

**Investigation into the death of a man
at HMP Swansea in June 2012**

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

April 2013

This is the report of an investigation into the death of a man at HMP Swansea in June 2012. The man was found hanging in his cell just five days after his arrival in the prison. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A review of the clinical care which the man received in prison was undertaken. Swansea cooperated fully with the investigation.

The man arrived at Swansea on 9 June and was held on the recently created drug recovery wing. He was subject to self-harm monitoring from the time he arrived as he had recently taken a drug overdose, was very emotional and was withdrawing from alcohol dependency. He was prescribed medication to treat alcohol withdrawal symptoms and was seen regularly by a mental health nurse. Appointments were booked for him at the mental health and alcohol clinics. The chaplaincy was counselling him about a recent bereavement.

The man became distressed in June, after some upsetting telephone calls with his partner when she indicated she wished to end their relationship. Prison staff tried to calm him down and took some practical steps to support him. However, an ACCT review was not held to consider the frequency of the man's self-harm monitoring checks, even though the breakdown of his relationship was recorded as a trigger for an immediate review.

HIW found that all those involved in the man's care acted professionally and appropriately. They considered that the man's death was neither foreseeable nor preventable. I agree that the man received appropriate care at Swansea. Although I would have expected a review of the man's risk after the distressing phone calls earlier in the day, it appears his fatal act was an impulsive action which would have been difficult to predict.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

April 2013

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SUMMARY

1. The man was arrested on 8 June 2012 and was remanded into custody at HMP Swansea the next day charged. A nurse began self-harm monitoring when he arrived, because of his emotional state. The man went to the drug recovery wing because of his substance misuse and received medication for alcohol withdrawal. The man shared a cell with a prisoner he already knew. A senior officer required staff to observe the man whenever they moved around the wing at night.
2. On 10 June, a mental health nurse assessed the man and made appointments for him at the primary mental health and alcohol clinics for 21 June and 9 July. He referred the man for further assessment by the mental health in-reach team. A doctor prescribed more medication and the man was checked again by the mental health nurse as he was tearful. He had a self-harm monitoring assessment and a first case review. The case manager set the level of observations at once every two hours during the day. He recorded on the self-harm monitoring document (ACCT) that the trigger for a further case review would be a breakdown in the man's relationship. The next review was scheduled for 14 June.
3. On the day of the man's death he saw the mental health nurse and spoke to the chaplain. He telephoned his partner and ended the call in a very agitated state. An officer calmed him down and called his partner to agree that they would not speak to each other for 24 hours. However, the officer noticed the man telephoning his partner again later that afternoon.
4. At about 6.15pm, the man made two further short calls to his partner. They argued and spoke about the end of their relationship. At about 6.40pm, an officer let him into his cell. The man was later observed by the same officer alive inside his cell at about 7.00pm. He was found hanging in his cell at about 7.25pm. Despite efforts to resuscitate him, by prison staff and paramedics, the man did not recover and was pronounced dead. He left a note in his cell.
5. Our investigation has identified some concerns about the way prison staff dealt with the man's distress on the day he died. An officer helped him in a sensible and constructive manner, but there was no case review although relationship breakdown had been noted as a trigger for a review to be held. There were other problems with ACCT management. Healthcare staff did not always make entries in the ACCT document when they saw the man wing staff did not make the expected number of ACCT observations on the day and one officer made an entry in the ACCT document on behalf of another.
6. Although the man reported auditory hallucinations, these do not appear to have been properly assessed. After the man was found hanging officers did not use the relevant emergency radio code and did not hold a staff debrief meeting as required. We make seven recommendations.

THE INVESTIGATION PROCESS

1. The investigator was informed of the man's death on 14 June 2012. Notices about the investigation were issued to staff and prisoners at HMP Swansea. Nobody contacted the investigator as a result.
2. The investigator visited Swansea on 19 June, and collected records of the man's time in custody. He spoke to the Governor, as well as the chair of the Independent Monitoring Board and the chair of the Prison Officers' Association. He saw the man's cell and interviewed his cellmate.
3. Healthcare Inspectorate Wales (HIW) carried out a review of the man's clinical care in custody.
4. On 9 and 10 July, the investigator interviewed nine members of staff at Swansea. He spoke to the Deputy Governor and subsequently provided written feedback about the investigation to the Governor. On 26 July, the clinical reviewer and a colleague interviewed a GP for the investigation.
5. The investigator informed the local coroner about the investigation, who will be sent a copy of this report.

