Investigation into the circumstances surrounding the death of a man at HMP Swansea in July 2010

Report by the Prisons and Probation Ombudsman for England and Wales

April 2011

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Swansea in July 2010. He was 24 years old when he died. The post mortem report indicated that he died as a result of hanging.

The man had come into prison two days earlier. It was not his first time in prison. He spoke to a number of staff, but gave no indication that he might harm himself. On an evening in July, an officer checked the man's cellmate (who was subject to self harm monitoring) to find the man hanging from the bars of his cell window. Sadly, despite the best efforts of staff, he could not be revived.

The investigation was completed by one of my investigators. One of my Family Liaison Officers contacted the man's mother and father. He told them more about my investigation and asked what concerns and questions they had about their son's death. I am grateful to them for their contribution, under what I appreciate are the most distressing of circumstances. I extend my sincere condolences to all of those who have been affected by this man's death.

A clinical review of the treatment which the man received in prison was undertaken by a clinical reviewer appointed by Healthcare Inspectorate Wales. He assessed whether the care that the man received in custody was comparable to that he would have expected in the community. I am grateful to the clinical reviewer for his assistance.

I would like to express my thanks to the Governor and the staff and prisoners at Swansea for their full cooperation whilst the investigation was completed. I particularly thank the prison liaison for liaising with the investigator and helping to organise interviews.

The man died only two nights after arriving in prison. Like other prisoners at Swansea whose deaths I have investigated, he took his own life soon after his remand on the induction wing. My investigator interviewed the staff who talked to the man during this short period. None felt that he gave any indication that he was distressed or planned to take his own life.

Nonetheless, the investigation has highlighted some important lessons for staff at Swansea. In particular, staff will want to think about the way in which the different members of a bereaved family are included and kept informed after a prisoner dies. I make five recommendations and endorse three others made by the clinical reviewer.

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

Jane Webb
Acting Prisons and Probation Ombudsman **April 2011**

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NB: The clinical review refers to the man's death taking place on [a date in July]. This is because his death was confirmed by a doctor shortly after midnight. For the purposes of my report, I consider the date of death to be the evening before, as the man took his own life and the resuscitation effort began and ended that evening.

SUMMARY

1. The man was arrested for breaching his bail conditions in July 2010. He spent the night in a police station and then appeared in a magistrates' court the following day. He was remanded into custody and taken to HMP Swansea. His next court appearance was scheduled for Friday 9 July.

2. The man spoke to officers and a nurse as part of the usual reception process. The nurse prescribed some initial withdrawal medication because he had been misusing drugs and alcohol in the community. He also talked to the duty governor and then moved to the induction wing.

3. The day after his arrival at Swansea, the man spoke to a safer custody officer and said that he was worried about encountering two prisoners in Swansea who had reason to be upset with him. The officer helped him to make an application to the Governor asking to transfer to Cardiff after his next court appearance. He did not want the officer to investigate the matter further because this would have alerted the other men to his presence in the prison. He did not come into contact with either man because he was held on the induction wing.

4. On the same morning, the man was also assessed by a doctor, who increased his withdrawal medication.

5. The next morning the man spoke to the chaplain and a benefits officer. He was also assessed by a substance misuse worker, but declined to engage with treatment for the time being. All of the staff who spoke to him between Saturday and Monday told my investigator that he did not present as especially low or anxious and did not indicate that he was thinking of harming himself. On several occasions this question was asked directly. He told staff that he had tried to harm himself about eight years previously, but not done anything similar since.

6. The man shared a cell on the induction wing with a prisoner who was subject to self harm monitoring. An officer checked his cellmate at 8.00pm that evening and briefly spoke to the man. When the officer returned at 9.35pm to check the cellmate again, he found the man hanging in the cell. The officer summoned his colleague, who was carrying keys to the cell. They entered the cell, untied the ligature, lowered him to the floor and one officer began giving chest compressions. A nurse attended the cell and an ambulance was called. However, sadly he could not be resuscitated and was declared dead a short while later.

THE INVESTIGATION PROCESS

7. The investigator was formally notified of the man's death the day after he died. Notices were subsequently issued to both staff and prisoners at HMP Swansea, informing them of the investigation process and giving them the opportunity to contact the investigator with any relevant information.

8. The investigator liaised with the prison liaison during the investigation. He visited Swansea on 12 July and was provided with all the documents relating to the man's time in custody. Whilst there, the investigator spoke to the man's cellmate. The investigator returned to Swansea on 12 and 13 August to interview 11 discipline and healthcare staff. He also visited HMP Bedford on 8 September to speak to a nurse who had left Swansea to work at Bedford after the man died. Following his interviews with staff, the investigator provided feedback in a letter to the Governor, summarising the progress of the investigation thus far.

9. The investigator wrote to the local Coroner's office to inform them of the nature and scope of the investigation. HM Coroner will be provided with a copy of the report of the Ombudsman's investigation.

10. The investigator contacted Healthcare Inspectorate Wales and asked for a clinical review to be carried out with regard to the man's healthcare at Swansea. The purpose of the review is to establish whether the care that the man was offered in prison was comparable with that he could have expected to receive in the community. The clinical reviewer completed the review. The clinical reviewer and his colleague visited Swansea with the investigator and took part in the staff interviews.

11. One of my Family Liaison Officers contacted the man's mother and father to discuss the investigation and to find out what concerns the family had. On Monday 23 August, my Family Liaison Officer and investigator visited the man's father and his partner at their home to discuss the investigation. They raised several concerns about the way they felt that the prison has dealt with the family since the man died. I outline and address these fully in the 'Issues' section of the report.

12. My Family Liaison Officer spoke to the man's family after they had had the opportunity to read the draft report of the investigation. I have included their feedback on page 33.

HMP SWANSEA

13. HMP Swansea is a small prison holding adult male prisoners who have usually been sent there by the nearby courts. It is located near the city centre and holds a maximum of 422 men. Swansea is notable for having started the Listener scheme in the early 1980s. The scheme (which involves the Samaritans training prisoners to work with other men in distress) has gone on to become a national initiative across the prison estate.

14. The man died on B wing, otherwise known as the induction unit, where prisoners are held when they first arrive in custody. In 2009, another man died in the same cell on B wing as this man. After this man's death, another man took his own life on B wing in September 2010.

Healthcare

15. The nursing team at Swansea is predominantly made up of general nurses, alongside a small number of mental health nurses. A registered nurse attends the reception area every day to assess newly arrived prisoners. The healthcare team use a number of assessment tools to check problems such as alcohol dependency and to decide on a plan for treatment.

16. A doctor holds a surgery in the prison from 8.30 until 11.30 each morning, seven days a week. In the weekday afternoons an on-call service is provided, and a similar out-of-hours service can be consulted by nurses both overnight and at weekends. The prison provides 24 hour nursing cover. One nurse remains on duty throughout the night. At the time the man died, the same two nurses tended to alternate permanent night shifts.

17. There is not a dedicated detoxification unit at Swansea. Prisoners experiencing withdrawal symptoms from alcohol and drugs stay on the induction unit for about a week or so after their arrival. If a prisoner experiences particularly acute alcohol withdrawal symptoms, he can be admitted to a bed in the healthcare department.

HM Chief Inspector of Prisons

18. The former Chief Inspector of Prisons last conducted a full inspection of Swansea in February 2010. She described Swansea as 'an impressively safe place, underpinned by excellent staff-prisoner relations'. She recorded a 'relatively small drug use problem' in the prison. The report noted that:

> 'Staff interacted well with prisoners new to custody and provided good support.'

19. The Inspectorate's report recorded that B wing, where this man was held, could sometimes feel more like a detoxification unit than a first night centre (because Swansea has no dedicated detoxification facilities). However, she described B wing as having a 'decent environment, good procedures and

positive staff attitude'. She wrote that the induction programme was well delivered, engaging and informative.

20. The Inspectorate commented that senior managers at Swansea showed a strong commitment to safer custody procedures and self harm monitoring. She wrote that:

> 'Good attention was given to increased risks in the early days of custody.'

