Investigation into the circumstances surrounding the death of a man at HMP Cardiff in September 2010

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

This is the report of an investigation into the circumstances surrounding the death of a man, a prisoner at HMP Cardiff. He died in September 2010, aged 33 years old.

I would like to offer my sincere condolences to the man's family for their loss. I would also like to apologise for the delay to this report.

The investigation was carried out by my colleague. I would like to thank the Governor of Cardiff and his staff for their co-operation during the course of the enquiries.

The man died in the custody of the police while serving a sentence at HMP Cardiff. He had been taken to the local police station to be interviewed but was subsequently seen acting erratically and drinking numerous cups of water. He collapsed suddenly and, although taken to hospital, died with his family at his bedside. The coroner recorded the cause of his death as brain swelling and hypoxic-ischaemic brain injury (a permanent brain injury resulting from a lack of oxygen or inadequate blood flow to the brain).

In many ways, this is troubling case. The man was clearly not a well man but he did not receive the care and attention which might have more quickly and effectively identified and responded to his problems. In the end, neither his psychological nor his physical issues were adequately addressed. As a result, a number of recommendations are made to ensure that lessons are learned.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2012**

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SUMMARY

1. The man was born in 1976. On 28 January 2010 he was sentenced to one year and nine months imprisonment for breaching a restraining order against his ex-girlfriend. He had served a number of sentences at HMP Cardiff for the same offence in 2009 and 2010.

2. During his initial reception health screen, he said he suffered from panic attacks, was withdrawing from alcohol and occasionally took drugs. He was referred to the doctor and the drugs treatment service, although he signed a disclaimer three days later stating that he wanted to withdraw from the service. No effort was made to obtain his medical history during this time. He also complained of crushing headaches a number of times while in prison. No medical review was undertaken to rule out a physical cause for his complaints, as healthcare staff linked these to a mental rather than a physical cause.

3. Staff found it hard to locate the man in a shared cell as he appeared preoccupied with his ex-girlfriend and his cell mates found his excessive talking and thoughts of her exhausting. He was located in a single cell and also spent some time in the Segregation Unit for displaying inappropriate behaviour and intimidating female staff. He displayed behaviour that wing officers described as “odd”. They found it hard to distract him from thoughts of his ex-girlfriend and struggled to engage him in conversation other than if it was related to her. He was referred to the counselling service and assessed by the mental health team and a psychiatrist. He was said to have poor coping skills and that he was struggling with the breakdown of his relationship. He also spent a short period of time being supported by self harm monitoring procedures, as he said he was severely depressed having spoken about his index offence.

4. The man was arrested while in the custody of Cardiff for sending a letter to his ex-girlfriend’s sister, which was a breach of the restraining order. He was taken into police custody on 22 September to be questioned and formally charged. He was assessed by a healthcare professional who assessed him as fit for detention and interview. He was placed in a cell monitored by CCTV and visited every thirty minutes.

5. Police records indicate that during the time the man was in the cell he behaved erratically and drank many cups of water from the water fountain in a short space of time. At 2.36pm he was seen on the CCTV monitor to be having a fit. Police staff responded immediately, put him into the recovery position and called an ambulance. The paramedics arrived and took him to hospital at approximately 3.05pm. His condition deteriorated and he was pronounced dead the next morning with his family at his bedside.

6. Eight recommendations are made in this report regarding medical treatment, mental health issues, communication and record keeping.

THE INVESTIGATION PROCESS

7. The investigator opened the investigation at HMP Cardiff on 6 October 2010. She met with senior prison managers and requested copies of prison documentation relating to the man.

8. Notices of the investigation were issued to staff and prisoners, inviting those who wished to provide information regarding the man's death to make themselves known to the investigator. No-one came forward with regard to the notices. The investigator visited the prison on 10 and 11 November 2010 to interview staff.

9. The investigator wrote to the Chief Executive of Healthcare Inspectorate Wales (HIW) to commission a clinical review. HIW asked a clinical reviewer to carry out a review of the care received by the man whilst at HMP Cardiff. She received a copy of the relevant medical documents upon which she based her findings. The review was received on 21 November 2011. The clinical review was delayed, in part, because of difficulty obtaining police documentation regarding the man's time in police custody and also because the review was revisited by HIW once the draft had been submitted. The report also seeks to address the issues raised by the family, which are outlined below.

10. The investigator contacted Her Majesty's Coroner for Cardiff & Vale of Glamorgan District to inform her of the nature and scope of the investigation. The inquest was held in January 2011, although the family requested that it be postponed.

11. South Wales Police conducted an investigation into the circumstances surrounding the man's death. A Detective Inspector conducted the investigation, the findings of which are restricted and therefore can not be repeated in detail here, but the investigator and the clinical reviewer both had sight of the full documentation. Events which occurred whilst the man was in police custody are outside of this office's remit, and therefore did not form part of this investigation, but are referred to in the clinical review.

12. The investigator provided feedback to a governor at Cardiff during the investigation highlighting preliminary findings and any issues that had become apparent. She also wrote to the Governor on 3 March and wrote to him again on 20 April 2011 to update him regarding the delay in issuing this report.

13. One of the office's family liaison officers contacted the man's family at the beginning of the investigation. She informed them of the investigation and offered them the opportunity to raise any questions or concerns they would like addressed during the investigation. Another family liaison officer took over the role and visited the family with the investigator on 18 January 2011. The family raised the following issues which are addressed in the report and it is hoped that this helps them better understand the events leading to his untimely death:

Healthcare

- Why were assumptions made that the man's headaches were a mental rather than a physical problem?
- Why was the noticeable decline in his weight not picked up by prison or healthcare staff?
- Did he see a doctor about his asthma?

Psychiatric Assessment

- Could more have been done by the prison to assess the man's mental health?
- Could an underlying physical illness been causing or exacerbating his behaviour?

Segregation

- Why did the man spend time in the segregation unit?
- Should he have received a warning before being moved to the segregation unit?
- Why was he located in a single cell?

Additional stress/causes of anxiety

- Could other factors, such as the man's proposed release to a hostel, reduced canteen money, possible bullying and his removal from education, have contributed to his anxiety?

Escapee Marker

- Why did the man have an escapee marker on his prison records given he had never attempted to escape from custody.

Escorting Officers

- Was the presence of prison officers in hospital appropriate given the man's deteriorating condition?

Family Liaison

- Why did the prison not respond to the man's mother following her efforts to alert prison staff to the concerns she had about her son's mental health?
- Why was there initial confusion about whether the prison would contribute towards funeral costs?

Issues outside the remit of the PPO investigation

14. The family also raised a number of issues relating to the period the man was in police custody prior to his collapse. These included:

- Why was he deemed fit for interview given his obviously agitated state?
- Why was there a delay of over six hours before they were notified that he had been taken to hospital?
- Why was he allowed to drink so much water in the police cell?
- Why were staff not more concerned by his behaviour?

