# Investigation into the circumstances surrounding the death of a man at HMP Cardiff In July 2009

## Report by the Prisons and Probation Ombudsman for England and Wales

## September 2010

This is the report of an investigation into the circumstances surrounding the death of a man who died aged 62 years. He had spent 25 hours in the custody of HMP Cardiff, where he was on remand for the attempted murder of a close family member. He was found by the officer who unlocked his cell after lunch.

I would like to echo the condolences expressed on my behalf by the senior family liaison officer to the man's family. Although the investigation team did not meet the family during the course of the investigation, I am grateful to the man's son for his valuable contribution I hope that my report provides some explanation into the circumstances of his father's death. I apologise for the delay producing the report and any anxiety it might have caused.

The investigation was led by an investigator from my officer, assisted by a colleague. An independent review into the man's medical care was undertaken by a clinical reviewer and a colleague from the Healthcare Inspectorate Wales. I am grateful for their clinical review that is the first annex to the report.

I thank the then Governor of HMP Cardiff for the support that she gave the investigation. I am also grateful to the prison liaison officer for the high standard of liaison he provided the investigation team.

The man assured four individual members of staff during his short time at Cardiff that he had no thoughts of suicide or self harm. A physically ill man, he had been treated for depression for a number of years. The violent nature of his offence and his close relationship with the victim increased his risk of harm himself. Nevertheless, staff who spoke with him were persuaded that he had no thoughts of suicide. I examine the reasonableness of this assessment in this report and I also consider whether family liaison was carried out appropriately.

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

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

**CONTENTS**

## SUMMARY

The man was remanded to HMP Cardiff on 22 July 2009, following his arrest two days earlier for attempted murder of his former partner. This was his first time in prison. On arrival at the prison he was interviewed by a senior officer and a mental health nurse. Neither had any concerns regarding the risk of harm he posed to himself. Due to the large amount of prescription medication he had brought into prison with him, he was then assessed by the prison doctor. It is unclear whether he was given the prescribed dose of these medications upon arrival and I therefore endorse the clinical reviewer's recommendation that staff ensure this is clearly recorded in future. The doctor did not assess him as at risk of harming himself either.

Having been interviewed by another officer in reception, the man was placed in the first night centre in a shared cell that evening. The following morning his cellmate went to court. The man was interviewed by a chaplain on the wing around 9.30am as part of the induction process. He also had further routine induction assessments with a drug worker and an officer working on the wing. He collected his lunch and was then locked back in his cell. When officers unlocked his cell after lunch, they discovered him hanging from the bunk bed. Attempts to resuscitate him were unsuccessful, but were carried out quickly and proficiently. I make no recommendations in this regard.

The local suicide prevention policy highlighted that prisoners who had never been in prison before and were facing serious charges were at raised risk of suicide. Both of these circumstances applied to the man. However, a number of staff carried out thorough assessments of him, all coming to the same conclusion that he was not at risk of suicide. I have considered whether it was appropriate not to make him subject to suicide prevention measures and have found the decision reasonable. However, not all staff were aware of the seriousness of the charge he was facing and I therefore make a recommendation about information sharing.

Following the man's death, his son was requested by the police liaison officer to identify his father's body in his prison cell. Understandably this has caused his son much distress and I have therefore referred the matter on to the Chief Constable of South Wales Police. I also endorse the second of the clinical reviewer's recommendations that details of a prisoner's death are noted in their medical record. Lastly, my investigators had difficulty obtaining statements from staff involved in the care of the man. I therefore recommend that the Governor ensures such statements are taken quickly in future.

## THE INVESTIGATION PROCESS

1. I appointed a senior investigator to lead the investigation into the man's death. She was assisted by another senior investigator. On 27 July 2009, an Assistant Ombudsman accompanied the second senior investigator to open the investigation on the first senior investigator's behalf.

2. During the opening visit, the investigation team met the then Governor, the Chair of the Prison Officers' Association and the Chair of the Independent Monitoring Board (IMB). The liaison officer for the investigation gave the team copies of the man's records and showed them around the prison. Notices were posted around the prison inviting staff and prisoners to contact the investigator with any matters of relevance to the investigation. There was no response to these notices.

3. My senior family liaison officer spoke to the man's son at the beginning of the investigation. At the time, the family were too upset to meet the investigation team but expressed several concerns that they wanted the investigation team to look at. I am grateful for their contribution to my investigation and I trust that the matters they raise have been effectively dealt with in the investigation report.

4. I am grateful to the Healthcare Inspectorate Wales for the appointing of a clinical reviewer to consider the medical care the man received during his short time at Cardiff. A clinical reviewer was originally appointed, but another took on the role after the first clinical reviewer moved organisations during the course of the investigation. Due to the change in personnel, there was some delay in receiving the clinical review, which in turn delayed this investigation report. The clinical review is the first annex to the investigation report.

5. After a review of the paperwork, the investigation team went to Cardiff at the beginning of September to carry out two days of interviews with staff and one prisoner. They fed back their preliminary findings to the Governor. The investigation team returned to Cardiff at the beginning of October to conduct some follow-up interviews with staff involved in the response efforts. The team also observed the reception process during this visit. Three members of staff from Reliance (the company who is contracted to escort prisoners between police stations, court and the prison) came to the prison to be interviewed on 8 October. Again, the investigation team met the Governor to discuss their findings and the investigator confirmed their discussion in writing.

6. The investigator wrote to the prisoner who shared a cell with the man on the morning of his death. The prisoner was released later that day and unfortunately did not respond to her request for information.

7. My investigator also wrote to the Chief Constable of South Wales Police in September about the request to the man's son to identify his father's body. This matter is outside the Ombudsman's terms of reference. I am grateful to the Chief Constable for passing the matter for the attention of an Inspector at

the Professional Standards Department of South Wales Police, who I was assured would look into the matters raised.