21. As regards recent deaths in custody and my subsequent investigations, the Inspectorate explained that:

> 'There had been two apparent self-inflicted deaths since the last inspection and there had been some progress in implementing subsequent actions, but recommendations from all [of the Ombudsman's] investigations in recent years were not periodically reviewed.'

22. As a result, she recommended that:

> 'Recommendations from all death in custody investigations over recent years should be consolidated into a single action plan and reviewed periodically.'

Independent Monitoring Board

23. Each prison in England and Wales has an Independent Monitoring Board (IMB). The Board consists of members of the local community who have full access to prisoners and all areas of the prison. IMB members undertake a variety of activities in prison including the consideration of complaints made by prisoners and visits to individual prisoners. They report on the condition of the prison and examine the treatment prisoners receive in healthcare. Each IMB produces an annual report. The last available report about Swansea was published in July 2009.

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

Assessment, Care in Custody and Teamwork (ACCT)

25. ACCT monitoring is started if a prisoner is thought to be at risk of harming himself. The prisoner is interviewed and a plan for his care is drawn up in response to his needs and concerns. The process is ongoing and the ACCT document remains open whilst the risk remains. An ACCT review should be held at least once a week. Any staff who have contact with a prisoner can make entries in the document.

26. The frequency of observations by staff is set out on the front cover, for example, 'hourly'. Staff must check the prisoner at least this often, they should conduct their observations at varying intervals and write down all the checks in the ongoing record. Some of the scheduled checks must be 'quality observations', meaning that the member of staff speaks to the prisoner at some length and has meaningful interaction with him in order to gauge his mood and the risk he may present to himself.

Previous deaths at Swansea

27. Since my office assumed responsibility for the investigation of deaths in prisons in 2004, I have investigated the self-inflicted deaths of four other men at Swansea. The two most recent self inflicted deaths took place in 2007 and 2009. Both men hanged themselves on the induction unit shortly after arriving at Swansea, just as this man did. Since he died, another man has taken his own life on the induction unit in September 2010.

28. The man who died in 2007 reported his anxiety about the presence of another prisoner in Swansea when he first arrived. The man who is the subject of this report also expressed very similar concerns, which I consider were taken forward appropriately in this instance.

29. When I completed my investigation in 2007, I was critical of the failure to make full use of information about the man's history of self harm on his Person Escort Record (PER) form. Information about the man's history of self form was included on his PER form when he arrived from court. As I outline in the 'Key events' section of the report, the information about him was read and taken into account by the receiving staff.

Performance

30. The most recent prison quarterly ratings published by the Ministry of Justice show that Swansea scored 3 overall, indicating a good performance. The prison achieved the same score in the previous quarter. The minimum score is 1 (serious concerns) and the maximum is 4 (exceptional performance). The rating takes into account 34 different aspects of the way the prison is currently operating.

KEY EVENTS

31. The man had been convicted of numerous offences and had served a number of prison sentences. During a previous prison sentence in HMP Swansea in 2008, he had been subject to self harm monitoring because of concerns about his welfare. He was also subject to the same sort of monitoring during prison sentences begun in 2002 and 2005 at different prisons.

32. The man had most recently served a custodial sentence in HMP Swansea between 12 April and 13 May 2010, during which time he was not subject to self harm monitoring. He had a history of substance misuse and told staff that he was being prescribed methadone when he came into Swansea in April. Despite his chaotic lifestyle, he remained in touch with both his mother and father. His family confirmed that he had planned to marry his partner on the day of his arrival at Swansea.

33. The man was arrested for a breach of his bail conditions in early July and, at 11.40pm that night, he was assessed by a doctor at a police station. He told the doctor that he was taking methadone (a heroin substitute). (The man was not in contact with a substance misuse treatment agency in the community when he was arrested.) His speech was slurred and he said that he had consumed ten units of alcohol. The doctor judged that he had 'no mental health problems and no current medical problems'. The doctor decided that he should not be given any additional medication until the morning because he was too intoxicated.

34. At about 7.30am on the day of his arrival to Swansea, the man was escorted from the police station to a magistrates' court. He appeared in court at about 10.30am. (He would normally have been taken to another magistrates' court, but it does not open on a Saturday.) His next court appearance was scheduled for Friday 9 July at crown court.

35. In South Wales, prisoners are escorted between police stations, courts and prisons by a private company called Reliance. A Senior Custody Officer (a member of the Reliance staff normally based at Powys Magistrates' Court) was working in the court cells and completed the man's paperwork. The Senior Custody Officer had been acquainted with the man since he was 14 years old, as he had frequently appeared at the local courts over the previous ten years. The officer recalled in interview that the man's mood did not seem different from usual or out of the ordinary on the morning of his arrival. He told the Senior Custody Officer that he was supposed to be getting married at 10.00am that morning.

36. The Senior Custody Officer noted that the man had numerous self harm scars on his arms and some on his chest. He told the investigator that the scars did not look recent and had healed over. He documented this information on the Person Escort Record (PER) form. The Senior Custody Officer remembered during interview that the man did not show any obvious signs of withdrawal from alcohol or drugs during the journey from the court to the prison (such as

shaking or shivering). He recalled that he was talkative as usual and laughing and joking with the escort staff.

37. The man arrived at HMP Swansea at 11.35am. He and another man were the only two prisoners arriving in the reception area from court that day. Every new prisoner goes through a standard assessment which is designed to identify and address their immediate needs, including identifying whether they are likely to harm themselves.

38. The acting senior officer on the induction unit and a nurse completed a Cell Sharing Risk Assessment (CSRA). (This is a document used by the Prison Service to determine if two prisoners should be placed together in the same cell. One man might present a risk to the other for a number of possible reasons.) Both members of staff assessed him as presenting a low risk of harm to other prisoners.

39. The acting senior officer wrote on the CSRA that the man had misused drugs and alcohol in the past but claimed that he was not currently dependent on them. The nurse ticked a box to indicate that no current concerns about self harm had been identified. The acting senior officer checked the PER and recorded the following:

> 'PER warnings self harm. States no S/H since 2002. No current intent to SH. Previous ACCT [The Assessment, Care in Custody and Teamwork document used to monitor self harm] at Portland 2002.'

40. The acting senior officer on the induction unit told the investigator that he knew the man from previous custodial sentences, and that his presentation was not noticeably different on this occasion. (He also assessed him when he came into Swansea on 12 April.) He did not remember him showing any obvious withdrawal symptoms or health problems. He said that the man was calm, easy going, relaxed and had a 'wry smile'.

41. There was nothing out of the ordinary which struck the officer about the man's behaviour. He did not seem obviously depressed. He showed the acting senior officer scars on his arms and chest, but the officer (like the senior custody officer at the magistrates' court) noted that none seemed recent and that they had long since healed. They discussed the warnings on the PER form. The acting senior officer told the investigator that the man gave no indication at all that he might be thinking of harming himself. At 1.40pm, the officer made an entry on P-NOMIS (a recently introduced electronic prisoner records system), noting that the man was 'aware of all avenues of support available to him'.

42. The duty governor talked to the man and made sure that both he and the fellow prisoner had their lunch. The duty governor had met the man during his previous custodial sentences and also thought that he seemed no different in presentation to those previous stays in Swansea. He told the investigator that the man seemed 'positive … amiable … [and] upbeat'. They chatted for a little while. He recalled in interview that the man gave no indication that he

might try to harm himself and exhibited no obvious signs of withdrawal from drugs or alcohol.

43. The nurse who had earlier completed the CSRA with the acting senior officer examined the man and completed the first night reception health screening. (Every prisoner undergoes a health screening when he first arrives in a prison.) Their meeting lasted about 20 minutes. He signed a consent form permitting healthcare staff to contact other agencies and request information about him. He also provided details of his community doctor and indicated that he was not currently receiving any medication.