- Why was he not allowed to make a phone call while in police custody?
- Did he suffer a seizure in the ambulance during his transfer to hospital?

15. It was explained to the man's family that these matters fell outside of the Ombudsman's remit. The Independent Police Complaints Commission (IPCC) referred this case for local investigation by the Professional Standards Department (South Wales Police) the finding of which formed part of this investigation.

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HMP CARDIFF

16. Cardiff has a maximum population of 784 adult men. It is located close to the city centre and was originally built in 1827. As a local prison, the majority of the prisoners arrive at Cardiff after making court appearances in South East Wales. As well as prisoners remanded into custody and those serving short sentences, a significant number are serving life sentences.

Mail

17. Mail is posted on the day it is sent, and prisoners receive their mail on the day it arrives into the establishment. There are arrangements in place to monitor the mail for prisoners subject to public protection measures.

Self harm monitoring

18. Prisons work to reduce the risk of self-harm and suicide through a whole-prison approach. Assessment, Care in Custody and Teamwork (ACCT) is a care planning tool used by the Prison Service to help monitor and support prisoners identified as being at risk of self harm or suicide. Any member of staff can open the ACCT procedures by filling in certain documents detailing their concerns and the process encourages staff to work together to tailor individual care to prisoners in distress. Regular checks and reviews of the prisoner's situation are built in to the process with the ultimate aim of diffusing circumstances where suicide or self harm can take place.

Listeners

19. Listeners are prisoners trained by the Samaritans to offer confidential and emotional support to other prisoners. Listeners can be called on by other prisoners needing someone to talk to at any time during the day or night. There is also a free Samaritans helpline that prisoners are able to use.

Independent Monitoring Board (IMB)

20. Each prison in England and Wales has an Independent Monitoring Board (IMB) responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The most recent Annual Report by the Cardiff IMB is for the period 2009-2010. The executive summary noted:

> "The Board has recognised, and is concerned about an increase in the number of complaints made to the board relating to healthcare, and treatments. This has been discussed at Board level and the Senior Management team of HMP Cardiff have undertaken a review of healthcare provision at the Prison."

21. There have been twenty deaths at Cardiff since the Ombudsman's office took over investigations from the Prison Service in 2004, nine of which were due to natural causes. There are similarities in relation to this investigation and

other deaths at Cardiff. Also, two recommendations made in other, recent, reports are repeated here. These concern secondary health screening and record keeping.

Her Majesty's Chief Inspector of Prisons (HMCIP)

22. Her Majesty's Chief Inspector of Prisons undertook an unannounced follow up inspection of Cardiff in June 2010. The report showed that:

> "This is a generally positive report which demonstrates that Cardiff has sustained much of the progress that we identified on our last visit, although we identify a number of areas for further improvement."

23. The report noted within the introduction that "there was still too little care planning for those who struggled to cope and other vulnerable prisoners. Moreover, overcrowding had led to some vulnerable prisoners being housed in the segregation unit and therefore receiving a minimal regime".

Healthcare

24. The prison has 24 hour nursing cover and 16 inpatient beds. During weekdays the core healthcare staff work until 5.00pm. Four nurses continue to work between 5.00pm and 8.00pm. Two nurses work between 8.00pm and 9.00pm and one nurse remains in the healthcare centre with a member of the prison staff through the night from 9.00pm onwards. That nurse will respond to emergencies and can contact the healthcare manager out of hours if need be. Using an out of hour's telephone service, the nurse on night duty can obtain medical advice, ask a doctor from a local surgery to attend or summon an ambulance if they have serious concerns about a patient. HMCIP said the new health care centre was:

> "A much improved environment but was underused, with GP and opticians' clinics held on the wings owing to a shortage of staff to escort prisoners to the centre… Primary mental health provision was fragile, with no designated staffing. The mental health in-reach team provided a good service to the small number of prisoners on their caseload. There was inadequate counselling provision. "

Offending behaviour programmes

25. Cardiff offers a range of offending behaviour programmes, which are appropriately prioritised based on risk and sentence length. The report showed that "The establishment was piloting the control of violence for angry impulsive drinkers (COVAID) programme, which had been identified as a gap in provision. The chaplaincy provided the restorative justice programme. The waiting lists for offender behaviour courses were manageable."

KEY EVENTS

26. The man was remanded into HMP Cardiff on 8 May 2009 charged with breaching a restraining order on his ex-girlfriend. He received a sentence of 120 days imprisonment. During his first reception health screen, he told staff that he suffered from panic attacks. He said he was prescribed medication for his asthma, diazepam (a drug used to treat anxiety disorders), citalopram (used for depression or panic attacks) and diclofenac (a non-steroidal anti-inflammatory drug). He said that he was suffering from alcohol withdrawal and had seen a psychiatrist for this in the community. He was referred to the doctor and to the drug treatment service. His medical history and clarification of his prescribed medication was not obtained from his community doctor. He did not have a secondary health screen which should have been carried out within three days of his arrival at Cardiff. The purpose of a secondary health screen is to discuss in further detail any issues or problems a prisoner may have and identify appropriate help which may not have been raised during the reception process.

27. Later that day he was seen by the detoxification team. He was said to be showing signs of withdrawal and was very low in mood. He told them he had been prescribed citalopram two weeks ago by his doctor, but was not suffering from thoughts of harming himself. He was admitted to the detoxification wing to receive the appropriate medication and support. However, he signed a disclaimer three days later to say he no longer wanted to engage in the detoxification process and was moved to a cell in normal location.

28. On 11 May, a harassment risk assessment, mail and telephone call monitoring form was completed. Harassment procedures mean that the Governor has a responsibility to ensure the order of the court is upheld and, in this case, the court order that the man was not to have any form of contact with his ex-partner. This order remained active until 11 February 2011.

29. Wing officers requested healthcare staff to attend the wing on 16 June. A Healthcare Senior Officer (HCSO) went to the man's cell as he was in a distressed state following the break-up of his relationship. He told the HCSO that things kept going around and around in his head and that he found it difficult to sleep, but was having no thoughts of harming himself. The HCSO noted in the man's medical record that he maintained good eye contact while talking and prescribed a mild sleeping tablet.

30. The man was released from custody on 6 July. However, within a matter of weeks he breached the conditions of the restraining order and was remanded back into Cardiff on 31 July. He received a sentence of 7 months and 29 days.

31. The man was assessed by a member of healthcare staff at the request of wing staff on 10 August. It was recorded in his medical record that staff found it hard to locate him in a shared cell as he was so preoccupied with his ex-girlfriend. Cell mates found his constant talking about her exhausting. It

was hard to distract him from talking about her and engage him in a conversation of any other subject. A doctor prescribed three nights worth of sleeping tablets and he was put on the GP list the next day for a discussion about anti-depressant medication. There is no entry in his medical records to determine whether this appointment took place.