## HMP CARDIFF

8. HMP Cardiff, situated near the town centre, is a local and a training prison. It can hold up to 784 adult male prisoners. The prison has six residential units, one of which is used exclusively for life sentenced prisoners, and one for those going through detoxification. A new healthcare centre was opened in May 2008 that provides 24 hour nursing and medical cover and beds for up to 22 in-patients.

9. In January 2008, Cardiff was inspected by HM Chief Inspector of Prisons. The report of that inspection commented as follows:

> "Cardiff was essentially a safe prison, where prisoners were much more likely to report feeling safe than at other local prisons … In general, support for newly-arrived prisoners was good."

10. The inspection report also commented that reception procedures were well organised and efficient. The Inspectorate found that suicide and self harm arrangements were centrally managed by an experienced safer custody team with well established policies. They noted that relationships between staff at the prison and the escort contractor (Reliance) were good, with prompt arrival of the vehicles and the efficient handover of custody.

11. An Independent Monitoring Board (IMB) is appointed to each prison by the Secretary of State for Justice. Its members are wholly independent of the National Offender Management Service (NOMS) and the prison's management team. The IMB of every prison is required to produce an annual report to the Secretary of State, highlighting good practice and areas of concern.

12. In their report on Cardiff prison for the period 1 September 2007 to 31 August 2008, the IMB noted that the safer custody team at Cardiff "… is very highly motivated and well respected". They also found that most suicide prevention monitoring was initiated in reception, induction and the detoxification unit.

13. The National Offender Management Service (NOMS) is responsible for the management of prisons in England and Wales. Every three months it publishes an assessment of an individual prison's performance against 34 measures. Prisons can gain a rating of between one (serious concerns) and four (exceptional performance). Cardiff has consistently scored 3s (good performance) for the last four quarters.

14. The man's death was the second of four self-inflicted deaths at Cardiff in 2009. There has been one in 2010 at the time of issuing this draft report. All the deaths were investigated independently by the Ombudsman's office, and the lessons were shared between the investigation teams. His death seems to have little in common with these other deaths.

## KEY EVENTS

### Police custody

15. The man went to a police station on 20 July to confess to the attempted murder of a family member. While in police custody, he was seen by several members of staff, including a Forensic Medical Examiner (FME). He told the FME that he suffered from a history of depression and that he had harmed himself a number of years ago by cutting his wrists. A note was made of this in the police medical record.

16. The FME prescribed 50 milligrams (mg) diclofenac (an anti-inflammatory) for the man's arthritis and 75 mg dosulepin (an anti-depressant). There is also a note of his previous heart surgery 12 years ago in connection with his chronic obstructive pulmonary disease (COPD). COPD is a lung disease which results in sufferers experiencing shortness of breath. The following day he was again prescribed diclofenac and dosulepin.

### Wednesday 22 July

17. The man was taken from police custody to a magistrates' court. Prisoner Custody Officer (PCO) A was responsible for processing the paperwork accompanying those in custody appearing at court that day. He is employed by a private company, Reliance. The PCO marked on the man's prisoner escort record (PER) that he was received into Reliance custody at 10.07am. (The PER is a form that accompanies each prisoner between court and prison. It provides information about the prisoner's needs and the risk he poses to others.) The first five sections of the PER had already been completed by the police with the man's personal details and any risk they assessed he presented to himself or others. The PCO did not meet him as was the usual procedure, since he was in an office as the desk officer that day. He was passed information by the court cells officers and recorded that information on the prisoner's files.

18. The man had a large quantity of prescription medication with him and he was therefore taken to an interview room so he could be easily observed rather than held in a cell. PCO A said neither he, nor any of the other officers, had any concerns that the man presented a risk of harm to himself. There was no information on the PER to indicate a risk of self harm. The PCO could not recall receiving the information from the police detailing that the man had self-harmed years ago. He said that if he had received this information he would have noted it down and informed the senior custody officer.

19. PCO A said he was unsure whether he knew the offence the man had been charged with, but that custody staff are not routinely informed. Their assessment does not differ depending on the seriousness of the charge they are facing and generally it is based on how the prisoner presents and the information they give themselves.

20. Due to the seriousness of the alleged offence and the likely length of sentence, the man's case was committed to crown court and adjourned until 31 July. He then travelled in an escort van (a large van with small cells holding around six prisoners) to HMP Cardiff. PCO A said that alternative arrangements can be made for a prisoner to travel in alternative transport when there are medical reasons. However, this had not been deemed necessary by the Reliance control base responsible for managing the process and he had not requested special transport either.

21. PCO B highlighted 'medical' and 'violence' as issues on the PER. The man was not identified as at risk of suicide or self-harm on the form, although reference was made to something "attached" to the PER which had "further information about risk". During interview, he thought that the attached sheet in question referred to the medication record. He said that, given the short time that the man was likely to be in the escort's custody, an estimated 25 minutes, his main concern was to ensure that he had taken all his required medication. He assured himself that this was the case by looking at the detained person's medical record.

22. Working with PCO B that day, PCO C was in the back of the escort van when court staff brought the man to him. He recalled that he "seemed perfectly alright". He said that if either of the prisoner custody officers working on the escort van were concerned about escorting him, they would have to contact the Reliance control base so that alternative arrangements could be made.

23. PCO C located the man in cell five of the van and collected his paperwork and property from PCO B, who proceeded to drive the van to Cardiff. PCO C explained that the escort van had cameras installed in each cell and a screen above his head. The screen flicked between the cameras every ten seconds so that he would be aware of anything "going wrong" in any of the cells within less than a minute. He remembered nothing of note from that journey, which he recorded as taking less than 20 minutes.

