INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT HMP CARDIFF ON 22 DECEMBER 2005

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

JUNE 2006

This is the report of an investigation into the death of a man at HMP Cardiff on 22 December 2005. The man, who was aged 35, was found hanging in his cell. His was the first apparently self-inflicted death at Cardiff since my office was entrusted responsibility for investigating deaths in prison custody in April 2004.

I offer my sincere condolences to the man's partner, family and friends for their loss.

The man's family have been in contact with both Cardiff prison and my investigation team from an early stage. A key part of the investigation was to ensure that the family had the opportunity to raise any concerns. One of my Family Liaison Officers, has spoken with the man's partner and, with one of the investigators, with other members of his family. In this report, we have done all we can to answer their questions.

Two of my colleagues undertook the investigation on behalf of my office. I also commissioned a clinical review through the Welsh Assembly. I am grateful to another colleague from my office, and two members of staff from the Healthcare Inspectorate Wales (HIW), for undertaking the review. I also thank a Detective Constable of South Wales Police who conducted the initial police investigation for his assistance to my investigators.

I must also express my gratitude to the Governor of HMP Cardiff, to the local branch of the Prison Officers' Association, and to the prison's Independent Monitoring Board for their help and active co-operation throughout the investigation. I am particularly indebted to a Principal Officer for his help throughout the investigation process.

The man had been remanded in custody in September 2005, and was later sentenced to five months 17 days imprisonment. He was due to be released on 18 February 2006. This was not the first time he had been in prison and he was well known to staff and fellow prisoners. It was known that the man had mental health problems, but he gave no indication to staff that he intended to take his life. However, he had communicated his thoughts to some prisoners, one of whom told staff - but tragically identified the wrong person.

I make a total of eight recommendations and have identified four areas of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2006**

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Summary

1. The man was serving a sentence of five months and 17 days imprisonment and was due to be released on 18 February 2006. He had been in custody at HMP Cardiff a number of times and was well known to staff and fellow prisoners. They described him as a talkative, nervous and anxious man.

2. The man had a long history of drug misuse, mental illness and problems with alcohol since he had been a teenager and these were identified at reception at the prison in September 2005. He indicated that he did not want to be in a cell on his own and staff located him with another reception prisoner who was a close friend. He did not like being locked behind his door and some staff regularly left it unlocked. The man was assessed by the Mental Health In Reach Team (MHIRT) on 22 September 2005.

3. On 21 December, the man received a visit from his partner who told him that she wished to end their relationship. The next day he went to work as usual where he told a fellow prisoner that he wanted to kill himself. The prisoner believed the man's name to be another name and reported what he had been told to the workshop manager. Tragically, he identified another prisoner whose surname was similar and who was sitting with the man.

4. The workshop manager notified wing staff of the prisoner's concerns and they spoke to the wrongly identified prisoner. He was bemused by the attention and told staff he had no suicidal thoughts.

5. The man returned to the wing and collected his meal. He spoke to the chaplain to ask to attend the Christmas services before going to his cell where he was alone as his friend and cellmate was at court. After lunch, the cells were unlocked at approximately 1:30pm. The man's door was opened slightly, but the officer opening the doors did not observe or speak to anyone. It is not known whether the man was alive at the time the cell was unlocked.

6. When the man did not arrive at work in the afternoon, wing staff were alerted and a wing Officer went to his cell at approximately 2:30pm. He found the man hanging from the window frame with a ligature made from a bedsheet. Officers and nursing staff attended immediately and cardio pulmonary resuscitation (CPR) was commenced. However, no signs of life were detected and, despite the prompt arrival of paramedics, the man was pronounced dead at 2:50pm. Police attended the prison and were satisfied that there was no third party involvement.

7. The prison suspended the telephone system to ensure that the man's family were not informed of his death before the Governor, the chaplain and family liaison officer visited them to break the sad news in person.

8. A post mortem examination took place on 23 December. It found that the man's death was due to pressure to the neck consistent with hanging and that were no other marks or injury to suggest any third party involvement.

Investigation Process

9. Two colleagues from my office conducted this investigation. One of these colleagues visited Cardiff on 30 December 2005. Notices were issued to staff and prisoners telling them of the investigation and its terms of reference, offering the opportunity to participate. My investigators examined cell B3-15 where the man died. It contained bunk beds, table, chairs, wardrobes, television and in cell electricity and sanitation.