The man's family

6. One of our family liaison officers contacted the man's mother and his partner to discuss the investigation. On 17 July, our family liaison officer and the investigator visited the man's mother.
7. The man's mother was anxious about bruising she believed she had seen on her son's body in the morgue. The pathologist who completed the post-mortem report found no evidence of 'soft tissue bruising in the neck, or elsewhere in the body'. There was no evidence of internal injury or trauma.
8. The man's mother asked whether her son had been suspended in the air when he was found hanging or whether he had been in a seated position. The man hanged himself in a seated position on the toilet at the back of his cell, tying a torn bed sheet around his neck and to the bars of the cell window.
9. The man's mother complained that the reverend, the prison's chaplain, had spoken to her inappropriately when he broke the news of her son's death over the telephone and had referred to a former partner of his own. The reverend explained to the investigator that he had been trying to make the conversation easier for the man's mother. She had said that her first name could easily be misspelled, but he remembered telling her that he knew how to spell it because a former partner of his had had the same name. After our draft report was issued, the Deputy Governor of Swansea confirmed that he was present during this telephone call and kept a record of it. He believes that the reverend spoke completely appropriately and refutes any suggestion to the contrary.

10. The man's mother also complained that she was not informed of her son's death by a Baptist minister. The reverend told the investigator that the man had registered as Church in Wales during his induction at Swansea and that he, as a Church in Wales minister and the coordinating chaplain at Swansea, was therefore the appropriate choice to break the news of his death to his next of kin. Swansea does not have a Baptist minister.
11. The man's mother wanted to know more about the self-harm monitoring process and how frequently her son was checked. This information is in the report.
12. The man's mother asked for his property to be returned to her. However, because the man had named his partner as his next of kin, prison staff returned his property to his partner. We were unable to make contact with the man's partner to discuss this matter. The prison provided the following response after seeing our draft report:

'The establishment sought advice regarding ownership of the man's property. There was clear conflict between the man's partner [who was recorded as his next of kin] and his mother, who was noted as the emergency contact. The legal advice received stated that the property must go to the named next of kin [PSI 12/2011] and, as the man's partner had asked for the property, it was returned to her.'
13. The man's mother and father were both provided with copies of our draft report. The man's mother has not as yet chosen to provide a response. His father responded through his solicitor and his comments are summarised on page 27.

HMP SWANSEA

14. HMP Swansea is a small local prison, near the city centre, holding approximately 400 adult male prisoners. The prison receives sentenced or remanded men from courts mainly in the South Wales area.

Drug recovery wing

15. Swansea is part of a pilot project with several other prisons aimed at addressing substance misuse and reducing associated offending. At the start of June 2012, B wing (previously the induction wing) became the drug recovery wing. C wing became the drug free wing in mid-June. As part of the project, healthcare staff assess prisoners during the reception process and refer them to the drug recovery wing if it is appropriate. The men on the drug recovery wing aim to reduce their dependency on alcohol or opiates with the ultimate goal of abstinence. The drug recovery wing is normally staffed by a senior officer and two officers during the day. The man moved onto this wing because he had a significant alcohol problem. The drug free wing is intended for prisoners who have completed their drug recovery plan.

Independent Monitoring Board (IMB)

16. Every prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who monitor standards to help ensure that prisoners are treated fairly and humanely. In their report for the year ending May 2012 (shortly before the man's death) the IMB included a section entitled "Death In Custody". They wrote:

"There has yet again been a death in custody to report during the period covered by this report.[we believe that this relates to the man] In addition there have been two very serious attempts to commit suicide which were thwarted by the prompt and extremely professional actions of the staff on duty at the time.

