Investigation into the death of a man whilst in the custody of HMP Cardiff in November 2009

Report by the Prisons and Probation Ombudsman for England and Wales

September 2010

The man was found at 6.55am in his cell at HMP Cardiff, having cut himself and bled to death during the early hours. He was 40 years old. I offer my sincere sympathy and condolences to those touched by his death.

The investigation was carried out on my behalf by my colleague. A clinical review of the man's healthcare was undertaken on behalf of the Health Inspectorate Wales. I am grateful for her review. I would also like to thank the Governor of Cardiff at the time of the man's death and her staff for their co-operation and assistance. Particular thanks go to principal officer and his team for their help throughout the investigation.

The man experienced several problems prior to coming into custody. He suffered depression, physical ailments, relationship breakdown and a suicide attempt in the years before he was arrested on a charge of arson. He was given a cell in the healthcare department as he needed a wheelchair and had other medical issues. Once in healthcare, staff thought that he settled well although he confessed to staff that he had no-one outside prison who could bring him in personal items that he wanted.

The death of a friend in the healthcare department upset him and he did not want to move to a residential prison wing. This attitude took the form of several breaches of discipline. Despite this, he did move to F Wing where staff were of the view that he was coping well. However, he took his life only a few weeks later. The note that he left behind seems to suggest he was suffering greatly from depression and loneliness. It is deeply unfortunate that he felt unable to share the depth of his unhappiness with staff.

The man met many of the criteria for those who may be at risk of harming themselves. However, I can understand why none of the staff took the step to open formal suicide and self-harming monitoring procedures. He did not unburden himself to them and seemed more preoccupied with coping with his physical ailments and medication. I believe that a revised system of assessing prisoners upon their arrival into Cardiff could help identify prisoners who may at risk in the future.

This case clearly highlights the need for a custodial system that has the time and resources to look at a prisoner holistically. When one stands back to look at his situation it becomes apparent that his life was on a decline and prison may have been too much for him to cope with. Considering his life in its entirety might have provided the support he clearly needed. I am satisfied that the man gave no indication that he was unduly distressed. Unfortunately staff did not recognise that he was especially at risk or that leaving healthcare had reduced the level of support. My only recommendations concern record keeping and the completion of documentation.

The 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 born on 15 December 1968. He developed pain in his legs which resulted in him losing his job and having to use a wheelchair. He entered HMP Cardiff on 24 September 2009 having been charged with arson and recklessly endangering lives. During his initial healthscreen interview, he explained that he suffered from depression, had attempted suicide two years earlier and required a different wheelchair to the one he had in prison. He denied any thoughts of harming himself and was allocated a cell in the healthcare centre.

The man began a hunger strike on 26 September as a protest against what he deemed to be his unjust imprisonment. This lasted until 7 October when he ended it. He told staff that his actions were a form of protest rather than a means of harming himself. Following his hunger strike, he settled into life in the healthcare centre and formed friendships with some of the other prisoners.

Staff began to plan for him to be moved to a residential prison wing as they judged that the man did not need to be in the healthcare centre for medical reasons. He was adamant that he did not want to leave healthcare and engaged in several breaches of discipline in an attempt to remain there. At this time, he also became distressed when a friend died in the centre.

Despite the man's efforts to remain in the healthcare centre, he was moved to a cell on F Wing, following a short stay on A Wing. Once he went to F Wing there was very little recorded about his life in the prison files. A prisoner told the investigator that the man was being bullied on F Wing. The investigator was unable to find any evidence that it happened or that prison staff were aware of it. The staff who the investigator spoke to believed that the man was getting on well on F Wing and had no concerns for his welfare.

Unfortunately, the man was clearly struggling more than anyone knew and apparently took his life during the early morning of 16 November. He was found during the morning roll check. Staff did not attempt to resuscitate him because he had already passed away. The Governor visited the man's wife to break the news to her. This report contains three recommendations concerning record keeping and completing documentation.