10. My investigators were given unrestricted access to the prison and obtained the documentation relating to the man's imprisonment. They received full co-operation from South Wales Police. Tape recorded interviews were conducted with prisoners and staff who had significant contact with the man.

11. An independent clinical review of the medical care the man received whilst in prison was requested from the Welsh Assembly, in accordance with my terms of reference for investigations conducted in Wales.

12. One of my Family Liaison Officers spoke and wrote to Shaun's family and partner on 13 January 2006, and subsequently visited his family with one of my investigating officers. My investigation has attempted to answer the questions posed by the man's family and partner.

13. The man's family initially raised the following concerns:

- Lack of information about what to do in the immediate days following the man's death, including the difficulty they had contacting anyone at the prison who could help. They did not accept the fact it was the Christmas period as an adequate excuse for these difficulties. However, they did praise the work of the family liaison officer when they were eventually referred to him.

- Although the prison offered to pay some of the funeral costs, it was initially only after the family applied to the Social Fund. The prison has since rectified this error and offered to pay the full costs of the funeral.

- Confirmation as to the whereabouts of the man's possessions, as it was thought some had been returned. We were able to confirm that his possessions remain at the prison.

- When his mother last visited her son he had seemed fine and shook hands with another prisoner who had been released and told him he would see him when he got out for a drink. He was apparently looking forward to the future. He was due to be released soon, and had been in the prison before so was able to cope with the sentence and the prison.

- The man's mother is aware that his partner visited him the day before his death and would like to know anything about the visit that could have affected his frame of mind.

- His mother wanted to know where the prison officers were and how her son's death happened.

- Although he stated in reception that he never wanted to be in a cell alone, he was left alone on the day of his death.

- The prison officer who unlocked the man's cell did not look inside or attempt to communicate with him.

14. The man's partner raised the following as questions and concerns:

- Whether he left a suicide note.

- Whether her letters to him could be returned.

- Was he given medication of around six tablets a day that he had not been given on previous sentences or in the community. She wanted a full assessment of why it was prescribed and whether it was adequately monitored.

- She noticed a change in him over the four weeks previous to his death which she felt was due to his medication.

Background

The man

15. The man was born on 4 June 1970, and was 35 years old when he died. He and his sister were brought up just outside Cardiff and continued to live in this area into adulthood.

16. The man's family described him as a happy-go-lucky and fun person. He enjoyed watching sport, especially rugby and football. He supported Ipswich Town Football Club. He was a talented pool and snooker player, and also enjoyed a game of darts.

HMP Cardiff

17. HMP Cardiff is a category B local prison for adult male prisoners, predominantly from south east Wales. It is situated in the centre of Cardiff and has six main residential units. The certified normal accommodation for B wing, where Shaun was housed, is 113. B wing mainly holds sentenced prisoners in double cells on four landings. Its regime includes full employment, programmes, and compliance drug testing. Landing B1 is separated from the rest of the wing and is the prison's induction unit. C Wing (where the man was located on first reception) is a 52 bed detoxification unit.

18. In a report on an unannounced inspection, Her Majesty's Chief Inspector of Prisons (HMCIP) said in February 2005:

    Two years ago we described Cardiff prison as being at a crossroads as it struggled with competing pressure, including the inexorable rise in population. This unannounced follow up inspection records that Cardiff had achieved a great deal despite these unpropitious circumstances. We found that most of our recommendations had been implemented and in some key areas, the prison had gone significantly further.

19. A former non-executive member of the Prisons Board visited Cardiff on 21 December, the day before the man died. He commented:

    I have been in a large number of prisons both in this country and in other parts of the world and against that background I have to say that Cardiff was one of the best establishments that I have ever visited.

    From the first moment the appearance of the building, the friendly attitude of staff and the air of professionalism were manifest.

20. Cardiff's suicide prevention officer, has been in post for 45 months. The man's death was the first apparently self-inflicted death in the prison during that time. The suicide prevention officer has been highly praised for his suicide

prevention work which is acknowledged in the HMCIP report. He has also received a Butler Trust award in recognition of his work in suicide prevention.