32. A pre-sentence report was written by a probation officer on 26 August. The report noted a " worrying pattern of offending developing, which was directly linked to his obsessive thoughts towards his ex-partner". The man had admitted that he was a socially isolated person and understood that alcohol abuse was a contributing factor in his offending and that he needed help for it. The probation officer wrote that he was more in control of himself when sober, however he would still obsess about his ex-girlfriend and did not seem to be able to control himself.

33. The man's family gave further examples of his behaviour and feared he had suffered a nervous breakdown when he split from his partner. They confirmed that he would talk about his ex-partner constantly and could not hold a conversation without shifting the focus back on to his relationship. They also said that he was constantly in an agitated state and would frequently break down and cry. He would find it hard to sit still and would pace around.

34. The man was released from Cardiff on 27 November. However, he breached the conditions of the restraining order once more and was arrested on 12 December. While in police custody, he was examined by a healthcare professional. It was recorded on his police medical form that he refused to sit down, was very wound up and angry about the situation. He was deemed fit for interview, charge and detention with a standard risk of self harm.

35. On 14 December, he was remanded to Cardiff and a court date was scheduled for January 2010. During his first reception health screen he told the healthcare staff that he was receiving medication for his asthma, diazepam and amitriptyline (an antidepressant). The member of healthcare ticked "no" to the question of receiving mental health medication and ticked "yes" to alcohol and drug abuse but did not elaborate as to the extent of how much he used. He was referred to attend the asthma clinic but not to see a doctor and was not referred to any drug or alcohol treatment services. His medical history and prescribed medication was not clarified with his community doctor. A secondary health screen was not undertaken.

36. The man was prescribed a salbutamol inhaler to treat his asthma which he was permitted to keep in his possession to use when he needed. It was noted that he had a history of overusing the prescribed inhaler, but that he requested a new inhaler when necessary. It was also noted that he had not complained of feeling unwell or of any difficulties relating to his asthmatic condition. There is no record of him complaining of any chest problems while at Cardiff prison.

37. A cell sharing risk assessment (CSRA) was carried out on 14 December to assess the risk of the man assaulting a cell mate. It was noted that he wanted to share a cell with another prisoner who was clean and tidy. The officer who completed the assessment said there were no issues regarding the possibility of assault or violence and he appeared "level headed". On this occasion, he was allocated a shared cell.

38. The man received an induction talk from an officer on 15 December. During the induction process, he told the officer that he would like to see a Counselling, Assessment, Referral, Advice and Throughcare (CARATs) worker (CARATS is a team at the prison helping prisoners with drug and alcohol withdrawal.) However, there is no evidence in any of the prison documentation to suggest that a referral was made or that he saw a member of the CARATs team.

39. An entry was made in his medical record on 15 January 2010 that a member of healthcare had been asked to attend the wing as he had been acting strangely. He had been seen on all fours in his cell picking up bits of dust off the floor. His cell mate was said to feel uncomfortable sharing with him, although it was noted that he had no psychiatric history. There is no documentation in the prison (medical) records to suggest that any action, including a mental health referral, was made.

40. On 28 January, the man attended court and was sentenced to one year and nine months imprisonment. When he returned to Cardiff later that day he was referred to the counselling service to receive support for his poor coping and the breakdown of his relationship with his ex-girlfriend. He said that he wanted to go to sleep and never wake up, but when asked he said that he was not suicidal. It was noted that he displayed low mood and low self-esteem. The counselling service was being restructured at the time, however he was on the waiting list for when it was operational again.

41. A review of the man's mail and telephone monitoring was held on 18 February, a week later than scheduled. He was still not to contact his ex-girlfriend until further notice.

42. His sentence planning meeting was held on 4 March. Targets were set for him to take part in offence related workshops but concerns were raised for his mental health. Contact was made with the mental health in-reach team for an assessment and to ascertain any concerns. A later report suggested that he had made little effort to engage in any offence related work.

43. On 9 March, the man had an appointment with a registered mental nurse. It was decided that he was to receive counselling once it became available in the near future. (There was no counselling available for prisoners before and up until he died.)

44. A Registered Mental Nurse (RMN) undertook a mental health assessment of the man on 11 March. She recorded in his medical record that he was still consumed by thoughts of his ex-girlfriend. He agreed to counselling to

address his anger issues and his inability to come to terms with the separation. She also noted that counselling would become available in the near future, although it does not seem that anything was done in the meantime. He was not prescribed any medication at this point and he said that tablets would not help him and would not take away recent events.

45. On 28 March, the man was taken to the segregation unit as he had been displaying sexual and inappropriate behaviour in the presence of female staff (simulating sex and urinating in front of them). Prisoners can be re-located in the segregation unit without any prior warnings about their behaviour. An officer recorded in his segregation documents that, at times, he displayed intimidating behaviour towards staff and would make late requests and demands for showers and exercise. It was noted that, if he did not conform to the segregation regime, he would spend a long time there. There is a note to suggest that healthcare thought he was a poor coper, but had no mental health issues. He was moved out of the segregation unit and back to normal location on 12 April.

46. The man was moved onto A1 wing which mainly consists of single cells. It was decided that he should be allocated a single cell, due to his reluctance and inability to share a cell. He was offered the opportunity to exercise and apply for work if he wanted to. He did not apply for a job and rarely exercised. Sometimes prisoners are allocated there because their behaviour warrants it, for example, if their behaviour is not deemed suitable for a normal wing. At some point during his time on A1 wing (it is not clear when) he was awarded standard status, so he was permitted to have a television in his cell. His behaviour on A1 wing was described as ‘strange’ and it was unusual for staff to see him leave his cell and venture onto the landing. It appears that he preferred to keep himself to himself.

47. An officer was interviewed by the investigator. He said during interview that, if a prisoner did not want to engage in life on the wing or with other prisoners, there was very little that could be done. The man was offered the opportunity to exercise, clean his cell (which the officer described as being in an awful mess) and shower, but he normally declined. The officer also said that he could be noisy, and other prisoners would ask him to stop singing. On other occasions he would be heard shouting and screaming to himself.

48. The man’s application for home detention curfew (where a prisoner is released from prison but has certain restrictions placed on their movements) was declined on 21 April. The reasons given were that he breached his restraining order on four occasions and this was an indication that there was a high probability of early re-offending and a high likelihood of failing to abide by his curfew. It was noted in prison records that he had, however, successfully completed a home detention curfew for a previous offence.