24. At 12.20pm the man arrived at the reception area at Cardiff. PCO C remembered escorting him from the van. The prison custody officer recalled specifically that he was joking because both men were of a similar age. He described him as being in "good spirits" when he arrived at the prison. The PCO told my investigation team that he did not consider him at risk of suicide or self harm throughout their brief contact.

25. This was the man's first time in prison. The investigation team interviewed Senior Officer (SO) A, who was working in reception the day the man arrived. The SO said the man would have waited in a holding cell with other prisoners until he could be seen. He said between one and ten prisoners usually arrive over the lunchtime period. On that day, 11 prisoners arrived at Cardiff.

26. The man was then called to the front desk where he was given tobacco, telephone credit and his private cash counted and secured. SO A had access to the PER which noted the risk of violence and medication issues. When asked about the reference to attached sheets on the PER, he said that he

thought it referred to the record of events, (the second sheet of a PER), where there is no information noted about risk. When shown the police medical record during his interview, he said he had not seen it. (The senior officer said the document would not have altered his assessment of the man's risk of self-harm, because the reference was historical.)

27. SO A said he was unaware of the nature of the man's offence or his previous history of self harm. When asked whether he considered him at risk of harming himself, he told my investigators that "there was nothing untoward" during their conversation that made him think he was at risk of self harm. The senior officer was unaware that this was his first time in prison since this information was not immediately apparent from the computer system. However, he told my investigators that officers always ask a prisoner if it is their first time in prison. The SO concluded that the man must have told him that it was not his first time. The senior officer generated a prisoner number for him, who then had his property logged and his photograph taken by reception staff.

28. A Registered Mental Health Nurse (RMN) was assigned to work in the reception area that day, completing the first reception healthscreen. (A first reception healthscreen is an assessment of the immediate mental and physical health needs of a prisoner.) She has worked at Cardiff for five years and estimated that she worked on reception about once a week.

29. The RMN told my investigators that she was aware of the seriousness of the offence against a family member for which the man was remanded. Officers in reception had told her the details of the offence. The nurse gave the following assessment of him during the interview for this investigation,

> "My general impression of him was that he was appropriate taking into account the nature of his offence, he wasn't over emotional. He wasn't withdrawn, he wasn't negative with what he was saying. He was talking about the future. He did show remorse but it was appropriate considering what he had done, he said he had flipped."

30. The man arrived at the prison with a bag of medication, each with a computerised record of his name and prescription attached to the bottle. He explained his medical conditions to the nurse who listed all of his medication. He had chronic obstructive pulmonary disease (COPD) and coronary heart disease (CHD), both of which required medication. He also needed to be nebulised twice a day for his breathing and chest pain to be kept under control. (A nebuliser is a device used to administer medication to people in the form of a mist inhaled into the lungs. It is commonly used in acute cases of COPD.) He took medication for gout, arthritis and tablets to prevent irritation in his stomach.

31. The man told the nurse that he had been taking dosulepin, an antidepressant, for five years. He explained that his poor physical condition made him feel low in mood and that the anti-depressants helped him to cope. He said that his doctor had gradually decreased the dosage, as his coping skills improved.

Both the RMN and prison doctor told the investigation that it was unusual for dosulepin to be prescribed by doctors any more because there is a high risk of overdose associated with it. The RMN said she considered the prescription of dosulepin as a "positive indication" that the man was not at risk of attempting suicide because a doctor would not have prescribed such a drug to anyone with such a risk.

32. When asked what she considered when assessing the man's risk of self harm, she told the investigation team that he was open about his attempted suicide following a family bereavement. She said "he had no reason" to be honest with her and was reassured that he was being so open. He was dismissive about the seriousness of the self harm and she said she believed his account. He told the nurse that he had no thoughts of harming himself at the time.

33. During her interview with the investigation team, she recalled that his body language "corresponded" with what he was saying, for example he made good eye contact. She acknowledged that the offence that he had committed was serious but thought that he demonstrated he was coping adequately with his situation through his body language and the way he interacted with her. She did not think he was at risk of attempting suicide, and therefore she did not open an ACCT document. (ACCT stands for Assessment, Care in Custody and Teamwork and is the Prison Service system used to identify and support prisoners at risk of suicide or self-harm.)

34. As a mental health trained nurse, she told my investigation team that it was her view that the man was not suffering from a mental health problem. There is a section on the first reception healthscreen that examines a prisoner's mental health needs. She said that the decreasing dose of antidepressants was an indication that his depression had stabilised over the previous five years. She told my investigation team that she did not consider the circumstances of his sudden violent offence as evidence of mental illness. She said "I think people get angry that doesn't necessarily mean they are mentally ill, it means they get angry."

35. She made a referral for a mental health assessment. During interview for this investigation, she explained that the man only needed a mental health assessment because he was prescribed anti-depressants. Whilst this is the case, he would also have needed to be referred as he told the nurse about a previous occasion when he harmed himself 25 years ago. Additionally, on the healthscreen template there is a note that if the prisoner is charged with murder or manslaughter, they should be referred for a mental health assessment. (It is not clear if this should also be the case if the prisoner charged with attempted murder, as he was.)

36. After the first reception healthscreen, the RMN contacted the doctor on duty in the prison that evening. The nurse explained to the investigation team that not all prisoners arriving at Cardiff are examined by a doctor in reception. Due to the man's complex medical needs, she thought it was appropriate to get a second opinion. The doctor was working in an office in the healthcare

centre when she received the call. She agreed to assess the man and made her way to reception. During interview for this investigation, the doctor told my investigator that the nurse sounded unsure about the man's diagnosis and, while confident in assessing his mental health needs, she wanted reassurance about his physical health needs.