21. The suicide prevention policy at Cardiff is one of the best my investigators have seen. The investigators also noted the high standard of Assessment, Care in Custody and Teamwork (ACCT) forms for self harm prevention.

Events prior to 22 December 2005

22. The man was remanded in custody to HMP Cardiff in September 2005, and subsequently sentenced in November. He received a total of five months and 17 days imprisonment, with a release date of 18 February 2006. He had been a prisoner in Cardiff in the past and was known to staff and prisoners. During his initial reception in September, the man informed staff that he had no history of self harm.

23. A local general practitioner working in the prison as a locum, completed the health care section of the Cell Sharing Risk Assessment (CSRA) upon the man's reception in September. (This form is used by the Prison Service to assess whether a prisoner presents a risk to others. The form is not used to assess whether the prisoner is a risk to himself.) The GP completed section 3 of the form before section 2 had been completed by an Officer. She assessed the man as low risk to other prisoners and noted:

    asthma, past history of mental illness, no history of self harm, request to share cell.

24. The officer said that he interviewed the man for part 2 of the CSRA after part 3 had been completed by the GP. The officer could not remember the man, but recalled noting he was of low risk of harm to others and was suitable for multi cell location. The officer wrote the following on the form:

    request that he never wants to be in a cell on his own feels scared and would get very depressed told the man that he needs to talk to the prison nurse/doctor.

25. The officer said that he did not refer the man to the doctor, but informed him that it was his responsibility to speak to a doctor or nurse if he had concerns. The man asked to be allowed to share a cell with a prisoner, who had also arrived at Cardiff the same day. They were friends who had known each for many years and had previously lived in the same house. His request was agreed and the two men remained as cell mates throughout their imprisonment.

26. The officer completed the first entry in the man's wing history sheet the same day, noting that he had been received on C wing and was assessed as low risk for cell sharing. He reinforced his earlier statement in the CSRA to the effect that he 'never wants to be in a single cell' and had advised the man to talk to a nurse or doctor.

27. Officers on C wing made entries in the history sheet on 8 and 9 September, indicating they had reviewed the CSRA and found the man remained a low risk for cell sharing. On 28 September, a community psychiatric nurse (CPN) wrote in the man's wing history sheet that a, consultant forensic psychiatrist, had

recommended that the man remain with his current cell mate for therapeutic reasons. There was no record that he should not be left in a cell alone.

28. On 7 October, an entry was made that the CSRA had been checked again before the man and his cellmate were moved to B wing. On B wing, entries were made on 9 and 21 October and 6 November, indicating that the man presented as unsure and nervous.

29. Subsequent records in the history sheet noted that:

- *20.11.05 He does not like being left in cell on his own and seems to expect his door left open all the time. He is becoming demanding on staff.*
- *25.11.05 As above loves being a drain on staff.*
- *3.12.05 Very demanding of staff resources. Always needs reassuring. Does not like being shut in.*
- *11.12.05 Every weekend he expects his door left open. I explained to him that he wasn't special and that if he didn't want to be "banged up" he shouldn't come into prison. Hopefully he got the message.*
- *17.12.05 Does not like being locked up and is very demanding on staff. Seems to be playing staff off against each other.*

30. I make no formal recommendation in relation to these records but deprecate some of the language used. The Governor will wish to remind staff of the importance of completing entries in history sheets in a manner that is appropriate and respectful. *In response to this paragraph the Governor, issued a warning to staff about inappropriate entries at a full staff meeting held on 25 May 2006, and in a notice to staff published on 30 May 2006*.

31. As part of the PPO investigation, five prisoners were interviewed. The first prisoner said he had known the man from their previous terms of imprisonment. He felt he was more extrovert previously and now seemed to have matured. The man gave no indication that he was at risk of harming himself. This prisoner felt that there was no way he would have been bullied, as he described the man as streetwise.

32. The second prisoner knew the man as they were related, and he also knew his cell mate as they all lived in the same community outside Cardiff. He was aware that prison staff had arranged for the man and his cellmate to share a cell together, which he said met the man's needs. The second prisoner said that he and the man had been located together on one occasion when his cellmate had gone to court. The second prisoner was aware that the man suffered from psychiatric problems and needed reassurance, but said that the last thing he expected was for him to commit suicide. He described the staff-prisoner relationships at Cardiff as good.