44. The man told the nurse that he misused alcohol and drank 12 litres of cider each day. He said that he had been drinking alcohol the day before. The nurse completed an Alcohol Withdrawal Assessment and scored the man '9'. (The form indicates that withdrawal medication should be offered if the patient scores more than '8'.) The nurse marked on the screening form that he should be referred for substance misuse treatment (specifically alcohol-related).

45. The man said that he also misused drugs. He said that he had last used heroin ten days previously, benzodiazepines (commonly misused drugs which have a sedative effect) five days previously and amphetamines (drugs that have the opposite effect, heightening the senses) a week before. He also told the nurse that he smoked cannabis and said that he did not inject drugs. The nurse tested the man's urine, which showed no signs of opiates (heroin) in his system, only benzodiazepines.

46. The nurse recorded that the man did not report any mental health problems. He told the nurse that he had tried to harm himself in the past. He said that he had cut his wrists at HMP Portland in 2001. (He subsequently told other staff that this happened in 2002.) He told the nurse that he was not currently thinking about harming himself.

47. During interview, the nurse told the investigator that the man made good eye contact and was smiling during the assessment. He recalled that he gave him no reason to be concerned about his welfare, particularly because he seemed to have been open and honest about his substance misuse. He asked to be examined by a doctor and the nurse referred him for an appointment.

48. The nurse wrote in the man's clinical record that he had a 'history of alcohol and substance misuse'. He told the investigator that he was not showing any obvious withdrawal symptoms, such as shivering and shaking. The nurse wrote: 'no issues of mental ill health and DSH [deliberate self harm] … at present'.

49. The nurse prescribed the maximum 15mg dose of diazepam (a benzodiazepine commonly used to treat alcohol withdrawal also known as Valium) permitted under the Patient Group Directions (PGDs). PGDs are a legal framework that the NHS and the Royal College of Nursing have agreed. They allow a nurse to offer initial treatment to a patient who reports a problem

such as alcohol misuse on their first night in prison without having to immediately refer to a doctor. A doctor will then examine the prisoner within 24 hours. In this instance, the PGD permitted the nurse to prescribe a safe dose of medication to start managing his withdrawal symptoms and stabilise him.

50. To assist the man's withdrawal from alcohol (the only substance that both his own self-reporting and the urine test showed he had recently used in significant quantities), the nurse also prescribed metoclopramide (used to treat nausea) and quinine (to treat cramps). He swallowed the medication with water in front of the nurse.

51. An officer conducted the first night interview at 3.00pm. His entry on P-NOMIS reads as follows:

> 'First night interview, well known to staff at Swansea, PER warning for self-harm 2002 at Portland, no intent since. All avenues of self help explained. No outstanding problems, expecting to be bailed when back in court this week.'

52. The man declined the opportunity to be given a PIN number to use the telephone. (He did not make any telephone calls using an authorised telephone whilst he was in prison.) He was issued with tobacco.

53. The man was taken to cell 2 on the third landing of B wing (the induction unit). He shared the cell with a fellow prisoner. (The man's cellmate was subject to self-harm monitoring, which is known as the Assessment, Care in Custody and Teamwork, or ACCT, process.) Prisoners can normally expect to remain on the induction wing for about seven to ten days. There is no dedicated detoxification unit at Swansea.

54. Normally, a prisoner goes before an induction board the day after he arrives at Swansea. (The board is made up of a number of different staff members such as a member of the safer custody team, the chaplain and a substance misuse worker. They check the prisoner's welfare and make appropriate referrals.) Because the next day was a Sunday, the man's induction was divided between Sunday and the following day.

55. On the eve of his death, the man was interviewed by a safer custody officer (who has responsibility for violence reduction) and the acting senior officer. The meeting took place in an office on the induction unit. Every newly arrived prisoner in Swansea attends a safer custody interview. The acting senior officer did not notice any change in the man's presentation from the day before. The safer custody officer knew him from his previous custodial sentences. She asked about any thoughts he might be having and wrote the following comments on a document entitled 'Safer custody initial interview / risk profile':

> ‘Self harmed in 2002. No [suicidal] thoughts now. Not dependent [on drugs and alcohol]. Polite, well known to staff. All avenues of support explained.’

56. The safer custody officer did not deem it necessary to either begin self harm monitoring or open a safer custody support file. (A support file may be opened if staff think that a prisoner, whilst not actively considering harming himself, is struggling to adjust to prison life.)

57. The man told the safer custody officer that he was afraid of a prisoner on D wing (from whom he had stolen drugs whilst in the community) and another prisoner on A wing (because he had assaulted the man’s brother a year or two previously).

58. The safer custody officer helped the man to complete an application to the Governor, asking to transfer to HMP Cardiff after his next court appearance on 9 July because of ‘trouble’ with other prisoners on A and D wings. The acting senior officer made an entry in the wing observation book which noted that the man had asked for the transfer and made staff aware of the potential problem with the other prisoners. On the P-NOMIS system, he noted that the safer custody department were ‘aware of the situation’.

59. The safer custody officer decided to open a ‘Violent incident simple investigation’ to explore the issues that the man raised about potential threats. However, she closed the investigation the next day without speaking to the other prisoners because the man was hoping to be taken to Cardiff from court on 9 July, thus resolving the issue. Additionally, he signed a form confirming that he did not want staff to pursue the matter with the two men, which would mean alerting them to his presence in the prison.

60. The man asked not to be moved off the induction wing in the meantime. The acting senior officer completed a Security Information Report about the matter. (The safer custody officer told my investigator that staff would have needed to reconsider the location of all of the men involved if the man had returned to Swansea from court on 9 July. He could not have stayed indefinitely on the induction wing.)

61. The safer custody officer told my investigator that the safer custody interview took place in an office on B wing and lasted about ten or 15 minutes. She remembered that the man looked clean and tidy, was in a good frame of mind and was in a ‘jokey’ mood. She had last seen him in April when he had been suffering obvious withdrawal symptoms. She thought that he looked ‘really well’ on this occasion and did not seem to be experiencing the same kind of withdrawal symptoms. She had no reason to be unduly concerned about him. She thought that he was somebody who coped with prison life and mixed well with the other men. She did not think that he was excessively worried about the two prisoners he had mentioned.

62. The same morning, the man was assessed by a doctor in the medical room on B wing. (This was a routine assessment of a new prisoner. A doctor

works from 8.30am until 11.30am in the prison on weekend mornings.) He complained of stomach pains, sweating, sleeplessness and muscle pain. The doctor recorded that his mood was stable.

63. The man said that he was not thinking about harming himself or taking his own life. The doctor told my investigator that he engaged and made eye contact. His presentation did not give the doctor cause for concern. The man said that he was not having any 'cravings' for drugs or alcohol. The doctor recorded withdrawal symptoms, but did not think that he was especially unwell in this regard.

64. Because the man said that he was withdrawing from heroin as well as alcohol, the doctor doubled his daily dose of diazepam to 30mg. He planned to reduce the dose by 5mg each week. The doctor also prescribed metoclopramide, quinine sulphate (for his muscle pain), thiamine (also known as vitamin B1, commonly used to treat alcohol withdrawal) and vitamin B compound strong tablets (again used to treat alcohol withdrawal). He was given this medication and also collected the same prescriptions the following day.

65. The doctor did not physically examine the man. Given the amount of alcohol he reported that he had been drinking, the doctor was mindful that he could suffer seizures as he began to withdraw. He told my investigator that he expected a nurse to inform him if he started to experience seizures.

66. At about 9.30am the next day the man went to an induction board meeting on B wing with the prison chaplain and a woman who advises prisoners about their benefit claims. The woman helped him to complete a form to ensure that he received his outstanding benefit payments.

67. The prison chaplain told my investigator that the man seemed optimistic and talked about how he might receive his benefit payments once he was released. He expressed concern about his partner and child, but told the prison chaplain and the benefits adviser that he did not yet want his family to know that he had come back into prison. He wanted time to gather his thoughts before he telephoned them.