49. The Governor’s secretary sent an email to the designated family liaison officer for the prison on 5 May. She explained to him that the man’s mother had called and expressed concern for his welfare. She had said that she thought he was having a nervous breakdown, as he was crying all the time

and had lost a lot of weight. She asked him if he could check if everything was OK. He noted on a printout of the email in the man's file that he had seen him and he said he had no thoughts of harming himself, but that he would refer him to a mental health nurse. There is no information in the prison records or medical record about whether any further action was taken. (The only related entry is a verbatim statement written during a psychiatric review on 7 September 2010, when he was asked how his appetite was and he confirmed that it was good but he was always "starving" as "they don't feed you much in here".)

50. The man sent a letter to his mother dated 13 May (a copy was passed to the investigator by his mother after his death). He wrote that he felt his head was "shot" and that he felt so down all the time. He wrote that he didn't want to feel down but he just couldn't help it. He then sent another letter ten days later again saying how bad his head was feeling. He said "it felt like it was locked in a vice with a dagger going through the middle" and again about how down he was feeling regarding his situation and the break-up of his relationship with his ex-girlfriend. It is recorded that his mother spoke and wrote to staff at the prison on several occasions, but it is unclear what, if any, action was taken.

51. The man complained of headaches a number of times whilst in prison. From the evidence it appears that he was referred to and seen by healthcare in a timely manner. However, these were in the main mental health professionals rather than a general doctor or nurse. Therefore, the healthcare staff who saw him treated his symptoms as having a mental, rather than a physical cause.

52. The RMN was asked to go to the wing on 27 May to see the man. She recorded in his medical record that he was going "nuts" saying that he could not take any more and had a crushing sensation in his head. She told the investigator during interview that she interpreted the crushing sensation to be his inability to come to terms with his offence rather than a physical pain. She noted that he would sit in his cell all day dwelling on his relationship break-up and advised him that partaking in some sort of activity during the day, such as visiting the gym or education, might help take his mind off things. He said that he thought he would benefit from some medication to calm him down or help him sleep. A GP appointment was made for the following day and he saw a doctor on 28 May. The doctor (whose name is illegible) noted that he had split with his girlfriend 18 months previously and could not get over it. It was noted that he had poor coping skills and the doctor advised him to move on. The note suggests counselling and a prescription for citalapram 20mg (an anti-depressant.) However, there is no entry on the prescription chart to suggest that he was given this medication.

53. There is no evidence of pain relief being offered to the man while in prison, despite his complaints of headaches. Also, following the prescription of citalopram 20mg daily, there is no documentation to show that he complied with this medication or it being administered on a regular basis. It is also unclear whether he was being monitored for the effects of this anti-

depressant or whether the prescription was ever reviewed. However there is evidence that he declined a review of his prescribed medication whilst in prison.

54. The next day a member of healthcare (again the signature is illegible) was called back onto the wing as the man was shouting and banging his cell door. (It seems that he was now in a cell on his own, but it is not clear exactly when this took place.) He told staff that his head was "going" and paced the cell and appeared fidgety. He seemed fixated with the breakdown of his relationship with his ex-girlfriend and requested medication to "chill" him out or to help him sleep. The member of healthcare present at his cell told him that he was unable to give any medication at that time, and he was not happy with this. He stared at the member of staff and swore. He was advised that he needed to give the anti-depressants a chance to work (although it is unclear from the records passed to the investigator whether he received the citalapram.) A note was made in his medical record that the member of healthcare would discuss this incident with a community psychiatric nurse (CPN) as he was requesting extra support. There is no note of this referral in any of his prison records. (The next entry in his medical records in 26 July, when a cell sharing risk assessment review was carried out.)

55. On 31 May, an entry was made in the man's security file with reference to the incident on 29 May. It said that staff had reason to believe that he was planning to assault staff, given the things he had said to them.

56. The man's mother sent a letter dated 19 July to the Governor's secretary. She outlined her concerns for her son's welfare and said that he had asked for help, but was not getting any. There is no note of any response from the prison.

57. A categorisation review was held on 20 July. This is held to determine whether his category status could be changed. In the review paperwork it was noted that the man intimidated staff, was a risk to females and had possible plans to assault staff. It was not recommended that his categorisation be changed. He was referred to the chaplaincy in an attempt to see whether it was helpful to discuss his problems with a member of their team (although there is no evidence of a meeting between them) and was to be assessed by a psychiatric nurse. There was nothing further of significance in his record until August.

58. A self harm monitoring document, referred to as Assessment, Care in Custody and Treatment (ACCT) was opened on the morning of 24 August. A forensic psychologist in training opened the document as the man became distressed when discussing his offence. He started crying in a psychology meeting about his upcoming release in October and had said that he could not live without his ex-girlfriend and wished that he could end his life. He said he held a razor blade to his wrist every night but could not end his life due to the distress it would cause his parents. He said he felt no different than any

other day, it was just that discussing his offence had upset him. He described himself as severely depressed.

59. The man was given information on the Listener scheme and the Samaritans helpline, and was also referred to the mental health team. He was placed on half hourly observations. It was noted that he was a quiet individual who spent a lot of time in bed.

60. The ACCT document was closed at 4.00pm the same day (as he said he had no thoughts of harming himself) although he was monitored daily over the next week before his post-closure review. He declined to attend a mental health review as he said he would prefer to stay in bed and mentioned that he had been put on anti-depressants, but had stopped taking them as they could not help with how he felt. (A post closure review was to be held on 31 August, but there is no evidence of this taking place until 2 September.)

61. On 25 August, an entry was made in the man's security file that the psychologist and a colleague thought that he had an unhealthy obsession with his ex-girlfriend.

62. An entry in his medical record, dated 26 August, said that he had no thoughts of harming himself, but appeared obsessed with his ex-girlfriend. (The signature is illegible.) He told this member of staff that he was to be released two months later and did not think he would be able to stay away from her. The member of staff said that he had been referred for an assessment by a community psychiatric nurse.

63. The man had an assessment with a RMN on 29 August. She noted in his medical record that he had good eye contact and coherent speech throughout the interview. She said he was socially isolating himself and appeared very tired, and that he did not attend exercise or education. He started to talk about his ex-girlfriend and said that he was seeing her face and hearing her voice. She recorded that there was no evidence of this actually happening, he was not distracted and was able to concentrate fully on their conversation. A referral was made for him to see the doctor for an urgent assessment, however he stated that he did not want to go on any sort of medication and was managing well without it. This is at odds with the earlier doctor's entry which said he was prescribed citalapram.

64. It was recorded in the man's security file on 1 September that while monitoring his telephone calls he had been heard telling his mother that he had sent his ex-girlfriend's sister a letter. As it breached his restraining order, his mother asked him how he managed to send the letter as it should have been stopped. He said that he had given it to someone to post "out there". It is not known if he had given it to a recently released prisoner or a member of staff.

65. He also wrote a letter to his mother dated for that day. He said that he needed help getting through what was going on and that he could not get his head around it. He said he had gone "loopy". He said that the night of his

offence kept replaying in his head and that loneliness was a killer as he had no-one to talk to and no-one visited him.