33. The third prisoner was the man's cell mate and a good friend both in and outside of prison. On the morning of the man's death, the cellmate left their cell at 7.40am to attend court. He said that the man seemed fine when he left. Prior to this, the cellmate said the man was coping with being in prison, was getting on with his sentence and was pretty happy. He was aware that the man's partner visited him on 21 December and that, as a consequence of her ending their relationship, he was a bit depressed. But he seemed alright in himself, and the cellmate fully expected to return from court and see his cell mate.

34. An officer who was the man's personal officer and he described him as a nervous individual, who did not like to be left alone in his cell, although this did happen on occasions. The officer said he was considering recommending the man for wing cleaner duties.

22 December 2005

35. On the morning of 22 December, the man attended morning workshop with other prisoners. The workshop manager knew the man as he had been in the prison previously. He described him as someone who needed constant reassurance and so he spent more time with him than with other prisoners.

36. A prisoner said that he and the man sat together in the workshop and he told him that his "head was gone", and talked about committing suicide which he said he had tried before. The man told him he wanted to kill himself with a Stanley knife or by hanging and asked how to make a noose.

37. The workshop manager said that, during the morning, the prisoner approached him in his office and stated that a prisoner was talking about committing suicide. The prisoner told the officer what he believed was the man's first name. He pointed to a prisoner sitting at the end of one of the benches. By a tragic coincidence, the man was sitting next to a prisoner whose surname was the same as his first name.

38. The workshop manager telephoned B wing and spoke to a Senior Officer (SO) about his concerns. The prisoner with the same name was interviewed when he returned from the workshop, and an entry was made in his personal record which noted that he had no thoughts of suicide.

39. At approximately 11:45am, the man returned to B wing where he approached a Chaplain to ask to attend the Christmas carol service and all other Christmas services. The chaplain knew the man as he attended church services. The man was then locked in his cell alone as his cellmate was still at court.

40. The man's personal officer, was on duty that day. He said that at lunchtime he unlocked the prisoners on the man's side of the landing. This would have been at approximately 12:30pm. He did not recall the man's mood as any different to any other day, and did not remember his actions when he went to collect his lunch. Once prisoners had collected their lunch they returned to their cell and shut the cell doors, the process taking approximately five to ten minutes. The Officer would then have locked the cells on the other side of the landing.

41. The prisoners remained in their cells until about 1:30pm when the officer said he unlocked the man's cell door, together with those of the other prisoners on the same side of the landing. He remembered unlocking the doors and opening them a few inches, but said that he did not observe or communicate with the occupants. It is not known whether the man was alive at this time. The wing operates a free flow system, allowing those prisoners due to attend workshops and education to leave the wing.

42. A senior officer (SO) said that he received a telephone call at approximately 2:25pm, and was informed that the man had not returned to the workshop after

lunch. He immediately sent a wing officer to see where the man was, and then heard this officer shout for assistance.

43. The wing officer went to cell B3:15 to speak to the man and saw that the cell door was slightly open. He looked inside and saw him hanging from the window frame at the back of the cell. He shouted for assistance and went into the cell. He lifted the man to take the weight off his neck and, as he was doing this, was joined by another wing Officer. This officer stood on the chair and cut the ligature, which was a bed sheet, using his anti ligature knife. First, he cut the ligature between the man's neck and the window frame; then, he cut the ligature off his neck.

44. The SOand a third wing officer immediately joined the two other officers. They laid the man on the cell floor and the SO instructed two of the officers to leave the cell so that he and the third officer could perform cardio pulmonary resuscitation (CPR).

45. In interview, the third officer said he was trained in first aid and also as a first responder, which meant that he could carry and use a portable defibrillator and give oxygen therapy. He had immediately responded to the radio call for assistance and attended B3:15, where he found the man lying on his back on the cell floor with his head towards the cell door and his feet towards the window.

46. This officer did not have a mouth piece and so gave skin to skin mouth to mouth resuscitation, whilst the SO administered chest compressions. The officer tried to use a suction pump from the resuscitation bag to clear the man's airway of bile, but said that the device did not work properly. The man's shirt was removed and the officer shaved his chest before putting defibrillator pads in place.