68. The man mentioned his anxiety about the two prisoners who he thought he might encounter in Swansea and they discussed his wish to transfer to Cardiff. The prison chaplain reassured him that there were no immediate plans to move him off B wing. He told him to wait for his court appearance, after which he would either transfer to Cardiff or Swansea staff would relocate him to an appropriate and safe wing.

69. Like all new prisoners, the man completed a Chaplaincy Admissions Form, allowing him to identify any needs or problems he might have. He indicated that he did not have a problem with either drug or alcohol misuse, but he confirmed a history of self harm about eight years previously. (In interview, the prison chaplain thought that he may have chosen not to disclose his substance misuse because he had grown tired of being asked about it. The

prison chaplain thought at the time that he was probably not telling the truth. However, the purpose of the form is to allow the prisoner to choose which problems he wishes to declare.)

70. The prison chaplain told my investigator that the man talked openly with both himself and the benefits adviser during their meeting, which lasted for about 15 minutes. He told them both that he was not thinking about harming himself. When he spoke to my investigator, the prison chaplain remembered that he gave 'no indication whatsoever' that he might be thinking about taking his own life.

71. The same morning, a senior practitioner in the Counselling, Assessment, Referral, Advice and Throughcare Services, or CARATS, team assessed the man. (There is a CARATS team in each prison working with prisoners who misuse either drugs or a combination of drugs and alcohol.) He had not been referred for assessment. All prisoners are subject to an initial assessment with a CARATS worker the next working day after their arrival in custody. The senior practitioner in CARATS had not met him during his previous custodial sentences and their meeting also lasted about 15 minutes.

72. The man reported 'recreational' drug use. He again mentioned his anxiety about the two other prisoners. The senior practitioner in the CARATS team thought that he was a little preoccupied and nervous because of the situation. They discussed his possible transfer to Cardiff the following Friday. However, he was not otherwise concerned by his presentation. He did not express any ideas about harming himself during the meeting and did not show any signs of withdrawal symptoms. He declined to accept the CARATS team's help for the time being.

73. After their discussion, the senior practitioner in the CARATS team recorded that the man was 'not yet ready to engage' with the CARATS team. He planned to check with him again about four weeks later in case he had changed his mind. However, the man agreed that he could refer him to Narcotics Anonymous (NA). (NA, an organisation intended to help people for whom substance misuse has become a major problem, holds meetings in Swansea on Wednesdays.) He telephoned a member of the community-based Transition and Support Scheme to let them know that the man had returned to custody.

74. Nursing staff dispensed olanzapine (an antipsychotic drug) and zopiclone (an aid to sleeping) to the man's cellmate at about 4.30pm. The evening meal was served at about 5.00pm, after which the prisoners were locked up for a while to eat. By about 6.00pm, the man's cellmate seems to have fallen into a deep sleep. Following an association period (when prisoners shower, make telephone calls and socialise) from 6.15pm, all of the men were locked up for the night on B wing between 7.30pm and 7.45pm.

75. Overnight, seven staff worked in the prison. A senior officer was the night orderly officer in charge of the running of the prison. Four officers were based in the centre of the prison and were responsible for staffing the wings and

checking any prisoners who were subject to ACCT monitoring. A nurse and the gate officer were also working the night shift.

76. One of the officers based in the centre of the prison came into work at about 7.45pm. He had not worked over the weekend and therefore this was the first time he had been in the prison since the man arrived. At 8.00pm he went to cell 2 on the third landing of B wing and checked the man's cellmate as part of his ACCT monitoring process. He was fast asleep on the bottom bunk and the man was standing up facing the door. The officer asked the man how his cellmate was, and he said that he was 'fine'. The officer continued to check other prisoners subject to ACCT monitoring.

77. At 9.35pm, the officer returned to check the man's cellmate. He looked through the observation hatch and saw the man's cellmate still sleeping on the bunk bed. However, he then saw the man's silhouette at the back of the cell. At first, he thought that he was standing up, but then he realised that he was hanging.

78. The officer did not have a cell key so he went back down the stairs towards the centre office between A and B wing and shouted to a fellow officer (who had a cell key in a sealed night pouch) to come with him because a prisoner was hanging in a cell. The fellow officer was just returning along A wing towards the centre office.

79. Overnight, only one of the two officers on A and B wing hold a sealed pouch with a cell key inside. This is a measure designed to ensure that an officer does not go into a cell alone and put their own safety at risk. Only a senior officer in charge of the prison can unlock wings and move around the prison. Each sealed pouch is accounted for in the morning to check whether the seal has been broken.

80. The officer led his colleague back to the cell. He told the investigator during interview that just less than a minute had passed since he first saw the man hanging. His colleague unlocked the cell door with the key from his night pouch and both officers went straight to the man at the back of the cell.

81. The man had hanged himself using a whole bed sheet that was twisted to form a particularly thick ligature (the officer estimated that it was three inches in diameter). He tied it around the bars on the cell window. The ligature was so thick that the officer could not use his anti-ligature knife to cut through it. Instead, together the officers managed to lift the man's weight, relieving the pressure on his neck and allowing his colleague to untie the ligature.

82. The officers lowered the man to the floor of the cell and one of the officers began cardio pulmonary resuscitation (CPR). At 9.36pm, he used his radio to call the control room and request emergency medical assistance. He initially told the control room officer that the emergency was on C wing. He quickly corrected himself and said 'B wing'.

83. The man's cellmate did not wake up until the officers went into the cell as his medication had made him extremely drowsy. An officer took him out of the cell.

84. A nurse was working in the D wing staff room when the call for assistance came through on the radio. She only heard the first part of the message before she started to hurry to the emergency. Although she was carrying a radio, she did not hear the correction in her haste. She asked the D wing officer who was with her to respond on his radio and confirm that she was en route to the emergency. Consequently, the nurse initially went to C wing and looked for the emergency, shouting out to the officers. This caused her to be briefly delayed.

85. As the call for assistance came over the radio, the night orderly officer was heading towards the gate lodge to lock the prison up for the night. He returned to the central area between the wings and heard the nurse shouting from C wing. He realised that the emergency was happening on B wing and collected the nurse, escorting her to the man's cell.

86. The night orderly officer and the nurse arrived on B wing shortly before 9.40pm and entered the cell. The nurse immediately told the night orderly officer to use his radio to contact the control room and ask for an emergency response ambulance to be called. The ambulance was called at 9.40pm. The night orderly officer made the call on his radio and then went to the gate lodge to collect another set of keys for staff, as he realised there would need to be a lot of movement around the prison during the emergency.

87. The nurse and one of the officers took turns giving chest compressions and she asked another officer to collect an oxygen pump and mask from the first aid cupboard. The man's cellmate sat on a chair on the landing away from the cell.

88. The night orderly officer collected the first response paramedic after they arrived and escorted them onto the wing at about 9.46pm. The paramedic took over CPR from the nurse. Two more paramedics arrived shortly afterwards and continued to try to resuscitate the man. However, after approximately 30 minutes, the paramedics decided that he could not be revived and declared that he had died.

89. After the man died, there was some confusion about how a doctor should be called to certify death. The officers thought that the nurse had responsibility to do so. She telephoned the out of hours doctor, who confirmed that it was actually the discipline staff who needed to contact the police, who would send a police doctor to the prison.

90. The duty governor came to the prison shortly after 11.00pm and was followed by a representative from the IMB at 11.55pm and the prison chaplain at 12.05am. A police doctor visited the prison at 12.20am to confirm the man's death. At 1.10am, the chaplain said prayers for the man. The Prison Governor arrived at Swansea at 1.40am.

91. The night orderly officer took the man's cellmate to a nearby cell on the third landing of B wing, to share with two other prisoners whom he knew well. He was subsequently moved to the 'safe cell' on B wing (a safe cell has no ligature points and is designed for prisoners thought to be at risk of harming themselves). In the early hours of the morning, he was interviewed by the police because he was in the cell when the man hanged himself.