66. A cell sharing risk review was held on 6 September (the signature of the officer appears to be Thomas, although it is not clear). It was noted that he spent most of his time in bed, was unhygienic, did not mix with others and was inappropriate towards females. It showed that he was on an ACCT document in August when he stated that he was severely depressed. He was recorded as a medium risk of harming another prisoner and that he had said that he did not want to share a cell. He also said that his sentence was not long enough to engage in any courses. It was decided that he was to be referred to the mental health in-reach team and that he would be reviewed again in two months time.

67. An entry was made in the man's security file on 7 September that he had contacted his ex-girlfriend's sister by mail and that she was on his list of people that he was not permitted to contact.

68. He had an assessment with a consultant psychiatrist the same day. The psychiatrist noted in his medical record that the man had seen someone in June 2009, who thought he was not mentally ill. He also wrote that, in August 2009, it was noted that he may have been depressed and in August 2010 he had been referred for counselling for anger management. He was then seen by another person who noted his previous alcohol problems but said there was no evidence of illness. He told the psychiatrist that his main priority was "to get out, see my mother and rebuild my life". The psychiatrist thought he remained very much preoccupied with the break-up of his relationship, but had no clear psychotic symptoms or obsessive concepts or thoughts. He said he had no thoughts of self harm, although he did get upset when talking about his previous relationship. The psychiatrist recorded that there was no clear evidence of mental illness, he was not obsessive in nature, there was no evidence of pathological jealousy, but he did remain angry. He did not have any insight into his alcohol problems and although he was aware that they made things worse, he was not willing to look at this.

69. On 12 September, the man wrote a letter to his mother. On the letter he had written "scared" and "really frightened" all over it. He talked about having been in custody for two years for making a one minute telephone call, that he had no options, his life was a mess and that his head was eroding all the time. He wrote at the end of the letter, "life's a horror book sometimes/closing it". As his outgoing mail was not being routinely monitored, this would not have been picked up by prison staff.

70. The man was arrested at Cardiff prison on the morning of 22 September for sending a letter to his ex-girlfriend's sister. He was not told about this beforehand to try to limit his agitation. When the conditions of his arrest were outlined to him, he replied "I know what this is about, all I said was I'm sorry and I did not want to hurt her anymore. I haven't got a restraining order against her sister." It was noted in his custody record that he had made a

further comment to the effect of the judge in court had told him that if he committed further breaches he would be dealt with at a mental hospital.

71. Custody Detention Officer (CDO) A made an entry in his custody record that, when he arrived at the police station, he appeared distressed and told police officers that he was an alcoholic but had not drunk alcohol in two years. He said that he was suffering from depression but was not currently seeing a doctor for it. It was noted that he was a risk to females and assessed as medium risk of self harm. He was placed in a CCTV monitored cell and was to be visited every thirty minutes. A healthcare professional was requested to come and see him to assess his fitness for interview and detention. He kept asking to make a telephone call to his mother to inform her that he was in trouble again. He was told by police staff that once he was booked in, enquiries would be made to see if this could be facilitated.

72. An officer at Cardiff informed the CDO that the man was not to be permitted a telephone call as there was no-one present in the establishment to check his barred numbers as they were all out on escorts. He was informed of this information and was seen pacing his cell and appeared very agitated. The custody record reveals that he was given a hot drink at 10.12am and 10.21am.

73. At 10.45am, the custody record shows that the man was in the medical cell with a nurse and another CDO. The nurse deemed him fit for detention and interview and wrote that an appropriate adult would not be required to attend with him. (An appropriate adult is required to be present during the course of the police interview and key stages of investigations conducted in the police station if a person is under the age of 17 or considered to be a vulnerable adult. The aim of the appropriate adult is to safeguard the rights and welfare of young people and vulnerable adults in police custody.) Another hot drink was recorded to have been given to him at 10.48am.

74. CDO A made an entry an hour later that he had been issued with a meal and a drink. At 11.52am, he had a private interview with his solicitor.

75. At 1.24pm that afternoon, the CDO made another entry in his custody record that the man had been issued with another hot drink, but that he had thrown it all over the cell floor. He was observed pacing the cell and shouting. He was in possession of a polystyrene cup with which he could help himself to water from the water fountain. The CDO wrote that he paced around, had a drink, paced around, had a drink as well as shouted random sentences and banged on the cell door. He was observed on a television screen by police staff.

76. The man was interviewed at 1.54pm. He admitted to sending the letter, but said that he did not intend to cause any distress, he just wanted to apologise for his past behaviour. He said that it was in no way intended to reach his ex-girlfriend as he had a restraining order not to contact her.

77. Just under an hour later, CDO B spoke to two Police Sergeants (PS) in the CCTV observation room. The CDO's attention was drawn to the monitor by

one PS as the man was lying on the floor by the cell toilet and he appeared to be having a fit. They went to his cell and he was lying on his back with blood coming from his mouth. An ambulance was called and they put him on his side. The nurse entered the cell. She told them to put him in the recovery position. However as his body was rigid due to him fitting, they were only able to keep him on his side.

78. The man sustained a cut to the back of his head and there was a small amount of blood on the floor. The nurse placed a towel on the wound to try and stop the bleeding. He had come round from the fit and was trying to get up. It was approximately 2.45pm and he was assisted in sitting up. He began to projectile vomit clear fluid, however he remained conscious and was able to talk to the nurse.

79. CDO A telephoned Cardiff to see if the man had any known medical issues. A nurse checked his file and rang the CDO back twenty minutes later. He said that he had been seen by a psychiatrist on a number of occasions and was last seen in healthcare on 28 May when he was prescribed citalopram, but had not been prescribed it since. The nurse described him as a poor coper.

80. (Close circuit television from the man's cell was subsequently viewed by the police, his family and the investigator. It showed that he drank numerous cups of water from a water cooler located in the cell, in a short period of time.)

81. The ambulance arrived at approximately 2.52pm and paramedics entered the cell. They prepared the man for transfer to hospital and put him in a wheelchair. They recorded his Glasgow coma as 15 which is the highest response rate. (The Glasgow Coma Scale (GCS) is a universally comparable way of recording the conscious state of a person. The GCS is a score between three and 15, three being the worst and 15 the best). Police escorting officers placed him in handcuffs and he was taken to the ambulance to be taken to hospital. It was noted by the paramedics that he suffered another fit while on the way to hospital in the ambulance. (The clinical review attempts to clarify this further. It notes that there is a discrepancy between hospital records and police records about whether he suffered another fit in the ambulance. Hospital records indicate that he did suffer a seizure, whilst police statements from the officers who accompanied him in the ambulance do not mention this. However, their accounts do say that he had another seizure about ten minutes after arriving at the hospital.)

