Investigation into the circumstances surrounding the death of a man at HMP & YOI Parc in March 2006

Report by the Prisons and Probation Ombudsman for England and Wales

December 2007

This is the report of an investigation into the death of a man at HM Prison and Young Offender Institution Parc in March 2006. The man was found hanging in his cell from a ligature attached to a door. He had been remanded into custody awaiting sentence for various offences. He was 44 years of age.

I would like to add my personal condolences to those already expressed by one of my Family Liaison Officers on behalf of this office.

This investigation has been undertaken by three of my colleagues. I would like to thank the then Director of HMP & YOI Parc and his staff for their participation in the investigation. Particular thanks go to the Senior Residential Manager who acted as the establishment's Liaison Officer.

The Investigation Manager in the Health Inspectorate Wales was asked to undertake a review of the man's clinical care, and I also appreciate her assistance.

Several aspects of this investigation have caused me concern. There is clear evidence that the man should have been referred for a mental health assessment at an earlier stage. Once he was admitted to the prison's healthcare centre, and medical treatment was started, his behaviour improved. However, I agree with the clinical reviewer that the decision to subsequently discharge him from the healthcare centre was wrong. It does not appear any risk assessment was undertaken, no case conference was held and no medical discharge report was completed, as local policy demanded. I am also critical of where the man was located following his discharge from the healthcare centre. I make six recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **December 2007**

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SUMMARY

The man was 44 years old when he was found hanging in his cell at HMP & YOI Parc in March 2006.

The man was on remand awaiting sentence for drugs related offences and rape. He had initially been remanded to HMP Cardiff on 22 December 2005, and transferred to Parc the next day.

He had told staff at Cardiff that he had self-harmed 20 years previously by cutting his wrists, but said he had no current thoughts of self-harm or suicide. He admitted to drinking heavily and using illegal drugs. He was assessed as a low risk for sharing a cell with other prisoners, but was located in the Segregation Unit as a vulnerable prisoner (under Rule 45) due to the nature of the charges against him. When he arrived at Parc, a nurse assessed that he had no physical health problems and was not considered to be at risk of suicide or self-harm. The nurse again noted that he was dependent on drugs and alcohol. He applied for vulnerable prisoner status under Rule 45 and was located in the Vulnerable Prisoners Unit (VPU), D Wing. He did not indicate that he had any thoughts of self-harm or suicide during his induction at Parc.

The man saw a chaplain on 27 December 2005 and told him that he had taken an overdose and cut his wrists 20 years previously, but would not do it again. He had various induction appointments on 28 December: housing, legal services, bail and sentence planning. On 29 December, he saw a probation officer who completed an assessment of risk. He again said he had self-harmed 20 years previously while in custody, but had no current ideas of self-harm.

On 30 December, the man asked a member of healthcare staff for something to help him sleep. He said he was stressed and was having trouble sleeping. On 3 January 2006, he saw a doctor who told him there was nothing he could do to help. The doctor did not prescribe medication, nor refer him for a psychiatric assessment nor place him on any sort of observation. The doctor did not see him again until 19 March when the man had been placed on a F2052SH, a form used to monitor prisoners who are felt to be at risk of self-harm or attempting suicide.

On 6 January, the man saw a member of the Counselling, Assessment, Referral, Advice and Throughcare services (CARATS) which provides support and advice for drug misusers. He attended a drugs and alcohol awareness course on 2 February.

There were no significant events until March 19 when an officer opened the F2052SH. The man had told the officer that he had snapped a blade in his cell, with the intention of self-harm. He was also paranoid about other prisoners on the wing. In consultation with a doctor and a Registered Mental Health Nurse (RMN), it was decided that he should be managed on D Wing and not admitted to the healthcare centre. He spoke

to a chaplain and to Listeners (prisoners who are trained by the Samaritans to help other prisoners who are having difficulties).

On 20 March, the man still appeared to be paranoid about other prisoners on the wing and asked to speak to an officer about an alleged incident that he said happened to him whilst at Cardiff. He was seen by the nurse who had seen him the previous day. In the nurse's opinion, the man was suffering from paranoid symptoms and acute anxiety. He would not accept any further assistance from healthcare staff, but consented to an appointment with the consultant psychiatrist on 23 March.

On 21 March, the man told wing staff that he was not going to harm himself, but thought that somebody else would kill him. He did not say whom. He was adamant that he was going to be moved to another prison, although this was clearly not the case. He said that he would not move from Parc, but staff could not reassure him that there was no intention of him being moved.

On 22 March, the man was becoming more paranoid. He still denied that he intended to kill himself, but said someone on the wing was 'out to get him'. Again, he would not say who this was. He now said that he wanted to transfer to another prison, but only to another private prison as he believed an officer wanted to harm him. It was unclear whether his concern related to Parc or Cardiff.

Early on 23 March, the man started throwing objects around his cell. He said that a specific officer on the wing had put him in prison and was trying to kill him. He said he thought he would be killed either at Parc or at another prison. He wrote a letter saying that people were trying to kill him. His cell sharing risk assessment was reassessed, and he was felt to be a high risk with regard to sharing a cell with others.

Also on 23 March, the man saw a Community Psychiatric Nurse (CPN). The man told her that he was not sleeping and had lost his appetite. He said he would be driven by prison staff to hang himself and that prisoners were going to harm him. He added that he wanted to move prisons as he feared for his own safety. The CPN concluded that the man was suffering from a mental breakdown, and recommended his admission to the healthcare centre. The man was admitted to the healthcare centre that evening.

The man was prescribed antidepressant tablets on 24 March and started taking the medication from 25 March. He appeared more settled but still seemed to be paranoid. The man was supported by various chaplains and spoke to Listeners while he was in the healthcare centre. He remained in the healthcare centre until he was discharged back to D wing by a doctor on 28 March. He was located in a single cell on D wing due to the high risk identified in the cell sharing risk assessment.