92. Because the man's cellmate was subject to ACCT monitoring and was understandably shaken by what had happened, an ACCT review was held at 1.30am. At 2.40am, the night orderly officer decided to move him to D wing in a cell with two Listeners for the rest of the night. (Listeners are prisoners trained by the Samaritans to sit with other men who may be feeling distressed and vulnerable.) Both the prison chaplain and the representative from the IMB told the investigator that the man's cellmate was not fully aware of his surroundings and his medication made him feel very sleepy. He seemed heavily sedated and unsteady on his feet.

93. The man had only provided his home address details and not those of his next of kin when he arrived. Although he had been held in Swansea before, the prison chaplain told the investigator that the introduction of the new P-NOMIS computer system meant that useful historical records could not readily be accessed. The police were able to locate his mother and went to her home at about 4.30am to break the news of her son's death.

94. The Governor held a hot debrief meeting for staff who had attended the emergency at about 6.30am, before they went off duty. (A hot debrief allows the Governor to check the wellbeing of staff and also provides an opportunity for staff to discuss any immediate lessons that might be learned from the incident.) The briefing lasted for about ten minutes. The Governor also spoke to the newly arrived day staff about the night's events.

95. The man's cellmate's ACCT monitoring was reviewed again in the morning and staff arranged for him to share a cell with somebody he knew. He also underwent a mental health assessment.

96. Having gone home at about 4.00am, the prison chaplain returned to the prison at about 9.00am. He acted as the family liaison officer (FLO) because the usual FLO was away on annual leave. The chaplain went with a colleague to visit the man's mother and partner on the afternoon of the following day.

97. The man's mother was concerned about the effect her son's death would have on his cellmate and kindly gave the prison chaplain a card to pass on to him, which he did. The chaplain told the family that they could visit Swansea if they wished. The Governor wrote a letter of condolence to the man's mother the same day.

98. The man did not leave a suicide note. Contrary to confusion which arose when the prison chaplain spoke to his family, he had not written a letter.

(Although the police found an empty envelope addressed to his partner in the bin in his cell.)

99. A memorial service was held in the prison on the morning of Wednesday 7 July. The man's funeral took place in Pembrokeshire on 15 July. The prison paid the funeral costs as per the policy of the National Offender Management Service (NOMS). The prison chaplain and the deputy governor attended on behalf of the prison.

100. A critical incident debrief meeting was held on 11 August. The meeting allows staff to further reflect on the death in custody and to discuss in depth any lessons that can be drawn from events.

101. The post mortem report indicated that the man died as a result of hanging. An amount of diazepam consistent with that prescribed over the weekend was found in his blood. Quinine and metoclopramide (which had also been prescribed to treat his withdrawal symptoms) were detected in his blood and urine. Traces of benzodiazepines were found in his urine.

ISSUES

102. Amongst a number of staff, the man spoke to a nurse, a doctor, a duty governor, a safer custody officer, a CARATS worker and the chaplain during the short time that he was in Swansea. He gave no indication to any of them that he was thinking of taking his own life. He had been to prison several times before and staff did not notice any significant deterioration in his presentation on this occasion.

103. The man's cellmate told the investigator that he gave no hint as to his state of mind between the time they were cellmates. He remembered that they chatted casually but that he never spoke about harming himself. He recalled that they had been joking with each other on the morning of the man's death.

104. The clinical reviewer comments in his review of the man's care:

> 'From interviews with staff that came into contact with [the man] it appears that there was no evidence that would have raised concerns or provided indication that [the man] was going to take his own life.
>
> '… we consider [the man's] death to have been neither foreseeable nor preventable. While we have made some recommendations, we believe that given the information available prior to [the man's] death, all those involved in his care acted professionally and appropriately.'

History of self harm

105. On the day of the man's arrival into Swansea, escort staff at the court recorded previous indications of self harm on the man's PER and reception staff identified these concerns when he arrived at Swansea. Staff noted historical self harm scars on his arms and chest. He said that he had harmed himself in HMYOI Portland in 2002 but had done nothing like this since. (In fact, he seems to have slightly confused his time in custody, as he actually spent time in Portland in 2005. Nonetheless, there is a record of self harm from that sentence.)

106. Staff who spoke to the man over the weekend asked appropriate questions and he replied that he was not currently considering harming himself or thinking about suicide. In deciding whether he required ACCT monitoring, staff responded to his presentation. He did not appear to be distressed. In fact, several staff commented that his mood was much the same as on previous occasions when he had been held in Swansea. Some even said that he looked healthier than before. Many remembered that his conduct was amiable and even 'jokey' and that he engaged in banter and conversation with them. All of the staff my investigator interviewed agreed that they had no reason to be concerned that he was actively considering harming himself.

107. My investigator checked Prison Service records which confirm that the man had previously been identified as somebody who might harm himself in prison. He was subject to self harm monitoring (known as ACCT monitoring)

during previous prison sentences in 2002, 2005 and 2008. He served the last of these sentences at Swansea. The man was not subject to self harm monitoring when he was in Swansea for a month earlier in 2010.

108. ACCT documents are handwritten. When they are archived they are not held electronically for reference. The earlier self harm monitoring documents would have been stored in the relevant prisons such as Portland and therefore were not accessible to staff at Swansea. The most recent one (dating from 2008) would have been archived at Swansea. If prisoners at Swansea serve a prison sentence of less than three months their ACCT record is kept for a year and then destroyed. The man spent three months in Swansea between April and July 2008, and therefore the ACCT record from that period would no longer have existed by July 2010.

109. The front page of the man's police record detailing his previous convictions shows two warnings about him cutting himself in 2006:

'Warning signals:

'1	Self harm	Cut arms with broken glass	11/06/06
'2	Self harm	Cut arm with sink bits	24/04/06'

110. This was a document that the investigator found in the man's previous custodial papers. The printout had been archived a few weeks earlier after he was released from Swansea in May. I would not expect staff to have seen it between the time of the man's stay. In any case, the warning relates to incidents of self harm which had taken place four years previously.

111. Although staff were not fully aware of all of the previous periods of ACCT monitoring and the information on the police record, they identified the man's old self harm scars. The man himself confirmed that he had been subject to self harm monitoring in the past. I consider that staff were able to balance sufficient historical information against what he said about his current thoughts and feelings to make a reasonable decision about the likelihood of self harm.

The man's worries about his safety

112. The man expressed concern about two other prisoners who he knew were being held in Swansea when he arrived. He was worried that his previous actions towards them and their relatives might result in reprisals. During the safer custody interview the day before the man's death, he told the safer custody officer that he would like to move to HMP Cardiff after his next court appearance.

113. The safer custody officer completed a safer custody interview form and began a violent incident investigation. The acting senior officer on the induction unit , who attended the same interview, completed a Security Information Report. The man completed an application to the Governor requesting a transfer to Cardiff. I consider that the safer custody officer and the acting senior officer

took appropriate action to address the man's concerns about potential bullying.

114. The investigation was concluded because the man did not wish to draw attention to himself in Swansea. Had it proceeded, the other prisoners would have had to be interviewed. I note that the other prisoners were on different wings. He remained on the induction unit, which has a small, separate exercise yard which prisoners on other wings cannot access. It is at the opposite end of the prison. The prison liaison told the investigator that the man could only have interacted with the prisoners if he went to chapel the day before his death. My investigator has found no evidence that he did so.

Drug and alcohol withdrawal

115. The man had a long history of drug and alcohol misuse. As recently as April, he told staff that he was being prescribed methadone to address his heroin misuse. He had been released from Swansea on 13 May. Since returning to the community, he had not engaged with a substance misuse treatment agency.

116. When he arrived at Swansea, the man told staff that he had used several different types of drugs in the recent past. He also said that he was heavily misusing alcohol. A urine test confirmed that there was no trace of heroin in his system. (Indeed, he told the nurse that he had not used heroin for over a week.) The toxicology report prepared for the coroner shows that the only drugs found in his blood and urine after he died were those prescribed to him by healthcare staff over the weekend (diazepam, metoclopramide and quinine).