47. An fourth officer heard the alarm bell and was directed to cell B3:15. He had known the man from previous sentences and had found him to be a polite, quiet and hard working man. When this officer reached the cell, he saw the man lying on his back, with his feet towards the rear of the cell and his head towards the door. The SO and third officer were performing CPR, and this officer assisted them by cutting the man's T-shirt to aid the application of a defibrillator. He was still present when the doctor pronounced the man's death.

48. A second SO said that at 2:20pm he was alerted by raised voices from cell B3:15. He went to the cell and saw the man lying on the floor on his back with his head near the cell entrance. Also present were a SO and two officers. The second SO used his personal radio to alert the healthcare team and the emergency ambulance service.

49. A Principal Officer (PO) was the duty orderly officer. He said that at approximately 2:25pm he was in the prison's centre office when he heard a member of staff shout for assistance on B wing, followed shortly afterwards by the alarm bell. He went to B3 landing and made his way to cell B3:15, where he saw an Officer leave the cell. The PO took control and ordered surplus staff

away from the immediate area to the landing below, in order to provide more room for the administration of CPR. He saw an officer giving mouth to mouth resuscitation and a SO carrying out chest compressions.

50. The PO began a log of the people attending the cell and their time of arrival.

51. At approximately 2:30pm, two nurses were on duty and responded to the emergency call. They collected oxygen and emergency resuscitation equipment and reached the cell within two minutes of receiving the call. When they arrived, they saw the SO and two officers were carrying out CPR.

52. In interview, the first nurse said that she had worked at the prison for eight years and recognised the man from his previous sentences. She used to observe him take his medication and ensured that he swallowed it. She described him as 'a model prisoner' and said that, when she arrived at the cell, she was shocked to see the man as he had given her no indication of harming himself.

53. The nurse placed a Guedel airway (a device for ensuring air enters the lungs) in the man's mouth, and both nurses continued the administration of CPR. They noted that the man was unresponsive to all stimuli, there were no signs of cardiac output and his pupils were fixed and dilated. An automatic external defibrillator attached to the man advised that an electric shock should not be given.

54. The prison duty doctor, went to cell B3:15 at 2:32pm whilst CPR was being conducted. The paramedics arrived at 2:40pm and moved the man on to the landing outside the cell so that they had more space to work on him. They secured an intravenous cannula and Atropine and Adrenaline were administered as part of the continuing CPR.

55. Despite all attempts to save the man's life, the doctor pronounced the man's death at 2:50pm. He was lifted back into the cell, placed on the bottom bunk, and covered with a blanket. A chaplain, who had arrived at 2:45pm, said a prayer in the company of two of the officers who had attempted CPR.

56. The following is an extract of the log:

2:25pm alarm bell/call from staff B3 Landing

Officers on scene throughout

2:30pm Healthcare staff arrived

2:32pm Duty Doctor arrived

2:40pm Ambulance arrived on scene

2:41pm Paramedics removed inmate onto landing to continue assessment

2:42pm Number 1 governor arrived on scene

2:45pm Chaplain arrived at cell

2:50pm Doctor pronounced death

2:55pm inmate placed back in cell

2:58pm cell door closed

3:40pm Works attended scene and sealed cell door

3:42pm Works staff left scene

4:05pm Police attended the cell. Cell door opened

4:00pm Police Liaison Officer attended scene and spoke to staff.

Events after the man's death

57. Immediately after his death, the prisoners' telephone system was suspended in order to prevent his next of kin hearing the news other than personally from the prison governor. Later that afternoon, the Governor visited the man's mother, and then his partner, together with a chaplain and the prison family liaison officer, to break the sad news of the man's death.

58. The man's partner told the Governor that, when she visited the man the day before his death, he had told her of his intention to end his life and she regretted that she had not made prison staff aware of this. She also said that he had cut his wrists two years previously. She felt that his mental health was more controlled and stable when he was in custody. In the community, he rarely took his medication.

59. A letter to the man from his partner arrived at the prison after his death which confirmed the account she had given to the Governor.

60. After the man's death, the prisoner realised that he had given the workshop manager the wrong name of the prisoner he was concerned about and was distressed by his mistake. In interview, he said that he has felt supported by staff.