37. The doctor joined the RMN and the man in the private healthcare room in reception. She remembered that he was remorseful when talking about his offence but otherwise appeared to be coping with his situation. As he described his medical conditions and related treatment, she was impressed by his grasp of such a complex set of needs. She told my investigator that he required nebulising twice a day and this was available on the wing. He said he often experienced a tight chest, she recommended that he be located on "the flat", that is the ground floor to avoid using stairs. She explained that he would have to collect his medication from the treatment hatch until such a time he was assessed as able to have it in his possession. (For the first few days of custody, he would have had to climb one flight of stairs for his medication, but would have been located on "flat" after induction.)

38. The doctor said she had no concerns about the man's risk of suicide. She did not discuss his history of self-harm, because she did not read it on the first reception healthscreen until after the examination. However, she was satisfied that the RMN would have made an appropriate assessment, because of her mental health training.

39. The doctor told my investigators,

> "I searched specifically to get a feeling, because of his past history of depression, about the risk to himself and I asked him first about depression in general, why he is on an anti depressant? How long he had been on them and then I asked him how did he feel about being in prison and would that change his depression? Would it make it worse? Would he think he would cope? I offered him all the help he can possibly get or who to talk to if he felt worse and I asked him whether he felt suicidal, to which he said, doctor I would never do that."

As the man maintained eye contact and his manner did not change when he responded to this question, she believed that he was speaking the truth. (She noted down an account of their conversation as soon as she learned of his death. She told my investigation team that she was confident that he used the words "I would never do that".)

40. Again, the doctor recorded in the man's medical records that his antidepressant was a decreasing dose. She told the investigation team that she "didn't detect any" signs of depression. She explained that there was "constant" eye contact during their meeting and "he smiled, we laughed about the smoking". The doctor did not assess him as having a mental health condition.

41. Having confirmed the man's prescription medication with his community GP by telephone, the doctor prescribed him a number of medications that afternoon including diclofenac and dosulepin. It is unclear whether he was given the diclofenac medication as prescribed.

42. Officers from the induction unit meet every prisoner in reception before they are escorted to the first night centre (part of the induction unit) for their first few days in custody. Officer A, an officer on the induction unit, explained the aim of the arrangement is to build up a rapport with prisoners, especially because the first night in prison can often be the hardest to cope with.

43. Officer A met the man in reception when he completed the first part of the Cell Sharing Risk Assessment (CSRA – used to assess a prisoner's risk to others and determine whether it is safe for them to share a cell.) During interview, he explained to the investigation team that reception staff were responsible for completing section one of this form. The 'current offence' section on the CSRA was incorrectly filled out as "failure to surrender", but it was not the officer's writing. All other information regarding his current and previous history of offending was gained from the man himself. The officer was unaware of the violent nature of the offence with which he had been charged.

44. Officer A also completed the reception screening part of the man's induction file. He disclosed that 25 years ago he had cut his wrists but had no current thoughts of suicide. The officer told him about the Listener scheme (this is a confidential service whereby prisoners can talk to other prisoners who have been trained as 'Listeners' by the Samaritans). The man was also offered a telephone call, which he declined. The officer judged that he was not at risk of harming himself and described him as "jolly" during this exchange. He cannot remember seeing him after this assessment until the following morning when he was working on the induction landing.

45. The RMN also filled out the healthcare section of the CSRA while he was in reception. She wrote: "Locate flat. First time in prison. Fit for normal location". The nurse indicated that the man was a low risk and was suitable to share a cell with another prisoner. When asked during interview what the alternative to "normal location" was, the nurse explained that prisoners can be accommodated in safer cells or admitted straight to the healthcare centre. (A safer cell has fixed plastic furniture, with the aim of reducing ligature points.) She told my investigators that she had not considered him at risk of suicide or self harm and so a safer cell was not appropriate. As for admitting him to the healthcare centre, she considered that, while he had complex medical issues, he would be able to manage these on a residential wing. Therefore, she did not recommend that he be admitted to healthcare.

46. While the nurse filled in part of the CSRA, the doctor signed and dated it. She told my investigation team that she agreed with the nurse's assessment that the man should be located on a residential wing. She explained that she was satisfied that he understood and managed his medication well and she wanted to promote the same independence that he was used to in the community. He was located in the first night centre in a shared cell. The

nurse contacted his community GP because he said he was taking Tramadol (a painkiller) but he did not have any evidence to support this. During her telephone conversation with the surgery, she discovered that he was not prescribed Tramadol, but she was able to confirm the other medication in his possession.

**Thursday 23 July**

47. Officer B arrived for his main shift duty at 7.30am on 23 July. He had not been on duty the previous day. During interview for this investigation, he remembered that instead of the usual three officers on the induction unit, there were only two working that morning, himself and Officer A. Officer A confirmed this. Officer B said they completed a roll count (when staff count prisoners) and then unlocked the prisoners who were going to court. The man's cellmate was due to appear in court that day, so he was escorted to the reception area at about 7.45am, leaving the man alone in his cell.

48. Officer B described the morning as "nothing out of the ordinary". Prisoners were unlocked at about 8.00am to make applications to use the telephone or for a medical appointment. There is no record that the man made any such application. He collected his medication from the treatment hatch at about 9.00am. The doctor remembered overhearing nurses arranging the nebuliser for his use. He then returned to his cell.

49. At 8.38am a worker from the prison's custody team sent two emails. (The custody team perform an administrative function, collating prisoners' records. They do not meet prisoners during the course of their work.) The first email alerted prison staff to the offences with which the man had been charged. The second was sent to safer custody staff advising them of a "self harm warning in his core records" and also that he suffered from depression. During the investigation, my team visited the custody team worker in her office and asked what information would have triggered that response. She said that she was acting as a result of the note in the police medical record about his historical self harm.