117. The nurse in the reception area referred the man to a doctor, prescribed a maximum dose of diazepam and some other alcohol withdrawal medication and recorded the need for treatment for alcohol misuse. The next day, the doctor prescribed a higher dose of diazepam and other medications used to treat symptoms associated with alcohol and possible drug withdrawal. The clinical reviewer considers that appropriate measures were taken to help the man withdraw safely from any substances he had taken before he arrived in prison.

118. The staff my investigator spoke to confirmed that the man did not show any obvious signs of severe withdrawal from drugs or alcohol, such as shivering, shaking or sweating. The head of healthcare told the investigator that the healthcare centre can provide beds for prisoners experiencing severe withdrawal symptoms. This was not deemed necessary in this man's case. There is no dedicated detoxification unit and I am satisfied that he was appropriately located on the induction unit.

119. The clinical reviewer comments in his review:

> 'From our interviews with staff and reviews of the documentation made available to us, we believe that all staff involved in the assessment,

> care and treatment of [the man] behaved in a professional and sensitive manner and they did everything that was expected of them to try to help [the man] with his drug and alcohol problems…'

120. A Department of Health report entitled 'Clinical management of drug dependence in the adult prison setting' (published in 2006) states that chlordiazepoxide (also known as Librium) should be used to treat alcohol withdrawal. Whilst this advice has been implemented in prisons in England, it has not been adopted in Wales.

121. Although the clinical reviewer advised the investigator that chlordiazepoxide would be his preferred choice to treat alcohol withdrawal, he indicated that the prescription of diazepam prevents adverse initial withdrawal symptoms during a period when staff may not yet be certain about the extent of the patient's substance misuse.

122. The Head of Healthcare told the investigator that Swansea's current policy regarding the treatment of alcohol withdrawal was formulated after consulting a number of sources of information, including the aforementioned 2006 document. The options of using either diazepam or chlordiazepoxide were discussed at a meeting in 2007 attended by all of the prison's doctors and the then local NHS consultant psychiatrist in substance misuse. The medical staff decided to treat withdrawal using diazepam.

123. The Head of Healthcare confirmed that the method of treatment of withdrawal was 'thoroughly considered' at the time. The review date for the policy is 2011. She told the investigator that treatment of alcohol withdrawal will be reviewed again and that a consultation process with the healthcare staff will take place.

Access to electronic clinical record

124. When the doctor talked to my investigator, he said that doctors working at the weekend in Swansea have to assess new prisoners on B wing rather than in the healthcare centre. This is a result of lower staffing levels at the weekends, meaning that insufficient officers are available to escort prisoners to the healthcare centre.

125. The doctor said that he and his colleagues cannot access the electronic clinical record system on B wing, and could overlook information about a prisoner who has been in custody before, such as this man. The clinical reviewer comments:

> '… had the GP been able to access previous health care records a more informed decision about treatment could have been made.'

126. I gather that there are plans to install a computer with access to clinical records on B wing. Nonetheless, I endorse the clinical reviewer's recommendation:

The Head of Healthcare should make arrangements to ensure that electronic medical records are available to nurses and doctors who assess new prisoners at weekends.

Assessment, Care in Custody and Teamwork (ACCT) training

127. The doctor told the investigator that he has not received any training about the ACCT process. Any staff who have contact with prisoners should receive appropriate training in order to be able to implement and make full use of ACCT monitoring. I make the following recommendation:

The Governor and the Head of Healthcare should work together to ensure that all healthcare staff who have contact with prisoners receive ACCT training.

Keys

128. During the night shift, two officers shared an emergency cell key in a sealed pouch. Only the senior officer (the night orderly officer) on duty can unlock the wing. The purpose of the sealed pouch is to ensure that staff cannot enter prisoners' cells during the night without other colleagues realising. The measure also preserves the safety of staff by preventing them from entering a cell at night without a colleague being present.

129. Having seen the man hanging in the cell, the officer ran to collect his colleague because the latter had the sealed pouch. The officer estimated during interview that this necessary diversion delayed entry to the cell by about 30 seconds to a minute, as his colleague was very close by on A wing.

130. The officer commented during interview that, even if he had had a sealed pouch and had felt safe enough to enter the cell, he would then have been unable to cope with the situation on his own. He said that two officers were required to lift the man, support his weight and untie the ligature. Alone, he said that this task would have proved too difficult and he would have had to wait for his colleague to assist him.

Anti-ligature knives

131. The man fashioned a ligature out of an entire bed sheet which proved to be too thick for the officers to cut through. The anti-ligature knife (a version of which all officers in prisons across England and Wales carry) could not be adjusted to accommodate its width. The officer who found the man said that the ligature was about three inches in diameter and that he only managed to make a small cut into it.

132. The officer had to lift the man's weight whilst his colleague untied the ligature. The night orderly officer, the officer who had found the man and the nurse suggested that the knives should be capable of encompassing a thicker ligature. The officer who found the man told the investigator that the

paramedics who came to the prison showed him their knives, which open to a wider angle and are capable of cutting through much thicker ligatures.

133. Whilst I do not make a formal recommendation, I draw the attention of the Offender Safety, Rights and Responsibility group to the observations of staff at Swansea. The Governor of Swansea may wish to review the type of anti-ligature knife supplied to staff.

Emergency response

134. When one of the officers used his radio to request the emergency response nurse, he accidentally initially asked her to come to C wing rather than B wing. He corrected his mistake, but the nurse told the investigator that she had already started to make her way in a hurry and did not hear the correction. She arrived on C wing and shouted for staff. The night orderly officer was passing and heard her cries. He knew that they were needed on B wing and together they made their way there. Whilst this mistake may have delayed the nurse by perhaps a minute or so, I do not consider that it had a significant impact on the resuscitation effort, as the officer had already started CPR.

135. After the nurse arrived in the cell, she asked the discipline staff to collect the necessary equipment. Although I do not make a formal recommendation, the Head of Healthcare may wish to consider the location of such equipment and which items nursing staff are supposed to gather on their way to an emergency.

Calling an ambulance

136. The officer who found the man and his colleague entered the cell, supported the man's weight, untied the ligature and lowered him to the floor. They used the radio to call the emergency response nurse. One of the officers gave chest compressions until the nurse arrived and took over. When she reached the cell, the nurse told the officers to call an ambulance. Several minutes had passed since the officer first discovered the man.

137. The clinical reviewer stresses that he does not consider that the slightly earlier arrival of paramedics would have affected the outcome of the resuscitation attempt. However, I am concerned that discipline staff should have the confidence to instruct their colleagues in the control room to call an ambulance in such circumstances. The man was undoubtedly in a critical condition when the officers entered the cell, and it would have been a relatively easy procedure to request an ambulance at the same time as the emergency response nurse.

138. The tendency for prison officers to wait for the arrival of a nurse to make the decision to call an ambulance is occasionally a theme in my investigations. The officer who found the man and the nurse both agreed during interview that it would be a good idea for staff to request an ambulance straight away, were similar emergencies to occur in the future.

139. I endorse the clinical reviewer's recommendation:

The Governor should remind discipline staff that, in the event of an emergency, they should use their own initiative and feel able to request an ambulance if they think one is needed.

Support for the man's cellmate

140. I would like to praise the care that staff offered to the man's cellmate after he died. Staff made full use of ACCT monitoring and took appropriate measures to ensure his safety. His cellmate was initially looked after by an officer and was located in a cell with other friendly prisoners on the wing. He was then moved to a safe cell. After the police spoke to him, his ACCT monitoring was reviewed in the early hours of the morning and he was taken to spend the rest of the night in a cell with two Listeners.

141. The man's cellmate's ACCT monitoring was reviewed again the next morning and staff arranged for him to share a cell with another prisoner whom he already knew. He also underwent a mental health assessment. The records made in the ACCT document throughout were thorough and considered. ACCT support and monitoring remained in place and the man's cellmate was checked three times a day and every two hours during the night.

142. When my investigator spoke to the man's cellmate, he was still affected by his fellow prisoner's death. He expressed gratitude to the staff for the care they had shown him and the measures they had taken after the man died.