82. At 3.05pm, it was recorded that the man had another fit while in hospital. Hospital staff moved him into the resuscitation bay and the police escorting officers then removed his handcuffs. The police officers assisted the hospital staff hold down him as he was so rigid they were unable to get a line into his arm to administer medication. Once they were able to get the medication in, his whole body relaxed and he was moved to another part of the resuscitation area for further medical assistance.

83. Prison officers took over escort duties at 6.15pm. His bedwatch log shows that he was taken for a computed tomography (CT) scan at 7.00pm and the results of the scan showed his prognosis as poor as his brain was swollen. He was moved to the Intensive Care Unit (ICU) at 8.30pm. Escort officers were not allowed on the unit and were not in sight of him.

84. The police notified the man's family that he had been taken to hospital, as he had been in their custody when he collapsed. The family complained that it took approximately six hours to be informed. This falls outside of this office's remit, but I raise it for the attention of the police and will forward them a copy of this report.

85. An officer made an entry in the bedwatch log at 9.05pm that they had been made aware by hospital staff that the man would not regain consciousness, that his pupils were fixed and dilated and the opinion was that he was brain dead.

86. At approximately midnight, further procedures were carried out to try and relieve some of the pressure on the man's brain. Shortly afterwards, his family approached the escort officers and asked for details of what had happened while he was in police custody. The officer wrote in the bedwatch log that he had explained as much as possible, given that he had not been present at the time of the incident.

87. At 1.20am, the hospital doctor said that the man had been coughing and this could be an indication that he was not brain dead, but would still have been severely brain damaged.

88. A nurse from Cardiff telephoned the ICU 1.30pm that afternoon. She spoke with a nurse and asked if compassionate release was appropriate given the man's condition. She wrote in his medical record that the nurse had told her she did not think it was, but would check with the consultant. As she had not heard anything by 4.30pm, she telephoned and enquired again. She also left an email address as another means of communication.

89. Hospital staff had not given a response to the nurse's question of compassionate release by the next morning and so she telephoned again. She spoke with a nurse who informed her that the man was in a very serious condition. The nurse requested that written confirmation of his condition be provided to Cardiff so that compassionate release or release on temporary licence (ROTL) could be considered. The consultant in ICU sent an email for the attention of the Governor and the nurse at 1.36pm that afternoon. He confirmed that the man's condition was life threatening and that he was not expected to survive.

90. An entry was made in the bedwatch log at 3.40pm that the consultant had asked the officer why he had not been withdrawn from bedwatch duties as he had sent an email to Cardiff explaining the gravity of the man's condition. There is no further reference to this in the prison records, but he remained the responsibility and in the custody of Cardiff prison and it would have

breached that responsibility to withdraw staff from the hospital. (However, staff who were on bedwatch duty said they remained a discreet distance from him, who was in the High Dependency Unit).

91. Another officer took over as escort officer on the morning of 25 September. He made an entry at 7.45am that he had been briefed at the start of his shift that the man's family wanted privacy and so he made an effort to distance himself as much as he could. At 3.00pm, hospital nursing staff told the officer that they would be reviewing his condition in 24 hours time.

92. The man's condition deteriorated in the early hours of the morning. His family were informed and made their way to the hospital. He was pronounced dead by hospital staff at 6.00am. His family were at his bedside.

Liaison with the man's family

93. On 28 September, the Governor sent the man's family a condolence letter. Two days later the appointed prison's family liaison officer (FLO) collected the man's clothes from reception and arranged for a cheque to be made to the man's mother for the money left in his prison account (£87.95).

94. He rang the man's mother on 1 October. She spoke of her concern about the lack of clinical care her son received whilst in prison. It was confirmed that the funeral would be held on 12 October and she said she would let him know if the family wanted the prison to be represented at the funeral.

95. The man's mother rang the FLO on 4 October. She wanted to know whether her son would have had any prior notice of the police production (to be taken to the police station for interview). He said he would find out. (He discovered that prisoners are not informed of external moves until the morning they are due to attend. However, it may be that sometimes solicitors give their clients prior notice.) She also confirmed that it was her family's preference not to have a representative from the prison at the funeral.

96. After meeting with the investigator on 6 October, the FLO said he would contact the family to offer financial assistance towards the funeral and see whether the family would wish to visit the man's cell. The family said they did not want anyone from the prison to attend the funeral. However, the prison contributed towards the cost. The FLO also forwarded the man's belongings and a cheque for his prison account to his mother.

Care and support for prisoners and staff

97. Once prisoners were informed about the man's death, all those who were on an ACCT had a review. Prisoners were also reminded that they could speak to staff, Listeners or the Samaritans should they feel they needed to do so.

98. The investigator could find no evidence of a de-brief taking place for staff after the man had died. This may have been because he died in hospital, but nevertheless some staff who had close contact with him may have felt

affected by his death. A de-brief should be held for every death in custody. She subsequently raised this with the Governor who has accepted this and will ensure that de-briefs are carried out for all deaths at Cardiff.

Post-mortem and inquest

99. A post mortem was held on 5 October 2010. The pathologist concluded that the man died due to brain swelling. The pathologist carried out an examination of the brain and spinal cord to investigate this further. He further concluded "Brain swelling and hypoxic-ischaemic brain injury (damage to the central nervous system) in a man with profound hyponatraemia (precise cause uncertain, but generally noted as not enough sodium in the body)." He said that in view of the CCTV footage taken in the man's cell at Cardiff Bay Custody Suite, and in the absence of any relevant pre-existing medical condition, that excessive water consumption remained a possible explanation for profound hyponatraemia and brain swelling. He added that "The possibility of there being a 'behavioural' explanation for 'excessive water consumption' is best addressed by a psychiatrist with expertise in such matters."

100. An inquest for the man was held on 25 and 26 January 2011. His family had requested that this be postponed to allow them time to consider all relevant evidence, but this was not granted. The jury's verdict was that he died due to excess water intoxication.

ISSUES

Overall clinical opinion

101. The clinical reviewer considers the overall care given to the man during his time in custody:

> "HIW therefore concludes that the level of care provided to him was not appropriate or timely."

102. However, the clinical reviewer believes the specific nature of the man's death to have been unpredictable and unpreventable:

> " … it remains unexplained as to why he drank the amount of water that he did in that short space of time and therefore it would have been impossible to predict or prevent his death in these particular circumstances."

103. The clinical review makes a number of recommendations that the Head of Healthcare will wish to consider. Some are endorsed below as part of our investigation.

Physical healthcare

104. The man's family were concerned that he had complained on a number of occasions that he was suffering from pains and crushing sensations in his head. His mother wrote to the Governor about her concerns regarding this. Those who he complained to assumed that he was referring to a mental health problem rather than a physical pain in his head. Given his behaviour and the fact that most of his assessments were with mental health staff, it is understandable why this may initially have been thought to be the case. However, there was no reason why a physical check could not have been undertaken to ascertain or eliminate any physical problems and it is surprising, and of some concern, that this was not the case.