50. No one visited the man as a result of the worker's email. During interview, Safer Custody Manager was asked what action would be taken on the receipt of such emails. He said usually safer custody staff would aim to see the prisoner the same day to assess their risk of self harm or suicide but at the latest they would be seen the next day.

51. A sessional chaplain visited the man at about 9.30am on the wing. A chaplain usually visits prisoners within 24 hours of their arrival. She spent about ten minutes at his open cell door, discussing his faith and any needs he might have. She told my investigation team that she talked to him for a bit longer than usual because, as a Christian Spiritualist, his faith was uncommon at the prison and she wanted to explain what was available to him. He asked her to put him on a list to attend the Sunday Church of Wales service and said he would consider being visited by a local Christian Spiritualist priest.

52. The chaplain asked him whether he had any thoughts of harming himself, and believed him when he said he did not. He mentioned that his offence was one of domestic violence but he did not go into detail and she did not ask him to. When she locked him in his cell after the conversation, she noticed no indication that he was at risk of harming himself. She told the investigation team that if she had any such concerns, she would have communicated this to the safer custody team immediately.

53. The investigation team tried to contact the man's cellmate during the investigation. He was released from Cardiff after going to court on the morning of 23 July. The investigator subsequently wrote to him to communicate the news of the man's death and ask for any information he thought would be relevant. The investigator received no response to that letter.

54. The investigation team spoke to one of the prisoners located on the induction landing on 22 July. Of the other prisoners who arrived on the same day as the man, only one prisoner remained at Cardiff. During interview he said that he had been talking to the man on the morning of 23 July while they were the only people in a room waiting to see someone. He thought they were waiting to be assessed by a Counselling, Assessment, Referral, Advice and Throughcare Service (CARATs) worker. Documents confirm that the man was seen that morning by a CARATs worker whom explained the services they could offer him. (CARATs works with prisoners with substance misuse needs and sees every prisoner as part of the induction process.)

55. The prisoner remembered that the man told him why he was in prison and he noticed he seemed upset as his bottom lip was "quivering". He said the man seemed "quiet, subdued and depressed". He also remembered talking to another prisoner who said the man had said to him "don't worry I won't be here for long". He did not mention suicide or self harm to the prisoner. He told my investigators that he had not thought the man was at risk of suicide otherwise he would have informed Officer A or Officer B who he said were "nice and approachable". He also said he was not aware of any prisoners on the landing reacting in a negative manner to the man. He thought it unlikely that he would have been bullied or threatened since he had been on the landing such a short time.

56. At about 11.00am that morning, the man undertook a voluntary drug test on the landing above the induction unit. After the test, at 11.30am, Officer B took him to a private office to complete the Induction Passport. He explained the incentives and earned privileges scheme. (This is a system to reward good behaviour in prisons. There are three levels: basic, standard and enhanced. Incentives can include access to in-cell television, more private cash or prisoners being allowed to wear their own clothes.)

57. Officer B also explained the prison's diversity policy and suicide prevention policy. He told my investigators that he always outlined procedures for monitoring suicide or self harm, and asked prisoners to approach staff with any concerns about themselves or others. The man signed to agree that he

understood the policy. The officer said he had no concerns about his risk of suicide. After the ten minute interview, the man returned to his cell until it was time to collect his lunch.

58. Lunches are collected from the landing above the induction unit at 11.45am. Other landings collect their lunch first and F1, where the man was located, is the last of the four landings to get their meal. The meals are given to prisoners on a tray at a servery. The prisoners take their lunch back to their cells where they are locked in to eat. Neither Officer A nor Officer B could remember which officer locked his cell that lunch time.

59. During the lunch hour, all the prisoners were locked in their cell and only one officer remained on the landing. On 23 July, Officer A had some errands to run and he left the induction unit, leaving Officer B to carry out the lunchtime shift. Officers do not check prisoners during their lunch, unless they are subject to ACCT or at risk of escape. Officer B did not check the man during that lunchtime. Cell bell records confirm that he was not called to his cell or those adjacent to it.

60. Officer A returned to the unit at 1.30pm. The two officers agreed to clear the lunch trays from each cell, a matter of routine. Officer A did cells one to ten and Officer B collected trays from cells 11 to 22. Officer B started at cell 22, collecting the two trays from prisoners in there. Next he moved to cell 21, the man's cell.

61. Officer B checked through the observation panel on the cell door. He thought the man was sitting on the bottom bunk. The officer used his key to unlock the door. As he did so, he noticed that the man had a plastic bag over his head. He had tied a leather belt around his neck and attached it to the bunk above. Officer B shouted to Officer A, who ran to the cell. He saw the man and then ran the few metres to the end of the landing to press the alarm button. Officer A told the investigation team that he used the alarm to alert staff that they needed assistance.

62. In the meantime, Officer B used the anti-ligature knife that he carried with him (all officers carry an anti ligature knife on their belts) to cut the belt and remove the bag from the man's head. Officer A then called a Code Blue over the radio and checked for a pulse but could not detect it. (Code Blue is the emergency code used when someone has stopped breathing.) Officer C then went into the cell and helped Officers A and B move the man to the floor. (A hard surface is more efficient to perform resuscitation than a soft surface, like the bed.) Officer B told my investigators that he thought the man had died. The officer remembered that he was cold to the touch. Officer C then started cardio-pulmonary resuscitation (CPR) since he was better placed to do so in the small cell than Officers A and B.

63. Physical Education Officer (PEO) A and PEO B arrived at the cell seconds later. As they are both first aid instructors, they offered advice to the officers trying to resuscitate the man. They suggested moving him out of the cell but PEO A said that this did not happen and they began moving furniture out of

the cell instead. Since the cell was becoming crowded, Officers A and B went to a nearby quiet room where they were supported by the care team.