THE INVESTIGATION PROCESS

1. The investigation was carried out by my colleague. My colleague visited HMP Cardiff the day after the man's death. He viewed the man's cell and the documents concerning him. Notices were issued to prisoners and staff to alert them to the investigation. No-one came forward in response to the notices. The Independent Monitoring Board and Prisons Officers Association were contacted to make them aware of the investigation.

2. My colleague asked the Healthcare Inspectorate Wales to review the clinical care received by the man. A clinical reviewer was commissioned to undertake this review. The review took longer than expected which has resulted in the delay of the publication of this report.

3. The Ombudsman's senior family liaison officer wrote to the man's wife and parents to provide them with information regarding the investigation. They did not raise any issues. I hope that this report offers greater insight of the man's time in prison.

4. My investigator travelled to Cardiff on 3 December to interview prison and healthcare staff, and a prisoner. The clinical reviewer accompanied him and was provided with the transcripts of the interviews. They returned to Cardiff on 12 January and 18 February 2010 to conduct further interviews.

The man

5. The man was born on 15 December 1968, and worked as a mechanic in the later 1990s. He developed pain in his legs, which developed to the extent that he could no longer walk. He had a spinal cord stimulator implanted to help cope with the pain. (This is a small machine located in the body that is used to send electric pulses to the spinal cord to control chronic pain.) He wore a hearing aid as he suffered from progressive hearing loss in the right ear. He was able to lip read.

6. Having left his job due to his disability, he took up wheelchair tennis and also began coaching tennis. He suffered from depression and was prescribed anti-depressant medication for over ten years. His relationship with the mother of his youngest child had also recently ended.

7. He told staff that he had taken an overdose of paracetamol two years before he came into prison. His alleged offence was arson and recklessly endangering lives. He was denied bail and this was his first time in custody.

8. Despite some breaches of discipline, he generally got on well with staff at Cardiff and several commented to the investigator how polite and respectful he was in their conversations with him. The reverend remembered that the man used to read a lot in his cell.

HMP CARDIFF

9. HMP Cardiff is a category B local and training prison. (As a local prison, Cardiff holds adult male prisoners received from the courts of South East Wales.) Cardiff has an in-patient healthcare unit with room for 22 prisoners. The clinical review includes the following summary of the healthcare facilities available:

> "The new Healthcare Centre at HMP Cardiff provides 24 hour primary care and has 22 in-patient beds. All cells in the centre have been designed to the "safer design" requirements. Two cells are gated and have cameras in situ while two further cells have cameras in situ but are not gated. [Gated cells allow staff to observe the prisoner at all times.] Clinical care is provided by doctors and nurses employed by the Prison Service. The team comprises two general practitioners (supported by locums from a local general practice), a senior nurse, practice manager, four supervisory grade nurse/senior healthcare officers and 26 registered nurses. There is one full time and one part time doctor who between them provide 13 sessions each week including Saturday morning. Out of hours doctor cover is provided by a local surgery."

Incentives and earned privileges scheme

10. The incentives and earned privileges (IEP) scheme is a means of monitoring prisoners' behaviour and rewarding good behaviour and punishing poor behaviour. Prison Service Order (PSO 4000) describes it as follows:

> "The IEP scheme complements the discipline system by rewarding good behaviour. In addition to any local aims, it is intended to encourage prisoners and YOs [young offenders] to behave responsibly, to participate in constructive activity, and to progress through the system. This will foster a more disciplined and controlled, and therefore safer environment for prisoners and staff. It should also contribute to the reduction of re-offending by encouraging prisoners to lead law-abiding, productive and healthy lives."

11. Within the local system prisoners are able to move up a level (basic, standard or enhanced) and earn various privileges. Poor behaviour can result in moving down a level or losing privileges. Privileges include association time and extra visits.