On the morning of 29 March, during morning roll call, the man was found hanging from a ligature attached to the toilet door in his cell. Healthcare staff attempted to resuscitate him until paramedics arrived. The man was pronounced dead by a prison doctor.

The clinical reviewer concludes that an opportunity to help the man was lost early on when he asked for help in December 2005. She also considers that the decision to manage him on D Wing when he was placed on a F2052SH, rather than in the healthcare centre, was mistaken. She concludes that, by this stage, the man had severe mental health needs and should have been referred for a full psychiatric assessment. She suggests that guidelines were not followed and appropriate documents not completed when he was discharged from the healthcare centre back to ordinary location on 28 March. The review also says that improvements could be made to systems of recording and sharing information. The clinical reviewer makes two recommendations which I fully endorse.

THE INVESTIGATION PROCESS

1. My investigators studied all relevant prison records relating to the man who is the subject of this report. These included his main prison record, medical record and statements made by prison staff.

2. The Investigation Manager at the Health Inspectorate Wales was asked to carry out a review of the man's clinical care. I am grateful for this comprehensive review being undertaken in a most timely manner.

3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation, and to request a copy of the Post Mortem report. This records the cause of death as hanging. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

4. One of my Family Liaison Officers met with the man's family in the company of one of the investigators. The family told them of their concerns. They queried the man's discharge from healthcare shortly before he died, when they felt it was evident that he was still unwell. They questioned why the prison ceased all contact with them since the visit on 29 March informing them of the man's death. The family said that the prison agreed to pay the funeral expenses, but this was not done until December 2006. They also believe the man had a tie and an envelope of letters in his property, which have not been returned. They expressed concerns that letters from his former wife were given to him, as they believe the contents led to his mental state deteriorating.

5. The family also believe that the man was "plagued" by prison officers, and was treated differently because he was remanded for a sexual offence. They feel that, had he been treated better, he would not have taken his own life. Finally, the family also feel that the prison did not adequately address the man's mental health problems. I hope this report and the clinical review will provide them with answers to their questions.

6. My investigators discussed aspects of the man's treatment with both staff at Parc and the clinical reviewer. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity of contributing. Two prisoners responded to the notice and asked to meet the investigation team. During the course of the investigation, 19 members of staff were interviewed. Five prisoners were also interviewed, including the two prisoners who responded to the notice.

HMP & YOI PARC

7. Parc is a modern Category B local prison on the outskirts of Bridgend, 25 miles from Swansea. The prison opened in November 1997 and is the only private prison in Wales. It is managed by Group 4 Securicor (G4S). The prison offers a range of activities that aim to equip offenders with the key skills necessary to reduce the risk of re-offending after release. It currently has space for 1,036 prisoners.

8. Healthcare is sub-contracted to Primecare Forensic Medical Services. Primary care is delivered by doctors and nurses who have the opportunity to draw upon the broader expertise and range of healthcare services within Primecare Forensic Services and local NHS providers. There is an in-patient unit with 17 beds, all with integral sanitation.

9. In a full announced inspection in January 2006, Her Majesty's Chief Inspector of Prisons noted that the Inspectorate's previous inspection report described Parc as being a safe and respectful prison that was poised to move forward. However, the January 2006 inspection suggested that the prison had in fact moved backwards, with three changes of Director, and many key areas of work slipping. HMCIP found there were relatively low levels of use of force and segregation, but that procedures and policies were not sound enough to provide protection for vulnerable prisoners.

10. The inspection concluded that reception, first night and induction procedures were weak. It noted there were gaps in the management and support for prisoners at risk of self-harm or suicide and a good violence reduction strategy was not being operated properly on the wings. Nor were managers monitoring this. The previous inspection report, and Parc's self-assessment, was that staff/prisoner relationships were respectful and positive. It was therefore a considerable surprise to inspectors to find that prisoners had an extremely negative perception of staff, and some recounted instances of poor or dismissive treatment. Inspectors did not find examples of actively disrespectful treatment. But they did find that officers, on very lightly staffed units, did not routinely engage with prisoners, were not able to deal informally with their queries and needs, and were not actively supporting prisoners as personal officers or in implementing prison-wide strategies..

11. HMCIP wrote, "Though this was in many respects a disappointing inspection, we were clear that the prison was, once again, moving forward under a new Director and a clear management strategy. The pockets of good practice, resettlement, the juvenile unit and the Kainos wing, show what could be achieved, given motivation, leadership and resources but it is of some concern that Securicor, who managed the prison, and the Office for Contracted Prisons, had not taken decisive action earlier to halt and reverse the drift downwards. Parc can be a significant resource for Wales but, in order for that to happen, its role

needs to be clarified, and its contract examined to ensure that it provides the right incentives and sufficient resources for that role. There is now a Director of Offender Management for Wales, with direct oversight of Parc, and we would urge that she and her team undertake that task with some urgency, to ensure that progress this time is sustained."

12. My investigation team found that the prison was in the process of adopting the Assessment, Care in Custody and Teamwork (ACCT) system to support those prisoners at risk of suicide or self–harm. The Deputy Director explained the plans for training staff in the new ACCT procedures, which at the time of her interview were being rolled out. She said that, when she arrived in September 2005, she found that private prisons were experiencing difficulties with the roll out of ACCT as it meant contractual changes. She took the lead on resolving this issue in Parc, as it was becoming increasingly difficult and not good for standards of care that prisoners were coming into the prison on the ACCT system and then being transferred to the old F2052SH system. She explained that there were approximately 70 staff who had completed the foundation training and all the case managers were due to be trained imminently. She said that Parc was experiencing difficulties in getting some of their tutors trained in national procedures. She said this was not uncommon in contracted prisons, which sometimes struggle to obtain suicide and race relations training. Consequently this has hindered the speed at which the prison has been able to implement the ACCT procedures.