105. The clinical reviewer agrees that there does not seem to be an informed basis for the assumption that the man's head pains were purely psychological. The reviewer says that it is difficult to understand why a medical review of his symptoms was not undertaken to rule out any neurological or physical cause for his headaches. It was also noted that there was no explanation why he was not offered pain relief or other medication for his head pains, which may have helped his symptoms. Despite his behaviour, and the problems he was experiencing regarding his obsessive thoughts about his ex-partner, healthcare staff should not have assumed this was the cause of his headaches (or perceived pain in his head) and investigated this further.

106. The clinical reviewer concludes that:

> "We found no evidence that he was offered any pain relief for his continuing complaints of headaches. From the evidence available, HIW concludes that he did not receive appropriate medication."

107. Therefore, we endorse clinical reviewer's recommendation that:

The Head of Healthcare should ensure that all patients with neurological symptoms are referred for a medical opinion.

108. The clinical reviewer also considers the man's noticeable weight loss. She concludes that his significant weight loss (15 stone 8lbs in May 2009 to 11 stone 3lbs in September 2010) would have been noticeable and finds it difficult to understand why this was not picked up on. There is no evidence to suggest that his decline in weight was recorded as a concern or explored to determine whether it was linked to a physical or psychological disorder.

The Head of Healthcare should ensure that issues such as unexplained, significant, weight loss should be thoroughly explored to determine whether a problem exists.

Secondary health screening

109. The man was not given a secondary health screening, after he was received into custody at Cardiff. HM Chief Inspector of Prisons carried out an unannounced inspection in 2010, and found that a previous recommendation they had made in 2008 had not been achieved. This concerned secondary health screening. They recommended that "secondary health screening should be mandatory unless specially refused". In addition, we have recently completed another investigation at Cardiff in which we discussed a specific aspect of the same issue, conducting secondary health screenings for prisoners with complex health needs. As a result of this investigation, however, it was clear that not all prisoners are receiving the secondary health screening, and we make a wider recommendation to address this issue.

The Head of Healthcare should ensure a secondary health screening is carried out for all prisoners.

Mental healthcare

110. The man's family asked if a psychiatric condition could have caused or exacerbated his obsessive behaviour. The psychiatrist thought, during his assessment of him, that he remained very much preoccupied with the break-up of his relationship, however he had no clear psychotic symptoms and no obsessive concepts or thoughts. He concluded that he was not suffering from a mental illness. The family find this hard to accept, given his behaviour and obsessive thoughts. The letters he wrote to his mother were confused and show he felt extremely anxious and distressed, and his mother raised this with the prison by telephone call and by letter.

111. The clinical reviewer suggests that there was no evidence to confirm whether the man was suffering from a psychiatric illness, however the reports of his obsessive behaviour and levels of anxiety, amongst other unusual behaviours, should have led to further and more vigorous investigation and assessment, diagnosis and some form f treatment. The clinical reviewer also writes that it is difficult to understand how healthcare staff were not able to establish, as a minimum, that the obsessive nature of his reaction, 18 months on from the relationship break up, was extreme and abnormal and may have been a trigger for the range of distressing physical and psychological symptoms he was presenting.

112. Another area of concern was the man's behaviour whilst he was on A1 wing. Given the fact that he refused to engage in any activity, rarely came out of his cell and could be heard shouting and screaming to himself, one might have expected staff to seek advice about him. Notwithstanding the fact that he was assessed by mental health staff and a psychiatrist, it is surprising that further assessments were not sought, given this behaviour.

113. The clinical reviewer is of the opinion that, although there is no evidence to confirm whether the man was suffering from a psychiatric illness, reports of his obsessive behavioural traits, combined with his ongoing level of anxiety

symptoms of alcohol withdrawal, possibly a depressive disorder and other bizarre and unusual behaviours, should have led to a more rigorous investigation and multi-disciplinary assessment. Without evidence of such an assessment the clinical reviewer concludes that, "while it is impossible to now attribute a psychiatric illness to his behaviour, there was insufficient investigation into what was causing his behaviour".

The Head of Healthcare should improve the communications systems and processes between the various healthcare professionals, to ensure better sharing of information and treatment of prisoners with healthcare needs.

The family's concerns about the man

114. The man's family were concerned about his physical and mental health and provided the investigator with copies of letters he had wrote to them, and also letters they wrote to the prison as a result. These were dated July and September 2010 and described how concerned they were about his well-being. There is no record of any action being taken by the prison. In May 2010 his mother telephoned the Governor's secretary, expressing her concerns. There is evidence that a senior manager went to see him and advised that he should be seen by a member of the mental health team, but there is no record that this happened.

115. Families hold valuable information about the welfare of prisoners. Following their letters, it would be reasonable to expect a member of staff to speak with the man, decide whether action was necessary, and also respond to the family. On the one occasion staff responded to his mother's telephone call, there is no record of action taken.

The Governor should ensure that when a family express concern about the well being of a prisoner, that processes are in place to check on them, determine any appropriate action, record the actions taken and inform the family.

Medication

116. The man was prescribed anti-depressants early on during his time in custody. However, he did not comply with the medication as he said it did not help him. He declined to attend a medication review, saying he preferred to stay in bed. Whilst it is not possible to force prisoners to attend a review, nor to be made to take medication, there should have been a more determined effort to explain to him the reasons for the medication and how it might help him. Notwithstanding that, there is no evidence in his prescription chart that he was prescribed antidepressants at all. This contradicts the information in his medical record. Had he been prescribed medication without it being written on the prescription chart, it would have been in direct contra indication of the legislative requirements for both medical and nursing practitioners.

117. The man signed for 'in-possession' salbutamol inhalers for his asthmatic condition. The investigator was told anecdotally that he over-used his inhaler, but there is no evidence that any help to manage his use of the inhaler more effectively was given.

118. The clinical reviewer comments that the man's medical record shows that he was prescribed zopiclone (a drug used for insomnia) for three days by the prison doctor and that he should have been seen the next day by a doctor to discuss his antidepressant medication. There is no evidence that this appointment took place.

The Head of Healthcare should initiate an enquiry to establish why the man's prescription charts did not include information and medication recorded in his medical record.

Standards of record keeping

119. The standard of record keeping looked at during this investigation was poor. Documents were unsigned and undated and entries vague. Information in medical records and prescription charts do not agree. If staff had completed entries properly then some staff would not have needed to be interviewed as part of this investigation. Entries needed clarification and explanation and were clearly not completed in accordance with the National Medical Council guidelines and statutory requirements.