61. A prisoner cleaner on B wing, had met the man on the wing a week prior to his death. He said the man talked about committing suicide and said he had tried it before. He told him of a visit which the wing cleaner believed was from the man's wife. The wing cleaner said that he did not take the man's threats of suicide seriously, as he said that a number of prisoners said similar things. After the man's death, the wing cleaner informed an Officer of his conversation with the man and made a written note which has been handed to the police.

62. The Cardiff coroner visited Cardiff on 23 December and saw inside the man's cell.

Post Mortem

63. A pathologist carried out a post mortem examination on the man on 23 December 2005 at a local hospital in Cardiff. He commented:

Post mortem examination of this 35 year old man showed evidence of a ligature mark around the neck rising to a probable suspension point over the back of the neck. Although I have not been shown the ligature and I have not been provided with details of the position of the body when found or measurements from the cell, the appearances would be in keeping with a hanging.

There were no other marks of injury on the body to suggest any "third party involvement". In particular, there was no head injury and there were no "defence type" injuries. Internal examination confirmed the presence of fractures within the hyoid bone and thyroid cartilage (larynx) in keeping with pressure to the neck from a ligature. Such pressure would be sufficient to account for death.

There were no other fractures and there were no collections of blood in the head, chest or abdominal cavities.

There was no naked eye evidence of significant natural disease-only mild to moderate degree of coronary artery atheroma. Microscopy will be performed on tissue sections and I recommend that blood and urine samples be submitted for a toxicology analysis. [I understand the toxicology results have given the coroner no cause for the concern.]

Cause of death

1A Pressure to neck-consistent with hanging.

Contact with the man's family

64. A PO acted as a Family Liaison Officer, keeping a log of his contact with the man's relatives. In interview, he said that officers at Cardiff had not undertaken any formal family liaison training. He acknowledged that he made little contact with the family after the initial visit, and explained that he did not want to contact them unless he had anything new to say. However, he did however discuss funeral costs and arrangements with them. After the first visit, a mobile telephone was issued to him so that the man's family and partner could make direct contact, rather than using the prison switchboard.

65. The Governor and Family Liaison Officer attended the man's funeral. Flowers were sent on behalf of the staff and prisoners at Cardiff.

66. At the time of writing this report, the man's family and partner have not accepted the offer from the prison to visit the man's cell. They may decide to visit in the future.

Issues considered in the investigation

Findings from the clinical review

67. The community psychiatric nurse (CPN) who saw the man on 22 September noted that the referral to the Mental Health In Reach Team (MHIRT) had been made by a doctor, the doctor who saw the man on 14 September, rather than by the doctor who saw him at reception. This indicated that the original referral had not been acted upon and was not known to this doctor. Although the delay was of no great significance to the man, it may indicate a failure to follow up actions proposed at the reception health screen.

68. Notwithstanding the delay, it was evident that the man's mental health was given a thorough assessment, followed by the best practice of contacting his community mental health team and obtaining, with his consent, his past mental health records. On 28 September, the man was assessed further by a consultant forensic psychiatrist. It was good practice that he wrote a report immediately in the man's clinical record, as well as later sending in a typewritten version.

69. It was also commendable that the CPN informed discipline staff via the man's wing history sheet that the forensic psychiatrist recommended it would be therapeutic for the man to remain with his current cell mate.

70. Although the man had a further appointment with the CPN on 13 October, he was not taken on to the MHIRT caseload because he was 'much more settled'. The clinical reviewer comments that it is possible to conjecture, in the light of the HMCIP comment that 'the team was small and lacked capacity', that with increased resources ongoing support might have been offered to the man.

    The Cardiff Local Health Board (LHB) should review the commissioning of the prison's mental health services in the light of the findings in this report.

Concerns expressed by the man's partner about his healthcare

71. The man's partner raised the following concerns:

- The man was given medication of around six tablets a day, which differed from his prescription during previous sentences and in the community. She wanted a full assessment of why they were prescribed and whether his medication was adequately monitored.

- She noticed a change in him during the four weeks prior to his death which she thought was due to his medication.