Adjudications

12. Adjudications are described in the following way in Prison Service Order (PSO) 2000 (Adjudications):

> "An adjudication has two purposes:
>
> - To help maintain order, control, discipline and a safe environment by investigating offences and punishing those responsible;
> - To ensure that the use of authority in the establishment is lawful, reasonable and fair.
>
> "The role of the adjudicator is to inquire into a report of alleged events and to decide whether an offence under Prison Rule 51 or YOI Rule 55 has been established beyond reasonable doubt. *The adjudicator must investigate the charge, being prepared to question, in a spirit of impartial inquiry, the accused, the reporting officer and any witnesses*."

Assessment, Care in Custody and Teamwork (ACCT)

13. Assessment, Care in Custody and Teamwork (ACCT) is a care planning tool used by the Prison Service to help support and monitor those prisoners identified as being at risk of suicide or self harm. The ACCT process encourages staff to work together to provide individual care to prisoners in distress and help to diffuse circumstances where self harm or suicide may occur.

Control and restraint

14. Staff are authorised, where necessary, to use control and restraint techniques which involve the use of reasonable force.

Sealed key pouch

15. Officers do not carry keys during the night. If they need to enter a cell, they must break a sealed key pouch to remove the key.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. The most recent report from the Cardiff IMB covers the period 1 September 2007 to 31 August 2008. The report stated that: "HMP Cardiff is a well-run establishment with good relationships between staff and prisoners."

Her Majesty's Chief Inspector of Prisons

17. HM Chief Inspector of Prisons conducted an announced inspection from 7 to 11 January 2008. The introduction to the report said: "Cardiff was essentially a safe prison, where prisoners were much more likely to report feeling safe than at other local prisons. This relied considerably on good relationships between staff and prisoners." Healthcare services were described as good, and "Self-harm and suicide prevention was supported by a comprehensive set of policy, procedural and guidance documents."

Previous deaths at Cardiff

18. Cardiff experienced three self-inflicted deaths in 2009, in addition to the death of the man. Two of the deaths were caused by hanging, and one by an overdose of medication. None of these prisoners were subject to ACCT monitoring procedures at the time of their deaths and, in two of the cases, the deaths came as a great shock – as did the man's.

KEY FINDINGS

19. The man was arrested on 22 September 2009 on a charge of committing arson recklessly and endangering lives. He was remanded into custody on 24 September and sent to HMP Cardiff. The prisoner escort record (PER) that accompanied him to prison listed no concerns, although it contained notes regarding his use of crutches and history of depression.

20. The initial reception healthscreen was undertaken. The initial impression was of a well-groomed and fit man. He was able to stand for short periods and did so for the height measurement. The nurse who did the initial reception healthscreen told my investigator that the man was very specific about his medical problems. He said that his wheelchair was incorrect and he did not have the remote control for his spinal cord stimulator. (This is a small machine located in the body that is used to send electric pulses to the spinal cord to control chronic pain.) The nurse said that she asked him if he had anyone who could bring them in for him, but he told her that he had no friends or family.

21. The man told the nurse that he was a social drinker but did not have any substance misuse issues. He said that he had been taking medication for depression for over ten years and had made a suicide attempt two years previously. However, he also said that he did not currently have thoughts of harming himself. She said to my colleague that he could not understand why he had not been granted bail.

22. The mental health section of the healthscreen was not fully completed. There was no information provided on the man's experience of psychiatric care, or how the man appeared to the nurse. The nurse told the investigator that the response to the questions should be read as 'no' if she had not marked either answer.

23. The nurse recommended that the man be initially accommodated in the healthcare department as she deemed him to be vulnerable. When questioned by the investigator, she confirmed that she did not mean with regard to harming himself but because it was his first time in prison and he had certain medical conditions. She did not consider it necessary to begin the Assessment, Care in Custody and Treatment (ACCT) procedures.

24. The cell sharing risk assessment was undertaken. This assessment contains a series of questions which are put to the prisoner. One refers to the offence and asks if the prisoner is accusing of committing one of a number offences, including arson. It appears that the man did not admit that he was charged with arson, as it is marked 'no' with a reference to the source of this information being 'I' (inmate).