120. The clinical reviewer notes that in almost every review they have undertaken they have found the standard of record keeping to be poor. It was similarly noted that entries in the man's continuous clinical record were poorly recorded, a large number of entries were not dated, significant elements of health related forms were not filled in correctly and some records were illegible. Whilst the clinical reviewer is not inclined to make another recommendation about this, having done so in many previous reports, it appears appropriate to do so:

The Head of Healthcare should ensure that all entries made in a prisoner's medical record adhere to statutory requirements and are in keeping with National Medical Council guidelines.

The Head of Healthcare should ensure that a robust process is in place for obtaining prisoners' previous medical history and to clarify prescribed medication where there are potential health issues.

Bedwatch

121. The man's family were distressed by the presence of prison staff at the hospital, especially as he was in a coma and not expected to survive. They found this to be intrusive. I can understand how this would be upsetting for them. However, as he remained in the custody of HMP Cardiff, it is in keeping with Cardiff's responsibilities that staff were present. Having read through all the bedwatch documentation and interviewed some staff who

carried out these duties, we consider this to have been handled as sensitively and professionally as possible.

Other family issues

122. The man's family were concerned that he had an escapee marker on his prison records. The investigator could find no evidence of this.

123. They were also concerned that prison staff failed to respond to information passed to them regarding the man's wellbeing. There was evidence to show that the FLO did speak to him after the prison received a telephone call from the family, however there is no evidence that the family were told about this. It would have been preferable for the prison to let his concerned family know that they had spoken to him and what action they had taken.

124. The prison did not offer to contribute to funeral expenses until reminded by the investigator that this was a requirement in Prison Service Order 2710. Whilst making no formal recommendation here, we remind the prison of their responsibilities in this matter.

Monitoring mail

125. Despite having a harassment order against him, it appears that the man's outgoing mail was not always monitored as effectively as it could have been. For instance, he was able to send a letter to his ex-partner's sister. Also, the letters he wrote to his family showed how much turmoil he was feeling, and would have been worrying for any recipient. This would have been noted if his mail had been closely monitored as was required, although it is possible He may have passed the letter to another prisoner to post out.

The Governor should ensure that where there is a requirement to do so, a prisoner's mail is monitored effectively.

Delay in informing the man's prison

126. The police took the man to hospital and handed over responsibility to the prison at 6.15pm. 45 minutes later he was taken for a CT scan. At that point staff were not aware of the seriousness of his condition. At 7.40pm, hospital staff said that his prognosis was poor. It took 20 minutes for prison staff to request next of kin details, which they did at 8.00pm. However, his family were not contacted until between 9.10pm and 9.20pm, and this was done by the hospital rather than prison staff.

127. The Ombudsman's office has no remit to comment on the actions of the police. However, once prison staff were informed of the man's condition, there appeared to be a lack of urgency in acquiring details and contacting his family. Prison Rule 22 requires the governor to inform the prisoner's next of kin when a prisoner becomes seriously ill. It is also unclear why this was left to hospital staff, and nobody at the prison took responsibility for informing his family.

128. What is also unclear is why another member of the man's family was contacted, instead of his mother who was his nominated next of kin and recorded as such in the prison records.

The Governor should ensure that, when a prisoner becomes seriously ill, the designated next of kin is informed without undue delay.

CONCLUSION

129. This is an extremely sad case of a prisoner who clearly was unable to cope with the break up of his relationship and was consumed by thoughts of his ex-partner. Despite a number of assessments by mental health staff at Cardiff, it was concluded that the man was not suffering from a mental illness and the psychiatrist could find no evidence of him having any psychotic symptoms or anything obsessive in his nature. To a lay person and also to his family this clearly seems at odds with the behaviour he displayed. He could be heard shouting and screaming to himself, he was unable to be located in a shared cell because of his behaviour and it appears that he was a virtual recluse on A1 wing. It is surprising that this behaviour did not warrant more investigation and this is a view shared by the clinical reviewer.

130. The overwhelming impression in this case is that the man was a man left to his own devices. Perhaps this was because he was undoubtedly a difficult prisoner to deal with and he was also a man who had little interest in engaging with any aspect of prison life. Nevertheless, more care and attention could have been given to discovering the problems he was experiencing, both psychologically and physically, and to have pursued these more rigorously.

RECOMMENDATIONS

To the Head of Healthcare

1. The Head of Healthcare should ensure that all patients with neurological symptoms are referred for a medical opinion.

   The prison partially accepted this recommendation. They said that "Headache is a common symptom with which many prisoners present within the establishment. In the first instance prisoners would be treated with simple analgesics (unless there are progressive or additional symptoms which would initiate further investigation)".

2. The Head of Healthcare should ensure that issues such as unexplained, significant, weight loss should be thoroughly explored to determine whether a problem exists.

   The prison accepted this recommendation.

3. The Head of Healthcare should ensure a secondary health screening is carried out for all prisoners.

   The prison accepted this recommendation.

4. The Head of Healthcare should improve the communications systems and processes between the various healthcare professionals, to ensure better sharing of information and treatment of prisoners with healthcare needs.

   The prison accepted this recommendation.

5. The Head of Healthcare should initiate an enquiry to establish why the man's prescription charts did not include information and medication recorded in his medical record.

   The prison did not accept this recommendation. They said "The doctor verifies writing the prescription and pharmacy computer records reflect citalopram, 20mg daily was prescribed for 28 days on May 28th 2010. This record would not have been made if a valid prescription chart had not been seen in the pharmacy. Whether this chart then reflects that the man did not attend on repeated occasions, and what happened to this chart subsequently will be impossible to verify 21 months later. Administrative systems and filing of paper records may have been inadequate but, again, we contest that this cannot be investigated 21 months later. Prescription and administration records are currently under review with the introduction of System One so the system should transform to a more robust one."

6. The Head of Healthcare should ensure that all entries made in a prisoner's medical record adhere to statutory requirements and are in keeping with National Medical Council guidelines.

The prison accepted this recommendation.

7. The Head of Healthcare should ensure that a robust process is in place for obtaining prisoners' previous medical history and to clarify prescribed medication where there are potential health issues.

   The prison accepted this recommendation.

To the Governor

8. The Governor should ensure that where there is a requirement to do so, a prisoner's mail is monitored effectively.

   The prison accepted this recommendation.

9. The Governor should ensure that when a family repeatedly express concern about the well being of a prisoner, that processes are in place to check on them, determine any appropriate action and that any actions are recorded, record the actions taken and inform the family.

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   The prison partially accepted this recommendation. They said "Written communication was received from the man's mother and replied to demonstrating systems are in place and working correctly. A new system will be put in place regarding telephone calls received from concerned family members and the actions taken by relevant staff to address the concerns raised.

10. The Governor should ensure that, when a prisoner becomes seriously ill, the designated next of kin is informed without undue delay.

    The prison accepted this recommendation.