Nurses on duty at night

143. Coincidentally, the man died in the same cell where another prisoner had taken his own life a little over a year earlier. The nurse was on duty on both occasions and tried to resuscitate both men. As the only member of healthcare staff working in the prison when the man took his own life, she quickly took charge of the emergency and directed the prison officers to assist her.

144. The nurse works every other week, completing seven consecutive night shifts. When she does so, she is the only nurse and (frequently) the only woman in the prison. Because of the nature of her role and the hours that she works, the nurse can become isolated from her colleagues in the healthcare department. Equally, her ability to refresh her practice during nights may be limited because her work necessarily involves very little prisoner interaction.

145. Since the man died, the nurse has attended a third self-inflicted death at night. However resilient the nurse, I believe that being present at three self-inflicted deaths within 18 months must inevitably take its toll. I endorse the clinical reviewer's recommendation:

The Head of Healthcare should review access to staff support, supervision and training for those staff that permanently work night shifts. They should consider offering rotation onto days so that such staff can be offered support, supervision and training.

Support for staff

146. The majority of the staff my investigator interviewed said that they felt able to access support after the man died. However, the nurse expressed dissatisfaction with the care which she was offered after the emergency. She was considerably affected by the man's death. She told the investigator that, as the only member of healthcare staff directly involved, she did not feel that she was offered adequate follow-up support by the care team at Swansea either after the man's death or after the death of another prisoner in the same cell in 2009.

147. The nurse expressed the opinion that there is a perception within the prison that nursing staff are expected to be able to deal with a death in custody because it is part of their duties, whereas officers may require greater support. However, the nurse praised the support she has been given by her manager. Although I make no recommendations concerning this matter, the Governor will wish to ensure that all staff, including healthcare, are offered support by the staff care team.

Contingency plans

148. When my investigator interviewed the Head of Healthcare and the nurse, they said that there had been some confusion about the procedures following a death in custody. The nurse said that discipline staff had thought that it was her responsibility, as the sole member of healthcare staff, to call for an out-of-hours doctor to declare a prisoner's death. The nurse telephoned the out of hours doctor, who fortunately had previous experience of working with the police. He confirmed that it was actually the prison officers' responsibility to call the police and ask for a police doctor in the event of a sudden death such as this. The nurse told the discipline staff to do this and a police doctor attended the prison after midnight.

149. The Head of Healthcare also queried which managers should be told about a death in custody and who amongst them should then go directly to the prison. The nurse telephoned a healthcare colleague after the man died, because she did not have the Head of Healthcare's telephone number to hand. Her colleague told her what had happened and she got in touch with the nurse to check her welfare.

150. The Head of Healthcare did not think it was always clear which members of senior staff needed to know about a death in custody. She thought that it might have been appropriate for her to come into the prison to relieve the nurse, who was greatly upset by the emergency. The Head of Healthcare suggested that procedures needed to be reviewed and that night staff could

benefit from refresher training regarding the aftermath of a death in custody. I make the following recommendations:

The Governor and the Head of Healthcare should work together to review and update the death in custody contingency plan. The plan should remind staff of the correct procedure for declaring death and should also outline the roles of senior staff.

The Governor and Head of Healthcare should offer refresher training to staff who regularly work night shifts, reminding them how to respond to a death in custody.

Contact with the man's family

151. When my investigator and family liaison officer visited them in August, the man's father and his partner asked why the family liaison team from the prison did not visit them after they went to speak to the man's mother on 6 July. Instead, they received only a visit from the police on the day after the man died.

152. In the days and weeks after he died, the man's father and his partner did not feel that they had been kept up to date about developments by the prison. They perceived a lack of communication and felt excluded from the process. After they did not receive any communication from the prison for a week or two, they talked to one of the Coroner's officers, who expressed surprise and provided them with telephone contact details for the prison. The man's father's partner telephoned Swansea and asked the prison chaplain to get in touch, which he did.

153. The man's father and his partner were also unhappy that the man's mother was given inaccurate information by the prison chaplain when he visited her the day after her son's death. The chaplain told her that the man had left a half written letter or suicide note. The family were left with this impression for two weeks.

154. A detective sergeant told the investigator that he searched the cell when he arrived at Swansea on the day of the man's death looking for any document that might give a clue as to the address of the man's next of kin. He remembered telling the chaplain that he had found an addressed envelope. It appears that the chaplain's confusion arose following this remark.

155. The chaplain later corrected the error in his telephone call with the man's father's partner on 19 July. He confirmed with the police and then relayed to the family that there had only been an envelope addressed to the man's partner found in the bin in his cell. The man's father and his partner felt that being given incorrect information led to unnecessary and unhelpful confusion and suspicion about what had happened at Swansea. They thought that prison staff needed to be certain about such details before they passed them on to family members.

156. The man's father and his partner also said that they were not told about arrangements for the payment of funeral costs. They gathered that the prison were supposed to pay, but they said that they were not told how or when. They were anxious that the bill was paid and wanted confirmation.

157. At the funeral, the man's father and his partner were unaware that any prison staff were present because they did not introduce themselves. They thought that the chaplain and deputy governor should have made themselves known.

158. The couple were also a little disappointed that the man's father did not receive any verbal or written communication from the Governor. The Governor explained to my investigator that he had written a letter of condolence to the man's mother. However, he accepted that he had not written to his father.

159. The investigator asked the chaplain to provide a written response to the concerns expressed by the man's father and his partner. The chaplain explained that the man's mother had indicated during his visit the day after his death that her son's father planned to visit the family home the following day. The chaplain assumed that all the details he had provided would then be shared with the man's father.

160. The chaplain explained to the investigator that he did not visit the man's father in person the day after his son's death because he had already driven 120 miles and had very little sleep on the night of the man's death after being called into the prison.

161. The chaplain wrote:

> 'As soon as [the man's] father rang the prison on 19th July and complained about the lack of information, I spent 40 minutes bringing his partner, whom his father asked me to speak to, up-to-date with the information that was available to me at that time.'

162. As regards the inaccurate information which the chaplain provided to the man's mother the day after her son's death about the possibility of a suicide note, he explained:

> 'I was told that there was a note in [the man's] cell. After speaking to [the man's] father [on 19 July] I then contacted the police officer in charge, who corrected me, and said there had been an addressed envelope found in the bin in [the man's] cell. When I discovered this I immediately phoned [the man's] father [and] passed on this revised information.
>
> 'When I visited [the man's] mother to return [his] clothes and the reception photos that had been taken when [he] came into prison, I told her and [the man's] partner that there was no letter, but just an envelope .

'I, like everyone else, regret any sharing of false information and it did not happen deliberately, however the only way of avoiding such a mistake is for those involved not to say anything, but to wait for official reports to be published. I tried to give as many details as possible so that the family were informed immediately. Sadly the only detail that was incorrect was the reference to the note. I reaffirm that I was told that this note did exist.'

163. The chaplain told the investigator that the funeral costs were paid by the prison. He explained that the head of finance at Swansea had to contact the funeral directors four times in order to obtain the bill before payment could be made. As regards attendance at the funeral, he confirmed that he and the deputy governor spoke to the man's aunts after the service, but did not speak to his father or his father's partner.

164. The chaplain confirmed in his response to the investigator that he visited the man's mother and partner twice and maintained telephone contact with his mother. He said that he spoke to the man's father and his partner on the telephone twice.

165. I am grateful to the chaplain and the Governor for replying to the family's concerns. I think that part of the reason the chaplain was left in a position where he did not meet all of the family's expectations may well have been that he is not formally trained as a family liaison officer. It is a specialist role and, despite the chaplain's own expertise and qualifications, family liaison requires specific understanding and duties. The designated family liaison officer was not at work when the man died and the chaplain instead visited the family with another member of the chaplaincy.

166. I note that the police had to trace the man's next of kin because this information was not noted in his prison record. It is appropriate that the news was broken to the man's mother in person, although Prison Service Order 2710 does stress a preference for Prison Service staff to go to the family home to break the news, rather than the police.