25. He said that he wanted a single cell due to his medical condition. He was assessed as being at low risk of attacking a cellmate, but was accommodated in a single cell in the healthcare centre. The cell he moved to was a 'camera cell'. (A 'camera cell' contains a video camera which constantly records what

is happening in the cell.) This was apparently because staff were initially unsure how mobile the man was.

26. The man told staff on 26 September that he had begun a hunger strike in protest at what he believed to be his unjust incarceration. Healthcare Assistant (HCA) told the investigator that the man was clear that his action was a protest, rather than a form of harming himself. She said:

> " … he was quite adamant on the point, it wasn't because he wanted to hurt himself, he felt he shouldn't be in prison and he felt that it was his first offence and he should have been given bail. And it was a way of drawing attention to the plight that he was in."

27. Staff moved the man to a different cell on 27 September as they judged him to be mobile enough for a regular healthcare cell. He signed a food refusal advance directive on 29 September. The directive explained that it was his decision to refuse food and he was aware of the potential consequences. The prison began a monitoring document to check his well-being while he continued to refuse to eat. The prison doctor visited the man on 5 October as required by the monitoring document. He told her that he was refusing to eat in protest. She confirmed that he was still taking fluids and medication. (His medication was for the pain he experienced in his legs.)

28. The man ended his hunger strike on 7 October. The HCA noted that, on the day of ending his hunger strike, the man specifically denied having any thoughts of harming himself. The HCA said that he thought that the hunger strike was having no effect:

> "He felt that it was pointless, that no one had taken an interest in his hunger strike and no one really beyond the prison knew anything about it. And I think he just felt he was hurting himself and he gave up with it."

29. The prison doctor saw the man on 7 and 14 October during her routine ward rounds. She told the investigator that he was always polite when she spoke to him. The clinical reviewer recorded that during this time the man:

> " engaged in the routines of the healthcare unit, he interacted with his peers and staff, attended to his hygiene needs and mobilised himself using his wheelchair and crutches."

30. On 9 October, the disability liaison officer undertook a disability questionnaire with the man. He told her about his leg injuries and that his hearing was impaired. He said that he could not always hear people if they spoke to him through the cell door, and his life would be improved if he could understand people better. The HCA told the investigator that the man was a good lip-reader, but found it more difficult to understand people if he could not see them properly.

31. The man told the reverend that he needed a different wheelchair and the remote control to his spinal cord stimulator, both of which were at his home. The reverend told my colleague that she asked the man if anyone could bring the items in for him but he told her that he did not have anyone who could do this as he had alienated his family. However she said that she believed that the healthcare department did not, at that time, view the items as necessary and so she offered to collect them for the man. She received permission from the prison to undertake this task but was unable to collect the items immediately because the man's home was sealed. (Unfortunately, she was unable to collect these items for the man before his death.)

32. It was decided that the man would be able to cope on a normal wing and no longer needed daily monitoring from healthcare staff, but he was very reluctant to leave. It appears that he had friends in the unit and got on well with the other prisoners. On 15 October, the man refused to move to F Wing. He was given an incentives and earned privileges (IEP) warning the following day for refusing to move. He was given another warning after writing insults about a second HCA on the reverse of the first warning. He received further warnings on 17 and 18 October for refusing to move to F wing and, on 20 October, was put on report. The next day, the man was reduced to the basic level of the IEP system because of the four warnings he had received. The first HCA explained to my investigator why she thought the man did not want to leave healthcare:

> "I got the impression that he was scared that it was his first time in prison, he had settled in quite well on healthcare, although he had found it initially difficult in the first few days, but he settled and made friends. And it was the thought of actually going into a proper prison. From talking to him, that's the impression that I got, although they weren't his exact words."

33. Another prisoner had taken his life in the healthcare department on 19 October. The man had spent time with this prisoner during association periods and was friendly with him. The first HCA described the effect the man's suicide had on the man:

> "He was very upset. He took it very hard, I think they had been the closest on the landing, he had been the closest person to the gentleman who died and he did take it hard."

34. All of the prisoners in the healthcare unit were offered support from the chaplain following the death. The first HCA told my investigator that the man was a regular attendee at the chapel, and accepted the chaplain's offer.