13. The Deputy Director said she had appointed a manager to oversee race relations and suicide prevention and, from 1 May 2006, a senior officer would be working permanently on the implementation of ACCT. She said, "the systems operating currently are fine and adequate and they meet the procedures but my view is that we should and can offer a great deal more by way of developing support, peer support and group work facilities for prisoners who are at risk of self harm. So I am actually not particularly content with just meeting the obligations I think we should be going further." She added that both the F2052SH and ACCT procedures are covered during initial training for new staff. She said, "staff are aware that it is my personal commitment to reducing suicide and self harm, so it has probably got I would say, a higher status now than perhaps it has ever had."

14. Before the man's death, my office had investigated five deaths from natural causes at Parc. Since the man's death there has been a further death from natural causes and another death that was apparently self-inflicted.

KEY EVENTS

15. After he was remanded in custody at Cardiff on 22 December 2005, the man was subject to a cell sharing risk assessment. He was considered to be a low risk for sharing with other prisoners (that is, he was suitable for multi cell location).

16. The man was advised that he could apply for Rule 45 (vulnerable prisoner status) due to the nature of his charges. However, he was in fact placed on normal location. The man admitted cutting his wrists 20 years previously, which was documented.

17. The First Reception Health Screen recorded the man as fit, with no significant physical history. It noted that he consumed 4-6 pints of cider every night. He also admitted to using amphetamines three or four times per week and ecstasy twice per month. He said he had last used both types of drug two days previously. The man answered 'no' to the question about harming himself. However, the section of the form used to record the impression of the prisoner's behaviour and mental state was not completed. Section 8 of the form noted that he had self harmed 20 years previously, but there was no further documented assessment or action at that time. I have copied this report to the Governor of Cardiff, highlighting this omission.

18. On 23 December, the man was re-located to the Vulnerable Prisoner Unit (VPU) under Rule 45. At Cardiff those segregated under Rule 45 are located in the segregation unit, until alternative accommodation can be found at another establishment. The segregation dossier was not completed in full and there is no name of the officer who completed the form. A nurse signed the safety algorithm and noted that the Duty Governor had been informed. The algorithm recorded that the man would not be able to cope with a period of segregation. He was therefore transferred from Cardiff to Parc the same day. The security risk assessment boxes on the Prisoner Escort Record (PER) do not indicate violence, the nature of his offence or that he was vulnerable due to his offence.

19. The transfer in check list at Parc was completed by the staff nurse. There were no physical health problems noted, but it was again recorded that the man had last taken 'speed' and ecstasy on 19 December. The nurse also completed the New Admission Risk Assessment form. The man did not mention any ideas of suicide or self harm at this time.

20. The first night compact, completed by the reception officer, said the man had been in prison before, was literate and numerate with no special needs or mental health problems, and no history of self-harm. (This directly contradicted what the man had told staff at Cardiff.) However, he had concerns about his ex-wife, which were linked to his offence. The man again applied for vulnerable prisoner status, after

telling his cellmate about the nature of his offence. The man said he feared for his safety and spoke to the Duty Governor who placed him on Rule 45. His cell sharing risk assessment was completed by a prison officer, the staff nurse and the reception officer. They assessed him as a medium risk of sharing a cell with others. (Medium risk meant there was no immediate risk, but the situation would need to be reviewed regularly.)

21. On 24 December 2005, the man's initial induction was completed by the induction officer who did not note any immediate concerns or problems. The officer told my investigators that the man co-operated fully with the induction and his emotional state seemed to be "normal". The man said he was happy with the progress on his case and denied the rape charge. He said he had no self harm tendencies and no history of self harm. He again admitted to regular use of ecstasy, amphetamines and above average quantities of alcohol.

22. On the same day, the reception officer was identified as the man's personal officer. The man was located in the VPU, D Wing. The induction officer noted that the man appeared "at ease with his surroundings". No concerns were recorded in his first 48 hours on D Wing. (There are three entries by the personal officer on the man's core record: 16 January 2006, 27 January and 22 March.)

23. On 27 December, the man had a routine induction meeting with a member from the chaplaincy. The man told him he had taken an overdose and cut his wrists 20 years ago, but would not do it again. On 28 December, he had housing, legal services, bail and sentence planning interviews. On 29 December, an induction assessment of risk was conducted by a probation officer. The assessment noted that the man had been in custody 20 years previously and had self-harmed 20 years ago, outside prison, as a reaction to splitting up with his girlfriend at the time. He refused to accept responsibility for his offence. He said he did not have any thoughts of self harm at the time. He again admitted to drinking five to six cans of alcohol daily and using six to seven grams of ecstasy and speed weekly.

24. On 30 December, a safer custody assessment was completed by the wing officer. This recorded that 20 years previously the man had cut his wrists and taken an overdose, but said he had no current thoughts of self-harm. The man later went to the medication hatch. He said he was unable to sleep and was feeling stressed and anxious. An appointment was made for him to see the medical officer.

25. The man saw the prison doctor on 3 January 2006. Again, he wanted something to help him sleep and said he was feeling depressed about being in prison. The doctor wrote in the medical record, "I have told him there is nothing I can do to help him." He said in interview that the policy in the prison is not to prescribe sleeping tablets, but to get to the root of the problem and see what is causing the anxiety and

sleeplessness. He said that most prisoners who arrive in prison say they are depressed and the aim is to establish, through observation over a period of time, which prisoners are genuinely depressed. He did not prescribe any medication for the man nor refer him for a mental health assessment, and the man was not placed on any formal system of observation. The doctor did not have any further involvement with the man after this meeting until 19 March when the man was placed on self harm monitoring procedures.

26. The man was seen by a mental health nurse on 20 March and agreed to see the consultant psychiatrist on 23 March. He in fact saw a member of the mental health in-reach team on 23 March having been referred by another nurse that day. He was apparently not prescribed antidepressants until 24 March.

27. Some notes in the man's medical records are dated out of order or the date has been changed.

28. On 6 January 2006, the man was given an induction to CARATS. The CARATS worker noted the man's history of substance misuse and assessed him as being alright at the time. He subsequently completed a drug and alcohol awareness course on 2 February.