64. PO A and Officer D then arrived with restart kit (continuing medical equipment for emergencies) with PO B. (As the Orderly Officer, PO B was in charge of the prison that day.) Officer D gave Officer C a face shield for protection during resuscitation. The radio controller called an ambulance. (According to the communications log, the ambulance was called three minutes after the initial alarm was raised.)

65. Four members of staff from the healthcare centre arrived with the defibrillator, one of whom was a Healthcare Senior Officer (HCSO). (A defibrillator is a device used to measure whether there is any activity in the heart that might be restarted using an electric shock.) The HCSO is also a qualified nurse. He had been carrying radio Hotel 3, meaning he was tasked to respond to any emergencies. The defibrillator was attached to the man and the relevant checks were carried out. Officer C recalled that the defibrillator, which he was trained to use, instructed that it should not be used and that resuscitation efforts should continue. PEOs A and B returned to their department at this stage.

66. CPR was continued by Officers C and D administering chest compressions, swapping on each set, while the HCSO inserted an airway and used an ambubag to pump air into the man. (An ambubag is a self inflating bag used to administer oxygen.) Two nurses offered to take over CPR every few minutes but this was declined and they remained outside the cell. They passed medical equipment to officers as requested.

67. The ambulance arrived at 1.49pm, 15 minutes after the man was initially found. Officers continued to administer CPR under instruction from the paramedics until their equipment was set up. The paramedics attached their own defibrillator and continued to attempt resuscitation until 2.16pm when they decided that nothing that more could be done for him. They waited for the doctor to arrive who could pronounce death. Officers C and D said a prayer over the body, while they waited for the chaplain.

68. The Chair of the IMB was on the induction unit visiting another prisoner. She remained on the unit to provide support to staff and answer prisoners' questions. The Governor arrived a few minutes later and evidence was taken from the man's cell. He was then blessed by a chaplain, with the Governor and Officer C present. The doctor arrived and pronounced the man dead at 2.55pm and an officer secured the cell. A debrief was held for staff involved.

**Family liaison**

69. When a prisoner is taken into custody, they are asked by escort staff for details of their next of kin. The man gave the name and contact details of his 17 year old son. Upon discovering the age of the named next of kin, PO A, charged with locating details of the family, decided it was inappropriate to break the news of his father's death to someone so young. He tried another

telephone number on the records but there was no response. (It was likely to have been the man's own telephone number.)

70. PO A asked the police liaison officer to find an alternative contact to break the news of the man's death. (A police liaison officer is a trained police officer, based in the prison.) The police found a mobile telephone number for an older son. When the PO contacted the man's older son, he was driving into Cardiff City Centre. During interview for this investigation, the PO said that he did not want to explain the reason for his call while the man's son was driving and over the telephone. The son offered to come to the prison to speak with the PO. In the interests of breaking the news of the man's death as quickly as possible to avoid his family learning of it from another source, the PO agreed to meet him about half an hour later at the prison gate.

71. The Governor and the PO met the man's son at the gate and escorted him to the Governor's office, where they broke the news of his father's death. On his way out of the Governor's office, the son passed the command suite, where the police remained carrying out their duties. A police officer asked him if he would accompany him to the cell and identify his father's body. Despite being unhappy with this irregular arrangement, the PO did not feel able to challenge the police officer's request and thought he had no choice but to escort them to the cell. I am surprised that, in the interests of efficiency, the traumatic and personal experience of identifying his father's body had to be carried out in such an inappropriately public environment. The man's son was still upset about this encounter when he spoke to my family liaison officer weeks after his father's death.

72. An associate psychologist, based in the safer custody department, was appointed family liaison officer for the prison on the Monday following the man's death. He telephoned the older son that day to explain that the prison would contribute to the funeral expenses. He also asked whether the family would like anyone from the prison to be at the funeral. The son confirmed the date of the funeral but asked that no one from the prison attend.

73. After the funeral, the psychologist arranged with the coroner's officer for the man's property to be released to the family. On 27 August, both he and the PO met the man's son with his property at the prison gate. The son discussed some of his concerns with them, who assured him that my office would seek to address these concerns as far as possible. I trust that I adequately explore these matters in the following section, insofar as they are within my terms of reference.

**Prisoner Support**

74. Although the man was not at Cardiff for long, prisoners on the induction unit were offered support from the Chaplain and Listeners. (Listeners are prisoners trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) A memorial service was held for him in the days after his death.

**Staff support**

75. Following the man's death, all staff were asked to remain in the prison to give statements to the police. Officer C asked to be relieved because he was not ready to give his statement. He was told that he was not allowed to leave the prison or clean himself, as his clothes had to be tested for evidence. Given that the man died in a locked cell on his own and third party involvement was unlikely, I am surprised that the gathering of evidence needed to be so intrusive. It is not the practice which I usually discover in my investigations. The Chair of the IMB brought this matter to my attention. I understand that it was the police liaison officer who asked the officer to remain in the prison. I referred the matter to the Chief Constable in South Wales, who assured me that it would be dealt with by the professional standards department.

76. All staff told me that they were able to access care and support services through the prison. Officer C explained that he was having some difficulty coming to terms with his phased return to work. I understand that such a time can be difficult, but was assured through discussions with the Governor, that the matter was being dealt with appropriate sensitivity.

77. A debrief was held after the man's death as an opportunity for staff to go through what happened on 23 July and offer support to each other. Officer C told the investigation team that he felt unable to attend the debrief because it was "not right for him at the time". He also said that he was surprised such a debrief would be held at the prison, although he acknowledged that it makes things easier for most staff for operational reasons.