35. At 2.20pm on 20 October, the man refused to return to his cell in healthcare. He became aggressive and staff restrained him and took him back to his cell. He was taken to the segregation unit the following day for adjudication by a governor. He was found guilty and punished with a loss of canteen. (Canteen is the method used by prisoners to buy additional items such as food.) He was then moved to A wing.

36. The man threatened staff and demanded more pain relief medication on 22 October at 10.00pm. A second nurse explained that insufficient time had elapsed since his previous dose so he was unable to have anymore. He threw his table around in his cell and struck his leg with his crutches. The nurse told the investigator that she considered this to be an act of anger rather than of self-harm. She dressed his wound, which was not serious, and provided more medication when sufficient time had elapsed. The next day, the man was provided with a pair of trainers from reception as he complained that the ones he had were hurting him.

37. An IEP review board considered the man's IEP level on 25 October. Wing staff told the review that, although the man could be difficult and arrogant, he did not present a control problem. The man agreed to move to F wing and was returned to the standard IEP level. He was given cell F2/01 because it was bigger and able to accommodate his wheelchair. It was the only single cell on the wing.

38. The first nurse who did the initial healthscreen was asked to visit the man on F wing as he had argued with staff regarding his medication. He was frustrated that his medication was dispensed four times a day in healthcare, but was only dispensed twice a day on the wing. The nurse told him that, as it was a Sunday, there was little she could do but she would organise an appointment with the doctor for the following day. She also discussed the possibility of using a slow-release analgesia such as Tradorec XL. This was subsequently prescribed following his visit to the doctor.

39. The man complained to staff on 29 October that he had not received his canteen. (This was because he had lost his canteen due to the punishment received at the adjudication.) On 2 November, he was found guilty of the offence committed on 20 October. Another prisoner said that the man was bullied by three other prisoners because he had borrowed tobacco from them and, now that he had lost his canteen, was unable to pay them back. (After the man's death the same prisoner also said that he heard two other prisoners talking about the man being bullied.)

40. The prison doctor saw the man on 11 November. The man said that the Tradorec was insufficient. The prison doctor agreed to increase the dosage although the clinical review points out that, according to the prescription charts, this does not appear to have happened. He explained that what really helped with the pain was his internal pain machine. The doctor agreed to fax the pain clinic to see if she could get a new remote control for it. She explained to the investigator that the man had seemed calm and rational at the time of this conversation, and she did not have concerns regarding his wellbeing.

41. The investigator spoke to several staff regarding the man's time on F wing. They consistently said that he seemed to have settled in, and raised no concerns with them. According to them, the man got on reasonably well with staff, but never came to them with any serious issues. Staff did not see him being bullied or threatened and said that it was a great shock when they heard that he had committed suicide. A note was made in his file on 15 November which said:

> "Had a quiet week. No concerns to report this week."

42. The investigator was told by prison staff that the man was sent legal papers related to his divorce from his wife. The investigator was unable to establish exactly when he received the papers but I understand that it was approximately at the start of November.

43. A prisoner told the investigator that on 15 November, the night before the man's death, they waited in the medication queue. The prisoner said that the man had seemed subdued as he believed he would receive a substantial custodial sentence for his alleged offence. Overall, the prisoner thought that the man seemed to be coping.

44. The evening roll check was completed at approximately 8.00pm by a second officer and all was in order. (A roll check involves counting the prisoners to ensure the correct number of prisoners are in the prison.) Following the man's death, the prisoners in the cell next door told staff that at approximately 11.30pm they had heard the man banging on the adjoining wall. The prisoners said that they believed the banging to be in relation to the volume of their music.

45. According to the report made by the paramedics, the man was last seen alive at approximately 00.30am on 16 November. Prisoners are not routinely checked during the night. He was found by a third officer while performing his morning roll check at 6.55am. The officer looked through the window in the door and saw the man sitting naked on his bed. This concerned him as it had been a cold night. Looking closer he noticed blood on the man.