29. On 9 January, the man appeared at the Crown Court. The escort record for his transfer from Parc to the court notes that his bail application was withdrawn. No problems were noted and the security risk assessment classifies him as vulnerable due to the nature of his offence.

30. On 11 January, a general application was sent in by the man's cellmate, reporting that the was man was bullying him. The man was subsequently moved from that cell and no further action was taken. On 16 January, the man was noted as being aggressive and abrupt on the wing, but was seen to participate and mix with others during association.

31. On 23 January, the man again appeared at the Crown Court. The escort record again categorised him as violent and vulnerable due to the nature of his offence. On 27 January, it was noted by his personal officer that the man was becoming a "drain" on staff time with his disruptiveness.

32. There were no significant events reported until 1 March when the man was given a direct order not to contact his ex-wife or daughter. He was told that all mail would be subject to security checks and any mail to his former wife and his daughter would be stopped. It was noted that he was attempting to contact them through his sister and friends, and was told he would be placed on a disciplinary report if he continued. It is unclear whether he received any incoming mail from his former wife.

33. On 17 March, the man appeared at the Crown Court and was again remanded in custody under section 92 of the Sexual Offences Act 2003. The escort record appropriately identified the presenting risk factors.

34. On 19 March, the man was placed on a self harm monitoring form (F2052SH) by the second wing officer. He spoke to the officer regarding his mental state. He told the officer that he had snapped a blade in his cell with the intention of self harming. He was noted to be very low in mood and afraid of the impending court case. He also felt that other prisoners on the wing were asking him too many questions and he was said to be worried that one prisoner on the wing was a police officer trying to obtain information from him. It was decided by the officer, in consultation with the prison doctor and the duty nurse, to manage the man on the wing and to review him within 72 hours. The man asked to speak to Listeners and a care plan was started to help him, including advice and support from healthcare and the chaplain. The healthcare assessment was completed by the doctor. His assessment noted that the man was depressed and having suicidal thoughts. He recommended 30 minute observations. Observations began at 10.20am, as noted in the daily supervision and support record, by the second wing officer. The man was apparently in a very low mood and spoke to Listeners on two occasions. The clinical review considers that the man was clearly suffering from extreme mental illness at this stage, and should have been admitted to the healthcare centre for a detailed psychiatric assessment and, if necessary, to start treatment.

35. On 20 March at 4.30am, the man asked the induction officer for his cell door to be opened so he could speak to staff about an alleged incident that he said happened while he was at HMP Cardiff. He was told that he would have to wait until the next morning. He did not want to speak to a Listener and the induction officer said in interview that the man seemed alright with that. At around 11.00am he saw the duty nurse on the wing. The nurse concluded that the man was displaying paranoid symptoms and acute anxiety (he was due in court again the following week). The man was unwilling to accept assistance from healthcare, but agreed to see the consultant psychiatrist on 23 March. Support was to continue on the wing until that appointment. At 9.15am, the man was moved from the cell to share with another prisoner. The move appears to have been authorised by the senior manager.

36. At 3.10pm, the man was visited by the chaplain with whom he had a long conversation which she recorded as “making little sense”. She noted he was paranoid and said he was not feeling safe, and she found it difficult to reassure him. At 11.00pm, the man again asked the induction officer if he could speak to staff, saying that he was worried people were out to get him. However, he could not explain why he was concerned or by whom he felt threatened. The induction officer said that, as the man was being very persistent, he asked a senior manager

to speak to him. The induction officer recorded in the man's F2052SH that he felt "somebody was out to get him on the unit and in his place of work", but could not explain why this was or whom he thought the person was. He said there had been no direct threats made against him. It is also noted that the man settled down and had a quiet night.

37. On 21 March, the man went to the wing office to tell staff that he was not going to move prisons as he thought there would be somebody waiting to kill him. He said he was not going to kill himself, but someone else would kill him. An officer spoke to him and noted that the man was adamant that he was going to be moved to another prison. The officer explained to him that this was not the case.

38. On 22 March, in the early hours of the morning, the induction officer noted in the F2052SH that the man asked again to speak to staff urgently. Due to the man's persistence, the officer arranged for his cell to be opened by the senior manager, who once again spoke to the man. The officer's note says that, when the man was spoken to, he did not make much sense. The man said he wanted to get out of prison. He was advised that he was wasting staff time and was told to take up any issues with the day staff. He had a supervised shave at 8.00am and his personal officer noted "no concerns". Later that day, at 10.00am, a F2052SH review was completed by the second prison officer, the personal officer, and the safer custody officer. During the review, the man denied any thoughts of self-harm, but said there was someone on the wing out to get him (he did not say whom). He now said he wanted to transfer, but not to a public sector prison as he believed there was an officer out to get him. The man also said he felt officers on the wing had been telling prisoners things about him. The man was paranoid that someone was "out to get him". The outcome of the review was that the F2052SH was to remain open and be reviewed in 14 days' time. The support plan was for 30 minute observations and continued assistance from healthcare, wing staff and Listeners.

39. On 23 March at 5.45am during roll count, the third wing officer put the light on in the man's cell to check him and he "jumped up" and shouted, "what are you doing, what do you want?" At 5.55am, the man pressed the intercom and asked to see security. He seemed to think that the second wing officer had put him in prison and was trying to kill him. The officer explained to him that he could not open the door unless it was for a medical emergency. At 6.00am, the man started throwing things around his cell. The second wing officer reassessed the man's cell sharing risk assessment and increased it to high risk due to the man's anxieties and his "smashing his cell up". The man said he thought he was going to be killed either in Parc or when he moved to another prison. Section 7 of the cell sharing risk assessment stated that the man's anxieties were starting to worry all prisoners who shared with him.