72. When he first came into prison he told the doctor he was prescribed olanzapine 20mg, which was later confirmed by his records from the CMHT. The doctor prescribed olanzapine 10mg twice daily. On 14 September, the man saw a doctor because he was not sleeping, and mentioned again that his prescription had been for 20mg of olanzapine. The doctor increased the dose to 20mg twice daily and also prescribed short term medication, probably zopiclone, for his insomnia.

73. The man saw the consultant psychiatrist on 28 September. The psychiatrist described him as 'very shaky', which was largely attributed to drug withdrawal. He recorded that he considered prescribing a beta-blocker to reduce anxiety and physical shaking. However, he decided against this course of action because the man was also suffering from bronchitis which the psychiatrist thought might be aggravated. Instead, he prescribed chlorpromazine 50mg twice a day. Subsequently on 14 October, a doctor prescribed mirtazepine 30mg to be taken at 4:00pm daily.

74. All these prescriptions were within the recommended dosage set out in the British National Formulary (BNF). Depending on which tablets of which amount were dispensed, these three medicines would account for the six or so tablets mentioned by the man's partner. The medication was prescribed by the consultant forensic psychiatrist, who the reviewer states could be considered to be an expert in his field. The prescriptions were reviewed on four occasions: 14 September, 14 October, 8 November and 1 December. The man was allowed to hold his medication in his own possession on a daily basis. This provided a reasonable level of monitoring of whether the man took the medication regularly and also of his ongoing state of health.

75. The clinical reviewer comments that both chlorpromazine and mirtazepine have a sedating side effect which could have accounted for the change in the man noticed by his partner. Although he had been prescribed olanzapine prior to coming into custody, he probably only took it intermittently. Olanzapine also has a side effect of drowsiness, and regular use might have affected him. Again, this could account for his seeming different to his partner.

Drug detoxification

76. Reception staff missed the opportunity to engage the man in detoxification or other drug treatment intervention. He had a known and substantial history of amphetamine abuse and had received treatment during his previous period of custody at Cardiff. However, there was no evidence that detoxification was considered during this sentence, even though he was described by the doctor as 'jittery'. The man's assertion that he had used nothing but cannabis in the previous month was accepted. Subsequently, the CPN recorded the man's intention to use amphetamines again at the earliest opportunity, but again no drug treatment or counselling was offered. The man was advised that, with his family and personal history of schizophrenia, the associated risks were very high but no alternative support was offered.

The drug detoxification and treatment policy should be reviewed to identify why the man did not receive a detoxification programme and prevent any similar omission in the future.

Communication between wing and healthcare staff

77. The other opportunity which was missed was the failure to bring together the assessment of the man and his behaviour by wing staff with the assessment of his mental health by clinical staff. On the wing, he presented as a nervous, unsure young man, who was described as demanding and draining when perhaps a better word would have been 'needy'.

78. Wing staff paid great attention to the man's CSRA, reviewing it no less than three times. Yet, due perhaps to a lack of flexibility of interpretation, their assessments failed to capture his individual needs. He was not a risk to anybody he shared a cell with, but tragically was a risk to himself when left alone. The man's mental wellbeing was at high risk if he did not share and have company when he was locked up. From the wing history sheet, it is evident that he showed his fear of being alone by making 'demands' on officers' time. They may not have understood this and some of their records evidence little sympathy.

79. However, clinical staff were aware of his mental health needs and the effect it might have on his behaviour. Improved communication between wing and clinical staff might have improved the outcome for him.

Consideration should be given to making arrangements for discipline and healthcare staff to share information about vulnerable prisoners, without any breach of medical confidentiality. The CPN's entry sharing the Psychiatrist's recommendation on 28 September is an example on which to build future practice.

Consideration should be given to providing training for discipline staff which would enhance their understanding and enable them to act appropriately in the care of and management of mentally ill prisoners in normal location.

Cell Sharing Risk Assessments

80. The interviews for the man's Cell Sharing Risk Assessment were not carried out in the correct sequence, meaning that the doctor's interview took place before that of the reception officer. This meant that the doctor did not assess the officer's judgement, as is the intention of the form. The doctor said that she believed the CSRA was often completed out of sequence at Cardiff.

The Governor of Cardiff should ensure that all staff completing CSRA forms are familiar with the correct procedure and arranged for regular audits of practice.