46. The officer shouted to his colleagues to issue a code red alert before he broke his sealed key pouch and went into the cell. (A code red means a medical emergency relating to bleeding.) He said that he was unable to find a pulse and the man was cold. The man had cut his femoral artery which is a large artery in the muscles of the thigh. I understand that the man used a sharpened plastic knife to do this.

47. The officer also telephoned the healthcare department to alert them to the emergency. The first nurse on the scene collected the emergency resuscitation bag and went to F Wing. She went into the man's cell and checked his pupils' response to light and his heart. She found no sign of life. The paramedics arrived shortly afterwards and performed further checks. They confirmed that rigor mortis had set in, and his heart had no electrical activity. Rigor mortis is the stiffening of the body after death because of a loss

of Adenosine Triphosphate (ATP) from the body's muscles. ATP is the substance that allows energy to flow to the muscles and helps them work, and without this the muscles become stiff and inflexible. Rigor mortis begins throughout the body at the same time but the body's smaller muscles - such as those in the face, neck, arms and shoulders - are affected first. I understand that rigor mortis normally appears within the body around two hours after death, with the facial and upper neck and shoulder muscles first to show its effects. However, the speed of rigor mortis is affected by a number of factors including the size of the person and the temperature of the room.

48. The man left behind a note addressed to his wife and child. The beginning of the letter outlines how the man felt:

> "I can no longer take anymore. I have no friends, no-one to talk to. I am alone. I do this to end what I consider to be hell."

49. Following the man's death, the prison worked through their death in custody contingency plans. The Governor of Cardiff at the time, principal officer and the prison chaplain left the prison to visit his next of kin. They informed the man's next of kin (his estranged wife) of his death at approximately 10.30am. The man's wife was not at her home and the Governor was told that she was probably at work. They telephoned her manager on their way there, so that support from her work was in place before their arrival. They broke the news and then left her in the care of her manager.

50. The officer who had been appointed the family liaison officer that morning and received a telephone call from the man's father. He had been told of his son's death by a solicitor. This occurred because the man had been due to appear at court via video link that morning, and the solicitors had been told why this would no longer happen. (The investigator has been unable to find out why the man was due to appear in court that day.) The investigator was told by the family liaison officer that the man's father was not listed in the next of kin details in the man's record. When the Governor arrived back in the prison, she telephoned the man's father. Letters of condolence were sent to the man's wife and father.

51. The family liaison officer arranged for the prison to pay the cost of the funeral, and returned the man's property to his wife. The prison chaplain was asked by the man's wife to officiate at the funeral. He did so, and the family liaison officer also attended the funeral.

52. Following the man's death, all prisoners subject to ACCT procedures on F wing were reviewed to ensure their well-being. Listeners and the chaplaincy was also available to prisoners who required it. The care team was immediately deployed and staff were then able to have access to their support. Staff that my investigator spoke to recalled the support provided to them positively.

ISSUES

Assessing the man's mental and emotional well-being

53. After any apparently self-inflicted death, it is important to consider whether there were any warning signs that were missed.

54. Although it is difficult to tell if prisoner will be at risk of harming himself or committing suicide when they come into prison, the man met several of the criteria for prisoners who a particularly at risk of harming themselves.:

- It was his first time in prison and he was accused of arson. PSO 2700 (Suicide prevention and self-harm management) states:

  > "There is a very strong link between charges and convictions of arson and self-harm, particularly prolific self-harm."

- A further risk factor was his history of depression.
- He had attempted to commit suicide several years earlier.
- Another risk factor was that he was estranged from his wife, and was served divorce papers while in prison.
- He was upset by the death of another prisoner in the healthcare centre.
- Another factor was the court appearance scheduled for the morning he died. The investigator has been unable to find out the details of that appearance, but it may have added to the emotions the man was feeling.
- Although it is not possible to verify this view, the alleged bullying that he underwent on F Wing provides another potential factor to add to his risk of harming himself.