40. Prisoner A, the man's cellmate, said that in the evening of 23 March he complained that he was distressed but still had to stay in the cell overnight with the man. He said the man told other officers and prisoners that everyone was out to get him and he was clearly scared of something. He said the man became very agitated during the night of 23 March, but staff took no action other than to tell him he would see a governor. Prisoner A alleged that the second wing officer opened the cell in the morning (24 March) and started shouting and swearing at the man. However, prison records say that the damage to the cell occurred in the morning of 23 March and it has not been possible to reconcile the conflicting accounts.

41. The senior manager was on the wing at this time. The man had written an undated letter saying that people were trying to kill him. It appears the letter was in fact written on 23 March. At 6.10am, it was documented that he was still paranoid and the manager had suggested he should be seen by healthcare and possibly removed from the wing. The man was also placed on a disciplinary report for smashing his television. The duty nurse was called to see him She said in interview that she recalled he was non-compliant with his medication. She said she spoke to him for about an hour and, in her opinion, he was paranoid and anxious and convinced staff were going to kill him. The man was referred to the mental health in-reach team, and was seen by a Community Psychiatric Nurse (CPN). She was concerned about his mental state, as he told her he might not be able to maintain his own safety. The CPN undertook a comprehensive assessment of the man and, in the clinical reviewer's opinion, she recognised the seriousness of his condition.

42. The CPN contacted healthcare by telephone. She recalled that she spoke to the wing nurse who agreed that the man was to be admitted for observation and respite. He was then to be reviewed further by doctors with a view to prescribing medication. The CPN's detailed assessment noted the man felt that officers were driving him to kill himself. He said that he would hang himself. He also felt that other prisoners in the workshop might harm him as he had told everyone why he was in prison. It was noted that the deterioration in his mental health had only started to occur in the last two to three weeks. He had lost his appetite and was not sleeping. He wanted to move prisons, as he feared for his own safety. The CPN recommended that the man be moved to healthcare and be given antidepressants immediately. On her assessment form, she stated, "The man's presentation is conclusive of a mental breakdown and he is mentally unstable." Both forms mention increasing the level of observations to 15 minutes. This was discussed at the Care Team Meeting and the duty doctor agreed to review the man on the following Thursday (30 March).

43. The man was admitted to healthcare at 6.05pm. It was noted that he appeared quite paranoid. The man kept asking if the cell doors were secure to stop people coming in to kill him. A member of healthcare

staff tried to reassure him and he said that he had no current thoughts of self-harm. He slept through the night but remained on 30 minute observations despite the recommendation of the CPN to increase the frequency.

44. On 24 March at 8.15am, the F2052SH was reviewed by the wing nurse and another nurse. The man refused to attend the review. It was decided to maintain an ongoing assessment of his mental state. He was prescribed a course of antidepressants, Cipramil. The support plan was to maintain 30 minute observations as required, for the doctor to review him, and for one-to-one support from the chaplain and Listeners. The man later had a visit from the chaplain who noted that he was still low in mood and felt everybody was against him. The man was also worried about his pending court case and seemed to be beginning to realise what he had done. He was assured of continuing chaplaincy support.

45. The man was reviewed by the prison doctor who noted that he was convinced there were people out to get him who would make him take his own life. The doctor noted that the man refused to take any antidepressants that day. The doctor explained in interview that, if a prisoner refuses to take medication such as antidepressants, he would expect the registered mental health nurses to speak to the prisoner to establish what the problem is, why they are not taking their medication and to try to persuade them to take it. From his medication chart, it appears the man was prescribed his medication on 25, 26, 27 and 28 March and there is no documentary evidence that he refused to take it on those days.

46. On 25 March, the chaplain visited the man again and noted that he was "a little brighter than yesterday but still not happy. No concerns raised." The man asked to see a Listener at 12.41pm. Two officers brought two Listeners to speak with him. The nurse on duty documented that the man had had a good day: "mixes well with staff while out on association." At 10.35pm, another chaplain visited the man and noted, "The man appears low in mood. Difficult to get him to engage in conversation but he did say that he feels safer now he is in healthcare." A care plan review was undertaken on the 25 March and noted that the man was to "remain in the healthcare centre, supported by the CMHIR [Community Mental Health In-Reach] team."

47. On 26 March, it was noted by the nurse on duty that the man had another good day, had been talking to staff for long periods, playing pool, and there were no problems to note. At 9.10pm, he asked to speak to a Listener but later decided he no longer wanted to.

48. On 27 March at 10.00am, the man was seen by another chaplain. He recorded that the man was, "Convinced an officer is trying to kill him. Explained that 'they' would blind him with sugar water and cut out his

tongue. It is difficult to know whether this is genuine or … from a drug induced psychosis. He is not making threats to self-harm however."

49. On 28 March, a chaplain saw the man at 9.00am. He noted that the man was concerned about the noise on the unit, but the chaplain reassured him it was because it was being cleaned and things would soon settle down. The next entry is from the CPN who reviewed the man. She noted that the man was expressing paranoid fixed beliefs that his "safety was at risk from others." However, he appeared less distressed than on 23 March. The CPN noted that there was a discussion about the man returning to D Wing, but it is not clear with whom the discussion took place. The CPN recommended that a full risk assessment be carried out before the man was transferred back. The duty doctor was to review him on 30 March.

50. There is no evidence that a risk assessment was carried out before the man was discharged back to D Wing. The medical record notes that the man was fit for normal location and is signed by the prison doctor. Section 4.14 of the prison's Operational Policy Standard and Procedures for Suicide Prevention refers to case conferences. It says that a case conference should be held prior to discharge from the healthcare centre to a 'normal' location. The purpose is to agree a location and support plan. It should be organised by the suicide prevention co-ordinator and chaired by a healthcare representative. Section 4.22 says that prisoners on an open F2052SH in the healthcare centre can only be moved to another residential area <u>after</u> a case conference has been held. Information used in the case conference should include reports from medical staff, healthcare officers, counsellors and other significant areas. All details of the case conference should be entered into the case conference report, using the approved form.

