86. The Inspectorate was concerned in 2010 that the prison was not using an electronic patient management system. Although this has now been implemented, its use alongside other systems has the potential to undermine effective record keeping and the effective delivery of health services. The PCT concludes that record-keeping undermined communication and continuity of care in the medical team for the man. We have commented previously on the quality of healthcare records at Cardiff and make the following recommendation:

The Head of Healthcare should ensure that healthcare staff use SystmOne to record all clinical entries and comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Discharge from healthcare

87. On 18 May, the man was discharged from the healthcare centre to Cardiff's remand wing without assessment by a doctor. The psychiatrist said that he only learned about his discharge during his ward round on 21 May. When asked if he would rather the man had stayed as an inpatient in healthcare, he said that he would as, at the time, he was still unsure of his diagnosis and wanted to monitor him.

88. The PCT considers that the psychiatrist should have been consulted about the man's discharge. The absence of documentation was poor and did not reflect a collaborative team approach for what should have been a clinical decision.

89. In her internal review into the man's death the Clinical Director reported that there was no documentation or evidence that he had been deemed fit for discharge from the healthcare centre by a doctor.

> "We are now developing a discharge from healthcare template for SystmOne. It was immediately reiterated to all healthcare staff that no patient is to be discharged from healthcare without a doctor assessing that patient and documenting on SystmOne. The discharge from healthcare is a mandatory process and needs to be documented as such."

90. We endorse the PCT's recommendation that:

The Head of Healthcare should ensure a psychiatrist or doctor is consulted before a prisoner is discharged as an impatient from the healthcare centre and a care plan is put in place in consultation with officers on the wing.

Renewal of prescription

91. The PCT is concerned that prescriptions were reviewed without the man being seen by the prescribing doctors. It was unclear from the records why his olanzapine dose increased or how it related to his care and treatment planning process. The PCT could not determine the reason he was prescribed diazepam from his medical records. We make the following recommendation:

The Head of Healthcare should ensure that clear reasons for prescribing are entered on the prisoner's medical records and that prisoners on antipsychotic medication are seen for regular reviews.

Psychiatry and mental health in-reach team reviews

92. The man was discharged from the healthcare centre on 18 May and not seen by a nurse until 21 June. The psychiatrist explained that the in-reach caseload is heavy and he seemed to settle on the wing quite well. The nurse said that he was satisfied that he was well when he saw him on 21 June and that he was seen by nurses at the treatment hatch every day.

93. The man was first seen by a psychiatrist on 16 April, and his case was reviewed weekly at the ward round. The psychiatrist recorded that he was paranoid, bizarre and possibly psychotic, but that there was information from other agencies who felt he was not mentally ill but displayed significant behavioural disturbance as a means of manipulation. The PCT concludes that the decision by the psychiatrist that he should be assessed over a period of time was appropriate.

94. On 23 May, it was agreed that he would be monitored by the in-reach team, but he was then not seen for four weeks.

"In light of his presentation, his past history and the short period of time he was in healthcare, the PCT consider that ongoing clinical assessment and review process to be essential, however, there was no recorded evidence to show this had happened."

95. The PCT finds that the man received clinically appropriate treatment for his psychotic behaviour, and assessment in healthcare but concludes:

> "… the length of time from his in-reach referral and being assessed by the in-reach nurse and not being formally reviewed by a mental health professional for more than six weeks, is not

considered appropriate or timely."

96. The PCT reports that the staffing levels of the in-reach team were insufficient to manage prisoners with mental health problems effectively. The in-reach team comprises two CPNs, an occupational therapist and seven psychiatric sessions a week and they are responsible for the delivery of primary and secondary mental healthcare throughout the prison. Whatever the reason, he should not have had to wait so long to be seen by the mental health in-reach team. We make the following recommendation:

The Head of Healthcare should ensure that the mental health in-reach team sees new patients promptly for assessment and reviews their care at appropriate intervals.

Emergency Equipment

97. The first defibrillator brought to the man's cell did not work as the battery was flat. Another was subsequently brought and used. The Clinical Director reported that a lead nurse would now be appointed to be responsible for regularly checking all resuscitation equipment at the prison including defibrillators. It does not appear that the delay caused by the flat battery would have changed the outcome for the man, but in other circumstances this might be crucial.

The Governor and the Head of Healthcare should ensure that there are regular recorded checks of all emergency equipment.

Ambulance

98. The control room log records that the emergency code blue was called at 8.53am, but an ambulance was not requested until four minutes afterwards. The SO first asked for a doctor to attend but when he was told that there was no one available, he asked for an ambulance.

99. Cardiff's own local guidance requires an ambulance to be called when a code blue is called. A letter written jointly to all prison governors and primary care trusts by the Chief Executive of National Offender Management Services (NOMS) and the Director of Offender Health on 17 February 2011, made it clear that where there are concerns about the immediate health of a prisoner an ambulance should be called without waiting for healthcare staff to attend. Cardiff's policy reflects this, but was not followed. Even a short delay in such circumstances can have a significant impact on a person's chance of survival and we consider an ambulance should have been called when the man was found hanging. We make the following recommendation:

The Governor and Head of Healthcare should ensure all staff understand the need to call an ambulance immediately in a medical emergency.