55. None of these factors alone might have been significant but cumulatively they were and should have warranted further monitoring. Indeed, it may be that all of them would not justify suicide and self-harm monitoring procedures. Nevertheless, I believe that ACCT monitoring should have been considered. The man – despite all of the factors outlined above – appeared to settle into life in the healthcare centre and did not commit suicide until almost two months had passed. However, he was very reluctant to move to a normal prison wing and engaged in several breaches of discipline in an attempt to stay in healthcare.

56. It is important that one does not criticise retrospectively and argue that staff must have missed warning signs and are at fault for not beginning ACCT procedures. As mentioned above, the decision on whether to open ACCT procedures lies with the staff in contact with the prisoner. The man met many of criteria for someone at risk of harming himself, but appeared overall, to be coping with his imprisonment.

57. I understand that Cardiff has adopted a system where if a prisoner comes into their custody accused of one of a number of offences, a form is automatically opened by the Safer Custody Team. Following a specified period time, the decision is then taken to either open an ACCT, maintain the limited monitoring

or end the monitoring altogether. I am pleased to hear of the pro-active way Cardiff is attempting to identify those prisoners most at risk of harming themselves. However, as outlined above it is not simply the offences that someone is accused of that indicates their risk. Although I make no recommendation, I would encourage the prison to consider whether their system could be modified to also take into account factors such as whether it is their first time in prison, previous history of self-harm/suicide attempts and personal issues (e.g. family estrangement).

58. Given the close link between arson and self-harm I also suggest that the list of offences is widened to include it.

Clinical care

59. The man's health needs centred around his desire for medication to treat the pain in his legs. This was provided to him and modified following conversations with him. He was looked after in the healthcare centre during his early time in Cardiff which I consider an appropriate means of assessing his needs. The clinical review did not identify any significant clinical issues regarding the man's care although comments were made on the following issues.

Record keeping

60. The clinical review identifies several concerns with the quality of the record keeping in the medical records:

> "The Medical Records were generally in good order, however some entries were illegible, abbreviations were used throughout the records and medical entries were often unsigned and lines were left blank between entries."

61. The clinical review includes a recommendation regarding this which I include as:

The Head of Healthcare should ensure that the entries made in medical and nursing records are legible, signed and that abbreviations are not used as set out in the Nursing and Midwifery Council Guide to Record Keeping.

62. The clinical reviewer also comments on the confusing nature of the format of the record keeping. There were two sets of clinical records for the same period of time and both included notes made by doctors and nurses. The clinical review includes a recommendation relating to this which I have written as:

The Head of Healthcare should ensure that there is either a clear division between medical records and clinical (nursing and other clinicians) records, or a unified record keeping approach is adopted.

The initial healthscreen document

63. It appears that the initial healthscreen document was not fully completed. The mental health section is empty, and there is no description of the man's presentation. The initial healthscreen meeting is vital in ascertaining the immediate and ongoing health needs of a new prisoner.

The Head of Healthcare should ensure that staff complete the initial healthscreen document in full.

The man's practical needs

64. The nurse who did the initial healthscreen recommended that the man be initially housed in healthcare due to his specific medical issues and because it was his first time in prison. The nurse explained that this would allow staff to appropriately assess his needs. I consider this to be a responsible and sensible reaction to the healthscreen interview and a good example of staff considering the needs of the prisoner. The disability liaison officer offered to help the man collect the items he needed but was unable to do so before he died. This was a compassionate offer to a man who told her that he had no-one else who could help him and it is unfortunate that she was unable to fulfil her offer.

65. The disability liaison officer told the investigator that, although she did not think that the man took part in education or work, the prison would have tried to facilitate that for him should he have wanted it. She said that education facilities were available in the healthcare centre and the man did make use of the reading material available to him.

Bullying

66. The investigator was told by a prisoner that the man was being bullied by three other prisoners on F wing. The investigator enquired whether there was any information regarding this. He reviewed the security information reports (SIRs) and wing history sheets but there was no information regarding bullying the man.