51. There is no evidence that a discharge report was completed for the man, as required. Nor is there any evidence that a case conference was held, as per section 4.22 of the prison's Operational Policy Standard and Procedures for Suicide Prevention. In his interview, the prison doctor said he was not aware that he needed to organise a case conference and complete a discharge report. He said he assumed that the F2052SH would continue and the man would remain on 30 minute observations. An entry from a nurse notes that the man was discharged to D Wing, "following being seen by Medical Officer and CMHIR team."

52. The man was discharged back to D Wing from healthcare at 3.03pm and arrived there at 3.05pm. He was initially located in a double cell and was then moved to a single cell (cell 39) at 3.43pm. A cleaning cupboard is located by cell 39 and consequently the observation hatch into the toilet area of that cell is obscured. The cell also has a toilet with a door. Section 2.2.1 of the prison's Operational Policy Standard and Procedures for Suicide Prevention states: "Consideration should

be given as to whether those prisoners on an open F2052SH should be located in cells without toilet doors (to remove a possible ligature point). The decision must be well documented in the F2052SH. In cases where these prisoners are in single cells, location in a cell without a toilet door should be considered the norm."

53. I note that some of the F2052SH observation record sheets are undated, which makes it impossible to confirm whether 30 minute observations were carried out each day as per the operational requirements.

Events on 29 March

54. The third wing officer was on night duty on the evening of 28 March from around 8.30pm. He said he was surprised that the man had returned from the healthcare centre, considering his erratic behaviour on 23 March. He said he was told by staff on handover that the man had been discharged from healthcare, but did not say he was behaving strangely and did not note any concerns. He said he went to check the man at around 8.50pm, looked through the spy hatch and saw him standing with his arms folded, watching television. The officer asked him if he was alright and the man replied, "yeah, why?" The officer said he checked the man again at around 9.00pm and continued with his checks every half an hour.

55. The F2052SH supplement log is ticked and signed by the third wing officer to show 30 minute checks from 8.30pm on 28 March to 6.30am on 29 March. He stated that he turned the cell light on every time he checked on the man.

56. The third wing officer recalled that the man watched television until around 10.00pm, when the lights were turned out. He said he saw the man's feet sticking out of the bottom of his bed at around 2.00am and that, when he checked him at around 3.00am, he had moved to a different sleeping position in bed. He said that the man had moved from lying on his front to lying on his right hand side. Entries made in the man's F2052SH, by the officer, are as follows:
    8.45pm –"Checked by night officer at start of shift. Standing by his bed watching TV."
    2.00am (29 March) – "Appears asleep lying on his front, movement noted."
    3.45am – "Lying on right side still fast asleep."
    6.00am – "Appears to have slept all night. No concerns raised during night state."

57. The duty officer arrived on D Wing at 6.45am to start her shift, and at around 6.50am she started the F2052SH checks. She went to the man's cell and looked through the spy hole. Initially, she could not see anything as it was too dark. She switched on the light and observed what seemed like him asleep in bed, wrapped in his duvet. She

became concerned when she could not observe any movement. She said she then "jingled her keys in the lock trying to provoke some response." There was still no response so she opened the cell door. As she made her way towards the man's bed, she observed him out of the corner of her eye. She immediately called a 'Code Red' emergency on her radio. The man was found hanging from the inside of the toilet door by a ligature made with a bed sheet.

58. His personal officer arrived almost immediately and supported the man while the duty officer ran to get a first aid kit from the wing office. The duty officer then cut the ligature and the personal officer laid him on the floor. At 6:53am, healthcare was informed by the control room of the 'Code Red' and a call was put out for the Duty Manager. At around 6.55am, nurse1 arrived, followed by nurse 2. Nurse 1 commenced Cardiopulmonary Resuscitation (CPR). When nurse 2 entered the cell, the man was lying on his back on the floor and nurse 1 was giving chest compressions. At 6.56am, an ambulance was called. Nurse1 and nurse 2 gave oxygen therapy and applied the defibrillator. It was noted that the man's body was cold and rigid and no shock was advised throughout the CPR cycles. They continued giving chest compressions, taking it in turns to complete 15 compressions each. At 6.57am, the Duty Manager arrived to manage the situation.

59. At 7.00am, the duty officer was relieved of her role by the second wing officer. Nurse1 and nurse2 continued with CPR until the paramedics arrived at around 7.10am and advised against further action. At 7.12am, the paramedics pronounced the man dead.

60. The man was certified dead by the prison doctor at 8.15am. The post mortem gives the cause of death as hanging.

61. At around 9.15am, a post incident debrief was held in the prison's conference room for all staff involved.

62. Shortly after the man's death, the duty officer, the man's personal officer and the third wing officer wrote incident reports. Parc's emergency orders for dealing with a death in custody and role briefs require the Duty Governor and Orderly Officer to ensure that all witnesses remain in the vicinity for taking of statements. There are no incident reports or statements from nurse1 and nurse2.

63. At 10:20am, the man's body was removed from the cell by the undertakers and taken off the unit.

64. One of the chaplains contacted the man's sister by telephone at approximately 8.15am and advised her of her brother's death. The chaplain made further contact throughout the morning. At approximately 1.00pm, another chaplain arranged with the man's brother that prison representatives would visit the family at around 2.00pm. At that time, the brother questioned why the prison had

broken the news of his brother's death over the telephone. The chaplain explained that the prison did not have an address or telephone number for the man's stepfather who was recorded as his next of kin, but had contact details for his sister. The man's family (his brother, two sisters and their partners) were visited by a Senior Residential Manager, along with one of the chaplains and the Deputy Director that afternoon.

ISSUES

The family's concerns

65. Although the family suggested that contact from Parc ceased after they were advised of the man's death, the prison maintains that ongoing contact and support was offered to the family through the family liaison officer and the chaplains at the prison.

66. The family believe there was a tie belonging to the man and an envelope of letters in his possessions. The prison has no record of such property. The Coroner has advised that the man's family should put a formal request in writing, asking the Coroner if he has the property and, if so, requesting its return after the inquest is closed.