RECOMMENDATIONS

1. The Governor should ensure reception officers prioritise the assessment of prisoners who arrive at the prison with suicide self-harm warning forms from the police and other agencies.

   Accepted – *All staff in reception have been made aware that any prisoner who is received in to reception with a self-harm warning form from police and other agencies must be given priority for assessment.*

2. The Governor and Head of Healthcare should ensure that healthcare staff have access to and consider relevant documentation, including PER forms and suicide self-harm warning forms in order that they can carry out an informed assessment of a prisoner's risk.

   Accepted – *Governor's Order 53/2012 The Person Escort Record and Self-Harm Suicidal Documentation was issued on 13 December 2012. This reminds staff that all self-harm warning forms and other documentation from the police or other external agencies must be passed to all staff carrying out assessments / reviews on prisoners.*

3. The Governor should ensure that all reception staff are aware of their responsibility to open an ACCT if there is information that a prisoner has self-harmed or threatened to do so.

   Accepted – *Staff at HMP Cardiff will be reminded to adhere to PSI 54/2011 and QTLB no 12.*

4. The Head of Healthcare should ensure that community GP records are routinely requested for all prisoners to ensure continuity of healthcare.

   Rejected – *Currently we only request GP records for patients on medication or as the need arises. Whilst we accept in an ideal world we would request GP records on every patient, given the churn that we have, is this realistic expectation? The system for information sharing in the community is under review.*

5. The Head of Healthcare should ensure that secondary health screens are completed in a timely manner.

   Accepted – *This is a performance area that is under constant review, we do complete more than 75% of our secondary health screens within 24 hours. We are looking at improving the secondary health screening process and making it clinically more effective via a 1000 lives workshop, part of this is auditing time taken to deliver care to patient via secondary health screening.*

6. The Governor and Head of Healthcare should ensure prisoners who may experience a change of status either on their return from court or after appearance via video link receive a screening for any potential healthcare or suicide and self-harm issues and that wing staff are notified.

Accepted – *Hotel One will now be radioed and informed of patients that need to be seen following a change of circumstance form Video Link and all prisoners will be seen and reviewed by a member of the healthcare nursing team. An entry will be made into the System One record.*

7. The Head of Healthcare should ensure that healthcare staff use SystmOne to record all clinical entries and comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Accepted – *From November 2012 all nursing records are kept on System One only, no paper records are kept. For In-patients, care plans are completed on System One. Additional medical records are scanned onto System One, In-reach also document on System One alongside PARIS.*

Since record keeping has been a learning from previous investigations, training on record keeping has been arranged for all staff, this will be provided by the MPS.

8. The Head of Healthcare should ensure a psychiatrist or doctor is consulted before a prisoner is discharged as an impatient from the healthcare centre and a care plan is put in place in consultation with officers on the wing.

Accepted – *Discharge template form to be completed for all patients being discharged from healthcare. Part of this is documentation that patient has been discharged by either GP or the Psychiatrist. This has been audited and will continue to be audited on a regular basis. Admission and discharge policy from healthcare being updated.*

Minimum of two patient to be identified on a daily basis that could be discharged if bed needed on emergency basis, this is to be noted on NOMIS and System One.

9. The Head of Healthcare should ensure that clear reasons for prescribing are entered on the prisoner's medical records and that prisoners on antipsychotic medication are seen for regular reviews.

Accepted – *Reason for prescribing to be read coded and linked to prescription, pharmacy to check that this is done before prescription is dispensed. To discuss at next medicines management meeting.*

Medication reviews face to face with patient.

10. The Head of Healthcare should ensure that the mental health in-reach team sees new patients promptly for assessment and reviews their care at appropriate intervals.

Accepted – *In line with mental health measure, we now have a primary mental health team, with clear referral pathway to In-reach; this should reduce workload for In-reach with effective triage. In-reach to audit timings of assessment and reviews.*

11. The Governor and the Head of Healthcare should ensure that there are regular recorded checks of all emergency equipment.

Accepted – *Weekly detail for nurses to check resuscitation equipment, including batteries of all defibrillators, this is signed for. We now have two more defibrillators, so there is easy access to a defibrillator on all wings and healthcare. Mandatory Annual ILS Resuscitation training for all staff arranged pharmacy check emergency drugs.*

Resuscitation lead nurse to oversee the above.

12. The Governor and Head of Healthcare should ensure all staff understand the need to call an ambulance immediately in a medical emergency.

Accepted – *Governors Order 49/12 applies and ahs been issued. This informs staff the importance of calling for an ambulance at the earliest opportunity where there are grave concerns for a prisoner's health. The establishment's protocol has been updated. The establishment complies with PSI 03/2012 published 21 February 2013.*