## ISSUES

### Did staff miss any signs that the man was at risk of suicide?

78. During the 25 hours the man was at Cardiff, his risk of attempting suicide was formally assessed by a nurse, doctor, reception officer and a chaplain. Other officers and a CARATs worker also met him in his short time in prison. No one raised concerns about his risk of self harm and, as a result, no ACCT was opened.

79. The man was on remand for a violent offence, the victim of which was a close family member. It was his first time in prison and his physical health was poor. The prison's suicide prevention guidance for staff describes three categories of prisoner who are at greater risk of suicide. Firstly, a prisoner who has poor coping abilities, secondly a prisoner with or facing a long sentence and thirdly prisoners with mental health issues. He came into the second category of prisoner as he had been charged with a very serious offence. Within this category the guidance says that violent offenders are at a particularly high risk, especially for offences within the family. The risk is further increased during the period a prisoner is on remand. Both of these additional risk factors applied to him, who was also being treated for depression.

80. The guidance notes that the "main motivating factors are guilt, shame, worthlessness and lack of hope for the future". According to the guidance, levels of previous self harm among such offenders are low and suicide attempts tend to be well planned and more determined than with those with poor coping abilities. The man's apparent suicide could be seen as a determined effort given the use of both a ligature and plastic bag.

81. The same document also gives detailed information regarding verbal and nonverbal cues which indicate an increased risk of suicide. For example, poor personal care, withdrawal, food refusal, expression of boredom or of missing their family and hopelessness. The guidance goes on to list behavioural cues to an increased suicide risk, such as mood changes or a prisoner being unable to sleep. The section concludes:

> "Suicide is ultimately a matter of choice. We can usually influence that choice and should always seek to intervene. However, there will always be some who do not seek or respond to help. Not all suicides are preventable."

82. I am pleased to have found a system whereby information given to the prison is considered and every prisoner arriving in custody with a self harm warning is visited by a member of the safer custody team. The worker from the prison custody team emailed on the morning of 23 July to notify staff of the man's history of self harm, as recorded on his police custody record. Unfortunately, the safer custody team did not visit him that morning. The investigation team made a spot check of all these emails which had been sent in July. They found that out of 30 alerts, all of the prisoners had been visited at some point

by a member of the safer custody team. The vast majority, 25 prisoners, were seen the same day or the day afterwards. Of those, only one prisoner was placed on an ACCT as a result of the Safer Custody team's visit.

83. However, whilst the risk factors described above are concerning, they must be weighed against the clinical judgement of staff who saw the man during his brief time in prison. The RMN and the prison doctor were aware that it was his first time in prison and understood the nature of his offence. However, whilst taking this into account, his presentation did not give them any concern that he was at risk of suicide. They remembered what he told them during his conversations, and also recalled how consistent his body language was with his assurance that he was not going to harm himself.

84. I understand that the Cardiff safer custody team has introduced a system to support prisoners who have committed serious violent or sexual offences against a family member. I am pleased that they continue to recognise the risk associated with such a prisoner. I am careful not apply the benefit of hindsight in my investigations. I am satisfied that all those who came into contact with the man considered his risk of self harm. Some were aware of the details of his offence and some were not, but he was spoken to at length about any thoughts of harming himself. It is my view that staff considered his risk of self harm sufficiently and made an informed decision based on what he told them and how he presented.

85. The man's family were concerned that he had been allowed to keep his belt when in prison. My interviewers questioned PO A about this decision. He said that, since staff did not consider him to be a risk of suicide or self harm he was allowed to keep his belt. If staff had thought him to be at risk they would have taken it away and considered relocation to a safer cell. The PO pointed out that other items in the cell, such as bed sheets, could have been used to make a ligature and it was not possible or appropriate to confiscate all such items from all prisoners. This would only happen when a risk of self harm or suicide was assessed. This is in line with the requirements set out in Prison Service Order (PSO 2700) – Suicide and Self Harm Management. (PSOs set out the rules by which prisons are run.) According to PSO 2700, staff should consider alternative action before removing personal items from prisoners who have been assessed as at risk of self harm. Given my opinion regarding the reasonableness of not opening an ACCT, I believe that staff allowing him to keep his belt was appropriate.

**Information sharing**

86. Some members of staff were not aware that this was the man's first time in prison or of the nature of his offence. They included the two officers who worked on the induction wing where he died. Prison Service Order (PSO) 2700 relates to suicide prevention and self-harm management. It says:

> "Establishments must make provision for additional risk assessments and care to keep safe prisoners who have been charged with domestic violence and/or domestic murder/murder of a family member. Such

provision must include ensuring a record is maintained to show what action has been undertaken."

87. PSO 2700 also says that all new prisoners are asked whether they have been in prison before and that all information gathered during reception should be available to staff commencing the induction process.

88. I conclude that the decision not to make the man subject to ACCT procedures was reasonable. Their judgement was based on in-depth and frank conversations about how he felt at the time of his remand. However, in order to make more informed risk assessments and accurately note changes in mood, it seems the officers in contact with him should have known about his offence and that it was his first time in prison.

89. My investigators were told that this information was not shared because it was recorded on the first reception healthscreen, which formed part of the medical records. Medical records were considered confidential. Information relating to a prisoner's safety needs to be shared. Aside from this, since it was the man's first time in prison, he was likely to need a more thorough explanation of the regime and his rights. I therefore make the following recommendation:

**The Governor should consider a system whereby information which is known to be a risk factor in self harm or suicide is shared fully amongst all those who come into contact with the prisoner.**

90. I am pleased to note that a new system has been introduced at Cardiff, whereby prisoners who have committed a certain class of violent offence, especially involving a family member, are monitored by staff in the early days of custody.

**Prescription of medication**

91. The man arrived at Cardiff with a number of different types of prescription medication. Having spoken to his community GP, the prison doctor re-prescribed these, including the anti-inflammatory diclofenac. However, the clinical reviewer notes that it is not clear whether he was given this medication as prescribed. It was not signed for and the nurse was unsure if she had administered the medication or not when asked during interview.