67. The prison agreed to pay for the funeral expenses. However, the expenses were not paid to the family until December 2006.

    The Director should remind senior colleagues of the importance of maintaining good contact with the family and the timely administration of offers of support, financial or otherwise.

68. The family believe that the man was "plagued" and treated differently by prison officers because of his alleged sexual offence. They felt that, if he had been treated better, he would not have taken his own life. My investigation has found no supporting evidence to suggest that the nature of his offence affected the man's treatment by any prison staff.

69. The family also asked why letters from the man's ex-wife were given to him. The family believe that the content of such letters led to a deterioration in his mental state. My investigation found no substantive evidence that the man received any letters from his ex-wife. However, it remains to be seen if the Coroner has in his possession any letter, and who these were to or from. It is known that the man had tried to write to his ex-wife and daughter, despite a court order prohibiting him from doing so.

Clinical

70. The clinical review was undertaken on behalf of the Health Inspectorate Wales, under the arrangements agreed by my office with the Welsh Assembly. The reviewer draws attention to a number of issues and has made recommendations which I endorse.

71. The initial reception healthscreen at Cardiff on 22 December 2005 did not make any comment about the man's behaviour or mental state. The clinical reviewer considers this would have been helpful "for someone who drank alcohol to excess and used drugs regularly. A person dependent on alcohol and drugs, when these are suddenly denied, such as on entry to prison, may exhibit other mental health

problems."

72. The man was not helped when he asked for medical help to assist him sleeping on 30 December. The reviewer says that "healthcare staff should have been more understanding and commenced referral at this stage for a mental health assessment." She suggests that in the community some form of medical intervention would have been commenced. As it was, antidepressant medication was prescribed for him on 24 March, which he received from 25 March.

73. There is no documentary evidence to show that a risk assessment was carried out on 19 March after self-harm monitoring was started for the man, even though he was referred to the healthcare centre. The clinical reviewer considers that the man should have been classified as high risk and admitted to the healthcare centre at this time for his own safety and to start treatment. She concludes that the decision to continue to manage him on D Wing was wrong. In her opinion, he was clearly suffering from extreme mental illness and should have been referred for a psychiatric evaluation from 19 March. Furthermore, staff appeared to ignore the verbal and written threats that the man made to kill himself. The clinical reviewer considers that, following the man's assessment by the CPN on 23 March, the seriousness of his illness was recognised and the CPN correctly recommended his admission to the healthcare centre. She concludes that it can be seen from the man's medical notes that, once medical treatment was started, his behaviour became calmer. However, she considers that the decision to discharge him on 28 March was mistaken and says it does not appear any risk assessment was undertaken, no case conference held and no medical discharge report filled in, as demanded by local policy. In his interview, the prison doctor said he assumed that the man's F2052SH would continue and he would be kept on 30 minute observations. He said he was not aware of the need for a case conference and discharge report to keep discipline staff informed.

74. This local policy was reviewed after the man's death and Primecare issued a memorandum, reinforcing the proper process for staff to follow when any prisoner on an open F2052SH or ACCT is discharged from the healthcare centre back to a wing.

    The Director and Healthcare Manager should undertake a self-audit of the self-harm documentation to ensure compliance with agreed procedures by healthcare staff.

75. According to the clinical reviewer, the prison doctor has agreed to undergo further training and Health Inspectorate Wales will keep a watching brief on his performance. She has also written to Primecare Forensic Services and they will monitor the quality of care delivered.

76. During another investigation, the clinical reviewer interviewed the

healthcare manager and another medical officer about the processes and training for doctors dealing with mental health at Parc. She was satisfied that the systems for referral and treatment of prisoners were robust. Health Inspectorate Wales are offering training days for healthcare staff from all the prisons in Wales in February 2007, and the Welsh Assembly has recently issued updated guidelines for the treatment of mentally ill prisoners.

77. The clinical reviewer also draws attention to the fact that paperwork was poorly completed. Some F2052SH observation record sheets are undated, which makes it impossible to confirm whether 30 minute observations were carried out. The clinical reviewer also notes that, "there are … some entries in the medical notes which are dated out of order or the date has been changed." This was also a feature found in two earlier reports from my office on deaths from natural causes at Parc.

    The Director and Healthcare Manager should remind staff of the need for clear, concise and contemporaneous record keeping (records made at the time) in relation to completing F2052SH paperwork, as per the prison's Operational Policy Standard and Procedures for Suicide Prevention.

    The Healthcare Manager should remind staff of the need to complete medical notes appropriately and in accordance with the guidelines of the professional bodies for doctors and nurses with regard for the expected standards of records and record keeping.

The man's behaviour in prison

78. It is recorded that, early on the morning of 23 March, the man caused damage to the cell and threw his television set to the floor. Prisoner A, his cellmate, said that this happened late in the evening of 23 March and complained that he was distressed by events but had to stay in the cell overnight with the man.

79. Prisoner A said the man told other officers and prisoners that everyone was out to get him and he was clearly scared of something. He said the man became very agitated during the night of 23 March, but staff took no action other than to tell him he would see a "governor". Prisoner B said that the second wing officer opened the cell in the morning, and started shouting and swearing at the man. However, prison records state that the damage occurred in the morning of 23 March and it has not been possible to reconcile the conflicting accounts between staff and prisoners.

80. Other prisoners commented to my investigators about the man's interactions with the second wing officer and the fourth wing officer. Prisoner B works as a quality controller in the industry workshops where the man worked for a time. He said that it was clear to him that

the man was gradually becoming more paranoid. In his opinion, the man should not have been working in the workshop where there were sharp tools such as screwdrivers. According to the prison, the man worked in an industry workshop until 3 March 2006 when, due to increased risk, he was moved to work in a press room where electrical parts are assembled. Prisoner B thought that the man was becoming paranoid towards the middle of March when he said that the second wing officer was threatening him. Prisoner B said that he told the fourth wing officer that the man was in a bad way and, in his opinion, the man should not go to work. Prisoner B said that the fourth wing officer told him to mind his own business and told the man, in a gruff way, to "wake his ideas up." Prisoner B said that there were no other witnesses to this exchange between the man and the fourth wing officer and he did not mention it to any other members of staff.