67. It is hard to prove allegations of bullying as it often comes down to one person's word against another's. It is consequently more difficult when one of these people has died. Staff may be unaware of bullying because prisoners can fear reprisals if they speak up. It is not always easy to notice bullying behaviour on a large wing with few staff. Constant vigilance is required. The investigator was told by the third officer that, during association time, there would usually be eight officers, and a senior officer, on duty to monitor approximately 190 prisoners.

68. The investigator has been unable to find any evidence that the man was being bullied, other than the information volunteered by the prisoner on F wing. However, given the number of prisoners staff need to watch, it is impossible to know if it was happening without the knowledge of staff.

Use of a plastic knife

69. I understand that the man used a plastic knife to inflict the wound to his femoral artery. A plastic knife is an item that prisoners would ordinarily be allowed to keep in their possession. Staff would not routinely remove objects from prisoners unless they had a specific reason to do so. This did not apply to the man as staff did not consider him to be at risk of harming himself. Even if staff had considered him to be at risk the knife may still have been provided to him. PSO 2700 (Suicide prevention and self-harm management) states:

> "However, removing personal belongings from a person who is feeling hopeless and depressed … can increase feelings of distress and therefore increase the risk of suicide, self-harm or a higher risk method of self-harm. Where possible, prisoners at risk should be allowed to retain their belongings unless it is clearly unsafe to do so."

Liaison with the man's family

70. It is disappointing that the man heard of his son's death from a solicitor. However, the man's father was not listed on the next of kin details, and it is pleasing to hear that the prison engaged with him appropriately once they were aware of him.

CONCLUSION

71. The man had suffered several setbacks in his life prior to being sent to prison. He experienced depression and crippling pain in his legs, and left his job. His relationship with the mother of his child had ended and he had attempted suicide. The man had not expected to be remanded into prison following his arrest for arson. However it appears that, due to the nature of his alleged offence and the fact that he had nowhere else to live, the court felt compelled to remand him into prison. He told staff that his hearing loss made it difficult for him to communicate with people, and it appears that he felt very lonely in prison. During his initial healthscreen he had told the nurse that he had no-one outside of prison who could bring in the items he wanted. The note he left behind reveals the depth of his unhappiness.

72. However, I do not think that any of the staff realised the extent of his feelings. He was generally respectful to staff, albeit with some significant exceptions, and did not approach them with any important issues. Once the man went to F wing, staff believed that he had begun to settle into prison life. Looking at what we now know of his life one can see that the last decade featured many unpleasant events and his experiences in prison may have added more stresses than he could bear. Unlike many of the deaths my office investigates, he did not exhibit a sudden increase in risk. Instead, the tale of his life over the last decade seems to indicate someone on a steady downward slope.

73. While I do not consider that staff could reasonably have foreseen his death, I do think that understanding all the aspects of his situation might well have indicated a man at risk of harming himself. It is unfortunate that the prison did not have the resources to take a holistic view of one man's plight. However, I am pleased the Cardiff has responded to the circumstances of the man's death and hope that the prison continue to refine their method of identifying those most at risk of suicide and prevent future self-inflicted deaths.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that the entries made in medical and nursing records are legible, signed and that abbreviations are not used as set out in the NMC Guide to Record Keeping.

The National Offender Management Service accepted this recommendation:

> "Head of Healthcare will issue a Notice to staff referring to medical note entries. Also implement monthly management checks to ensure ongoing compliance."

2. The Head of Healthcare should ensure that there is either a clear division between medical records and clinical (nursing and other clinicians) records, or a unified record keeping approach is adopted.

The National Offender Management Service partially accepted this recommendation:

> "There is currently joint record keeping which include Medical, Nursing and visiting specialists. The Head of healthcare will issue a Notice to Staff reminding them to adopt a unified record keeping approach. Also implement monthly management checks to ensure ongoing compliance."

3. The Head of Healthcare should ensure that staff complete the initial healthscreen document in full.

The National Offender Management Service accepted this recommendation:

> "Head of Healthcare will issue a Notice to Staff reminding them to ensure they complete the initial Health screen in full. Also implement monthly management checks to ensure ongoing compliance."