Other matters

81. At his interview, an officer said that he attempted to use a suction pump whilst administering CPR to the man, but he said that the equipment failed to work properly. It is clearly essential that emergency equipment is in full working order when needed.

Schedules and procedures for the regular checking of emergency equipment should be reviewed and reinforced to include a check after any occasion when the equipment has been used.

82. My investigators found that it is usual practice at Cardiff, when unlocking cells after lunch, that prisoners are not seen or communicated with. Officers simply unlock the door and push it ajar. The officer who unlocked the cells after lunch on the day of the man's death did not see or communicate with the prisoners. Whilst there is no requirement at this time of day to carry out a roll check, it would be good practice to extend the routine. In his case, it is not known whether he was still alive at 1:30pm, and this was an opportunity to ascertain a prisoner's wellbeing which was missed.

The Governor should review the procedures for unlocking prisoners.

83. Our investigators found that, although family liaison was improved after the FLO was given a mobile phone to enable direct contact, officers at Cardiff have not received formal Family Liaison Officer training.

The Governor should identify suitable Family Liaison Officers and ensure that they undertake the necessary training as soon as possible.

Conclusions

84. In the short time that the man was in Cardiff, he gave neither staff nor his cell mate (who was someone he had known as a friend for many years outside prison) any indication that he was likely to harm himself.

85. Upon reception, he had indicated that he did not want to be in a cell alone, and staff arranged for him to share his cell with his friend. But whilst he always occupied a shared cell, inevitably his cell mate was not always present. On occasions, officers left his cell door open and also arranged for him to share a cell for short periods when his cell mate was absent.

86. The man had spoken to other prisoners about harming himself but not directly to staff. The day before his death, his partner had visited and told him that she was ending their relationship. He discussed harming himself with a fellow prisoner in the workshop during the morning of the day of his death. The prisoner was so concerned that he brought the matter to the immediate attention of the workshop manager who, in turn, took all the correct steps in drawing it to the attention of wing staff. Tragically, the wrong prisoner had been identified.

87. The man's cell mate was at court on 22 December 2005, and so he was in his cell alone at lunchtime. When his cell was unlocked at 1:30pm the officer did not see or speak to him or any of the other prisoners he unlocked. It is unknown whether he was alive at this time. Staff were alerted that he had not returned to work after lunch and went to look for him. At 2:30pm, he was found hanging in his cell. The staff response was immediate and professional.

88. In the circumstances that obtained, I do not believe that HMP Cardiff could have done more to have prevented the man's death. However, this investigation has raised questions about the sharing of information between healthcare and discipline staff and other issues.

Recommendations

Local

1 Consideration should be given to providing training for discipline staff which would enhance their understanding and enable them to act appropriately in the care of and management of mentally ill prisoners in normal location.

2 The Governor of Cardiff should ensure that all staff completing CSRA forms are familiar with the correct procedure and arranged for regular audits of practice.

3 Schedules and procedures for the regular checking of emergency equipment should be reviewed and reinforced to include a check after any occasion when the equipment has been used.

4 The Governor should review the procedures for unlocking prisoners**.**

5 The Governor should identify suitable family liaison officers and ensure they undertake the necessary training as soon as possible.

Health

6 The Cardiff Local Health Board (LHB) should review the commissioning of the prison's mental health services in the light of the findings in this report.

7 The drug detoxification and treatment policy should be reviewed to identify why Shaun did not receive a detoxification programme and prevent any similar omission in the future.

8 Consideration should be given to making arrangements for discipline and healthcare staff to share information about vulnerable prisoners, without any breach of medical confidentiality. The CPN's entry sharing the Psychiatrist's recommendation on 28 September is an example on which to build future practice.

Good Practice

1 The prisoners' telephone system was taken out of action immediately after Shaun's death so that his family could not be contacted by other prisoners before the Governor and staff could deliver the news of his death in person.

2 The issue of a mobile telephone to the prison Family Liaison Officer enabled the man's family to have unrestricted access.

3 The staff involved in administering CPR to the man should be commended for their attempt to save his life**.**

4 The liaison with the Community Mental Health Team who treated the man before he came into custody was timely and efficient, and resulted in full knowledge of his previous mental health history.