81. Prisoner B recalled that the second wing officer sent the man back to work on occasions when, in his opinion, the man was sick. He said that he felt that the second wing officer bullied the man, asking him where he was going and what he was doing. Prisoner B said he spoke to the landing officer and told him that the man should not be on the wing but in the healthcare centre. He said the officer told him he was not qualified to make such observations. He added that, on 28 March, when the man came back from the healthcare centre, he asked him if he was going to work the next day. The man replied, "no, I won't be around." Prisoner B assumed that the man meant that he was going to be moved from the prison. Finally, prisoner B said he is a light sleeper and the man's cell was located close to his. Despite this, he said he did not hear any checks being made by staff during the night of 28 March.

82. Another prisoner, prisoner C, said that the man gradually became agitated during the time he was in prison. He said that, two days after he was admitted to the healthcare centre, the man was taken off sick leave by the second wing officer who sent him back to work at the workshop. According to the prison, the man was signed off work when he was located in the healthcare centre. Prisoner C said he never heard the man say he was going to kill himself. He said he was aware that the man had problems with the second wing officer, although he did not himself observe any interaction between the man and the officer.

83. A third prisoner, prisoner D, said that the man did not have a good relationship with staff on the wing. He added that the man appeared to "have a general dislike of staff," although he did not mention anyone in particular. He said he heard the man and the second wing officer having a "shouting match" when the man smashed his television. In his opinion, the second wing officer has an attitude problem. He said that the man did have behavioural problems and was convinced that others were out to get him. The man visibly deteriorated during the time he knew him and it was apparent before he went to the healthcare

centre that he was withdrawn and deeply confused. He said that the man was pleasant when he was on association, but could be difficult and aggressive in a one-to-one situation. He was surprised that the man was discharged from the healthcare centre on 28 March.

84. A Listener said that the man did not have any problems on the wing between January and most of February, but towards the end of February he went into himself and became angry and his mood was very "up and down". He said that the general talk on the wing was that the man thought that everybody was out to get him, including Listeners, and that his food was being poisoned. He said that the man did not tell him this personally, he heard others talking about it. In his opinion, the man's mental state had deteriorated before he went to the healthcare centre in March and he was discharged too soon. He said he spoke to the man - as a fellow prisoner, not as a Listener - on 28 March and asked how he was. He said the man told him he was "OK" and knew what was going to happen. When he asked the man what that meant, the man said he knew the answer. The listener said that the man appeared a lot calmer at that stage. He said, "In my opinion the second wing officer dealt with him appropriately and was just doing his job. He did not treat him any differently to any other prisoner. I think staff dealt with him appropriately."

85. Given the man's apparent paranoia in relation to the second wing officer, it might have been prudent to limit their contact. The second wing officer would have been protected against accusations and the man's distress could have been eased. The second wing officer said in interview that he was patient with the man and did his best to help him. The investigation did not find any evidence to confirm prisoners' suggestions that the second wing officer's treatment of the man was inappropriate. Nevertheless, the investigators suggested to the Director that he might wish to investigate the expressed concerns further. The Director subsequently informed my office that after due consideration he felt there was insufficient evidence to warrant a further investigation.

Location

86. The man's location when discharged from the healthcare centre was clearly inappropriate. He was initially located in a double cell and was then moved to a single cell where the observation hatch into the toilet area of that cell is obscured. The cell also has a toilet with a door. The man's location was clearly contrary to the prison's Operational Policy Standard and Procedures for Suicide Prevention.

The Director should remind all staff to consider carefully the location of prisoners at risk of self-harm and suicide and ensure they document the rationale behind the decision making process.

Personal officer scheme

87. I must also comment on Parc's personal officer scheme. The personal officer saw the man on 24 December. There are three further entries which indicate that he saw the man on 16 January, 27 January and 22 March 2006. This clearly falls short of the policy as described in the prison's Operational Policy Standard relating to the personal officer scheme. This states (paragraph 3) that, "personal officers should talk to their allocated prisoners at least weekly to discuss any problems or concerns and help them access any services they require, prisoners should be encouraged to talk about their offending behaviour and its consequences for others as well as themselves. Regular entries, at least weekly must be made (in the prisoner's greens [i.e. history sheets]) identifying any significant events, summary of discussions and developments relevant to the prisoner." Appropriate and regular entries in prisoners' history sheets are an essential tool for all staff and should be seen as a core task.

The Director should develop a self-audit process to ensure that personal officers are complying with local policy and making timely and meaningful entries in prisoners' history sheets.

RECOMMENDATIONS

The Director should remind senior colleagues of the importance of maintaining good contact with the family and the timely administration of offers of support, financial or otherwise.

The Director and Healthcare Manager should undertake a self-audit of the self-harm documentation to ensure compliance with agreed procedures by healthcare staff.

The Director and Healthcare Manager should remind staff of the need for clear, concise and contemporaneous record keeping (records made at the time) in relation to completing F2052SH paperwork, as per the prison's Operational Policy Standard and Procedures for Suicide Prevention.

The Healthcare Manager should remind staff of the need to complete medical notes appropriately and in accordance with the guidelines of the professional bodies for doctors and nurses with regard for the expected standards of records and record keeping.

The Director should remind all staff to consider carefully the location of prisoners at risk of self-harm and suicide and ensure they document the rationale behind the decision making process.

The Director should develop a self-audit process to ensure that personal officers are complying with local policy and making timely and meaningful entries in prisoners' history sheets.

Comments from Prison Service:

The Prison Service were invited to comment on the draft report. The draft report was amended to take into account comments received from the second wing officer. There are no other comments from the prison service.