92. The clinical reviewer goes on to say:

"All healthcare staff should comply with the Nursing & Midwifery Council (NMC) Standards for medicine management which clearly states that 'You must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible'. The standard goes on to state that 'Where medication is not given the reason for not doing so must be recorded'."

93. I therefore endorse the clinical reviewer's recommendation that:

**The Head of Healthcare should ensure a clear record is kept of any medicine which has been administered, intentionally withheld or refused. If the medication is not given, the reason for not doing so must be recorded.**

## Emergency response

94. On discovering the man, the emergency code was effectively communicated and an ambulance promptly requested. Both officers and healthcare staff responded quickly and professionally to the emergency. Indeed, the clinical reviewer comments:

> "It appears from interview evidence that first responders acted quickly to attend to the man and undertook CPR appropriately until the paramedics arrived to take over**.** We have no recommendation in this regard."

I also have no recommendation to make in this regard and am pleased to observe the prison's contingency plans working effectively.

## Medical record keeping

95. The clinical reviewer notes that:

> "The clinical records provided only contain the first reception health screen and the doctor's initial medical assessment. There is no documentation related to the man's death in the clinical records.
>
> "Healthcare staff should ensure as far as is practicable that a description of the event of a death and the activity undertaken to resuscitate the individual is clearly documented in the clinical records including the time the ambulance arrived and doctor pronounced the prisoner dead. Records should identify any risks or problems that have arisen and show the action taken to deal with them as stated in the NMC Record Keeping: Guidance for Nurses and Midwives (2009)."

96. I therefore endorse the clinical reviewer's recommendation that:

**The Head of Healthcare should ensure detailed medical records are kept in relation to a prisoner's death in line with the NMC guidance.**

## Family liaison

97. The man's son told my Senior Family Liaison Officer of his distress at having to identify his father's body in the cell where he died. In my experience of investigations this is not usual practice and the Safer Custody Manager confirmed that he had never known it to happen before. Indeed, he went on to say he felt very uncomfortable with this happening in the cell. I understand that it took place at the request of the police liaison officer, located in the

prison. Since they are employed by South Wales Police they fall outside of our remit. My investigator has therefore written to the Chief Constable of South Wales Police to inform them of our concerns in this respect. I am unable to comment further and trust that this matter will be effectively investigated by the police. I will also send a copy of my report to the Chief Constable.

**Staff statements**

98. Cardiff has written its own compulsory guidance to staff following a death in custody. This is in addition to PSO 2710 which relates to deaths in custody. The Cardiff policy says that "the Orderly Officer will gather all written reports from staff prior to them going off duty, submitting the reports to the Duty Governor". According to the guidance, statements are supposed to be taken from staff and prisoners including:

- Staff who were first on the scene
- Other staff attending the incident
- Last person to see the prisoner alive
- Death in custody staff check lists
- Prisoners in adjacent cells
- Personal Officer report

99. In the man's case this would have amounted to over 20 statements. Despite requests, my investigators did not receive any staff statements until they visited the prison on 3 September when they were given three. After this they were given a further four statements during the course of the investigation.

100. The lack of statements caused difficulties for a number of reasons. Perhaps most importantly, those people who were interviewed were required to describe their involvement with the man in more detail. This could have led to unnecessary additional distress to staff who were the first find him and try to revive him. Officer C expressed his concern that it had been so long before he had been able to go through what happened on 23 July. It might also have led to a less accurate account of events being given to my investigation team as the time passed affected staff's recollections.

101. I acknowledge that it might be difficult for staff to recount their version of events so soon after going through something so upsetting. However, there is a requirement for statements to be made. I hope that systems will be put in place for staff statements to be written promptly in the future.

**The Governor should work with the safer custody manager to ensure prompt statements are taken following a death in custody, in line with the requirements of PSO 2710.**

## CONCLUSION

102. At the age of 62 the man was remanded into custody for the attempted murder of a close family member. Research has shown that this charge, along with the fact that this was his first time in prison, made him more susceptible to the risk of suicide or self-harm. He apparently committed suicide 25 hours later.

103. During his brief time in custody, the man was interviewed by a doctor, mental health nurse, chaplain and prison officers. No-one thought he was a risk to himself and an ACCT was not opened. Having spoken to staff, I am satisfied that their assessments were reasonable and am not critical of the decisions they made. It seems that he took the first opportunity he had to take his life and was determined both in his attempt and to ensure staff were not aware of his intentions to do so.

## RECOMMENDATIONS

All recommendations were accepted. The proposed action is written in italics following each recommendation.

1. The Governor should consider a system whereby information which is known to be a risk factor in self harm or suicide is shared fully amongst all those who come into contact with the prisoner.

   *Cardiff prison to comply with National Policy for Safer Custody issues. (PSO 2700 Suicide and Self Harm Prevention). This details effective information sharing protocols.*

2. The Head of Healthcare should ensure a clear record is kept of any medicine which has been administered, intentionally withheld or refused. If the medication is not given the reason for not doing so must be recorded.

   *Notice to staff to be issued reminding them that all medication must be recorded and if omitted or refused this is document.*

3. The Head of Healthcare should ensure detailed medical records are kept in relation to a prisoner's death in line with the NMC guidance.

   *The clinical record to be made available to medical staff to enable them to record clinical entries. Medical staff involved in death in custody to record in clinical record.*

4. The Governor should work with the safer custody manager to ensure prompt statements are taken following a death in custody, in line with the requirements of PSO 2710.

   *Cardiff prison to comply with PSO 2710 ensuring that statements are taken promptly from identified grades in conjunction with police statements.*