167. I make the following recommendations with the aim of improving practice and reflecting the concerns expressed by the man's father and his partner:

The Governor should review the provision of family liaison officers (FLOs) and the guidance they require. Consideration should be given to:

- **appointing a second FLO also with appropriate training**
- **having one trained FLO available at all times to respond to a death in custody**
- **ensuring that only verified information about the circumstances of the death is given to the family**
- **acknowledging and contacting other immediate family besides the named next of kin**
- **considering how to best represent the prison at a funeral.**

The Governor should remind staff to request and record a prisoner's next of kin details during the reception process.

Other recommendations in the clinical review

168. Aside from those recommendations made by the clinical reviewer which I have already endorsed, I draw the attention of the Head of Healthcare to two other recommendations in his review. At paragraph 6.8, he stresses the need to record the precise time that medication is given on a patient's prescription chart. At paragraph 6.9, he emphasises the need for healthcare staff to clearly print and sign their name and include the time and date when they make written entries in clinical records.

CONCLUSION

169. The man was only held in Swansea for a little over two days. He had been in prison many times before and was undoubtedly familiar with the routine. It is especially sad that this young man came into prison for the last time just before he was due to be married.

170. During the two days in prison, I have identified many examples of good, well considered yet routine practice. That it was the weekend did not detract from the man's induction. The staff completed a first night health screening and a cell sharing risk assessment. He was prescribed medication to treat his withdrawal from drugs and alcohol. Officers carried out a safer custody interview and took steps to deal with his worries about other prisoners. A reception board was held and he had the chance to speak to a member of the CARATS team (although he declined their help) and a chaplain.

171. When the man was found, the response to the emergency was rapid and staff did all they could to resuscitate him, but sadly he died in the cell. Afterwards, staff looked after his cellmate and took every step possible to keep him safe. As the clinical reviewer comments:

> 'We believe that given [the man's] presentation, the taking of his own life was not foreseeable. We also believe that on finding [the man] hanging in his cell, staff took appropriate, timely action.'

172. Nonetheless, the investigation has highlighted a number of areas where practice can be improved. In particular, I highlight how the bereaved family's perceptions of the prison's attitude towards them can be affected by decisions made in the immediate aftermath of an emergency. I hope that some lessons can be taken from the investigation to ensure that Swansea's staff deal even more effectively with any future death in custody.

The family's response to the draft report

173. My family liaison officer contacted the man's father and his partner after they had had the chance to read the draft report of the investigation. They did not have any further questions that they wished to ask. They told him that the man's mother had also seen the report and did not have any further comments to make. I am very grateful to the man's family for their contribution throughout the investigation process.

RECOMMENDATIONS

1. The Head of Healthcare should make arrangements to ensure that electronic medical records are available to nurses and doctors who assess new prisoners at weekends.

   The Head of Healthcare did not accept the recommendation and provided the following response:

   > 'HMP Swansea does not hold electronic records on prisoners. [The doctor] is confusing the VISION system with a full electronic record.
   >
   > 'The VISION system we do have was purely installed as a governance response to improve the legibility of doctor's handwriting on their prescriptions.
   >
   > 'To explain, when a prisoner arrives at HMP Swansea, the night staff put on the prisoners number and brief details. That means, a doctor, when it comes to prescribing and consultation, can write up their entry and prescription on a typed label. Some doctors use it, some doctor's don't, so it is no way a record of their care at HMP Swansea and it was never intended to be. Therefore, this recommendation is not relevant as the doctor's statement does not reflect the actual purpose of the VISION system.
   >
   > 'The only formal medical record we hold is paper based.
   >
   > 'We currently hold paper based medical records and are already well on our way to holding an electronic based record, System One, which will go live in May 2011. It has already been factored into the planning and installation of the system that a computer is available within every area of Healthcare, including reception, all wing treatment rooms and all areas of clinical activity within Healthcare, allowing the medical record to be available anywhere a clinician may be working.
   >
   > 'A notice has been sent to all doctors to clarify any the points raised in the report.'

2. The Governor and the Head of Healthcare should work together to ensure that all healthcare staff who have contact with prisoners receive ACCT training.

   The prison accepted the recommendation and provided the following response:

   > 'The recommendation regarding ACCT training is a prison wide recommendation and not restricted to Healthcare. The establishment will ensure that all areas will be covered with a new refreshed training plan.'

3. The Governor should remind discipline staff that, in the event of an emergency, they should use their own initiative and feel able to request an ambulance if they think one is needed.

   The Governor accepted the recommendation and provided the following response:

   'The Governor will make arrangements to formally communicate with staff that in the event of an emergency they should use initiative in initiating a request for an ambulance. A general notice to staff will be issued to reflect this.'

4. The Head of Healthcare should review access to staff support, supervision and training for those staff that permanently work night shifts. They should consider offering rotation onto days so that such staff can be offered support, supervision and training.

   The Head of Healthcare did not accept the recommendation and provided the following response:

   > 'The review of night staff in healthcare: they are already subject to yearly review as per prison requirement, where their suitability for the continued pattern of work is discussed and agreed. All night staff work their shifts as a result of application due to individual circumstances. They come under the annual appraisal process to ensure they are meeting all their professional registration requirements and they are always offered attendance at all training and development opportunities open to day staff. They are offered supervision, which [the nurse] has attended. They are not excluded from any aspect of any other nurse's support and supervision in Healthcare.
   >
   > 'The recommendation needs to reflect that [the nurse's] concern (having attended the interview with her) and issue raised was wider support from the prison and that nursing staff are often viewed amongst wider staff as not needing the level of support from such things as the Care Team etc due to their registration and assumptions made about their ability to cope.
   >
   > 'I feel the recommendation needs to reflect that [the nurse] clearly stated she had felt she'd had support from healthcare but the not the wider prison. I think this should go hand in hand with a recommendation that states following a death in custody, the debrief and information sharing should involve all staff involved and should be sensitive to all disciplines within the organisation.'

5. The Governor and the Head of Healthcare should work together to review and update the death in custody contingency plan. The plan should remind staff of the correct procedure for declaring death and should also outline the roles of senior staff.

The prison accepted the recommendation and provided the following response:

> ‘This will also include other managers as well in the process for good practice and shared responsibility. The death in custody contingency plan will be reviewed as a priority which will include identifying who should respond as senior managers.’

6. The Governor and Head of Healthcare should offer refresher training to staff who regularly work night shifts, reminding them how to respond to a death in custody.

   The prison accepted the recommendation and provided the following response:

   > ‘The Governor has recently refreshed the training needs for all grades of staff for ACCT training. This will also include those staff who work nights.’

7. The Governor should review the provision of family liaison officers (FLOs) and the guidance they require. Consideration should be given to:

   - appointing a second FLO also with appropriate training

     The Governor accepted this part of the recommendation and provided the following response:

     > ‘The establishment will advertise for this role and the appropriate training will be given. ‘

   - having one trained FLO available at all times to respond to a death in custody

     The Governor accepted this part of the recommendation and provided the following response:

     > ‘A pager will be issued to one FLO once the training has been completed to provide this service.’

   - ensuring that only verified information about the circumstances of the death is given to the family

     The Governor accepted this part of the recommendation and provided the following response:

     > ‘FLOs are trained appropriately to national standards which include the need for only the verified information to be passed on.’

- acknowledging and contacting other immediate family besides the named next of kin

  The Governor accepted this part of the recommendation and provided the following response:

  > ‘A full assessment will be carried out by our FLO’s when considering who should be notified.’

- considering how to best represent the prison at a funeral.

  The Governor did not accept this part of the recommendation and provided the following response:

  > ‘The representation at the funeral was sufficient. The chaplain and the deputy governor made every effort to speak to those directly involved.’

8. The Governor should remind staff to request and record a prisoner’s next of kin details during the reception process.

   The Governor accepted the recommendation and provided the following response:

   ‘The Governor will issue a notice to reception staff ensuring that contact details of next of kin are recorded appropriately.’