"Last year both the Board and Prison reviewed the process of induction that seems to be failing to pick up problems quickly enough with newly arrived vulnerable prisoners. As a result money was spent to improve the Induction wing facilities and a new "Early Days" programme introduced which provides a multi departmental approach to the review of all prisoners arriving at the jail. This has unfortunately not prevented yet another death".

HM Inspectorate of Prisons (HMIP)

17. HMIP last carried out an announced inspection at Swansea in February 2010. Inspectors noted that the reception area was clean and prisoners moved to the first night centre quickly. They described induction as engaging and informative.

18. Inspectors noted that senior managers had a strong commitment to monitoring the risk of suicide and self-harm and the safer custody team was active and caring. They found that good attention was given to the increased risks associated with the early days of custody.

Previous deaths at Swansea

19. In recent years, we have investigated four other self-inflicted deaths at Swansea in 2007, 2009 and 2010. All of these deaths took place on B wing (then the induction wing) during the first few days in custody. The man also died on B wing only five days after he arrived, although the role of the wing had changed to a drug recovery wing. We have previously recommended that healthcare staff should receive training in the self-harm monitoring process.

KEY EVENTS

Friday 8 June 2012

20. The man had 21 previous convictions for 68 offences, including a number of violent offences. He was arrested on 8 June 2012. The man's cellmate, who was also in police custody and who would become the man's cellmate in Swansea, told the investigator that the man was upset while in police custody.

Saturday 9 June

21. On 9 June, the man was taken from the police station to Cardiff and Vale Magistrates' Court. Police staff recorded on the Person Escort Record (PER) (the document accompanying the man) that he misused alcohol, had taken an overdose in May and had a long history of violence against police officers and women. They noted that the man was prescribed propranolol (used to treat anxiety) and mirtazapine (an antidepressant).
22. At court, the man was remanded into custody. His next court appearance was scheduled for 14 June via a video link from prison. He was taken to HMP Swansea because HMP Cardiff was full, and arrived at 1.20pm.
23. Nurse A conducted a health screen with the man who said that he had an appointment on 28 June to see a psychiatrist at his local community mental health team (CMHT) in Barry. He told the nurse that he was prescribed mirtazapine and propranolol and that he had tried to take an overdose of propranolol three weeks earlier.
24. Nurse A told the investigator that the man was initially quiet but became tearful. Because of his emotional state and his recent overdose, the nurse decided to open an Assessment, Care in Custody and Teamwork (ACCT) self-harm monitoring document. At about 2.30pm, the nurse wrote on the ACCT document that the man was hearing voices, was recently bereaved, was increasingly dependent on alcohol and had recently attempted to harm himself. He added that the man's mood was low and that he was withdrawing from drugs and alcohol.
25. The man reported a history of substance misuse. Nurse A completed the drug recovery algorithm (a tool on the electronic medical record used during the first reception health screen) and determined that the man should go to the drug recovery wing. The man told the nurse that he drank 340 units of alcohol each week. He had mild nausea but no tremors or sweating and did not seem especially agitated. He was experiencing itching and pins and needles, but was not significantly troubled by noise or light. The man had sustained some grazing on his forearms and his forehead during his arrest. Nonetheless, the nurse told the investigator that the man seemed fit, clean and well.
26. The man's urine tested positive for benzodiazepines and he also completed an alcohol withdrawal assessment. Because of the positive urine test and his

high levels of alcohol misuse, the nurse prescribed the following medication to manage withdrawal symptoms: diazepam (to treat anxiety, alcohol withdrawal and the risk of fitting), metoclopramide (for nausea and vomiting), paracetamol, ibuprofen (pain relief) and butylscopolamine (to treat cramps). Nurse A referred the man to the doctor and nurse the next morning for a secondary health screen to review his mental health and substance misuse problems.

27. Officer A completed a first night interview with the man. He recorded that the man was taking medication for depression and had taken an overdose of prescription drugs after a recent bereavement. The man said that he was not having any current suicidal thoughts.
28. The man named his partner as his next of kin and his mother as his emergency contact. He asked for a transfer to HMP Cardiff, which is nearer to them. At 3.46pm, the man telephoned his partner.
29. The man was assessed as suitable to share a cell with another prisoner and agreed to share cell B3-10 on the drug recovery wing with his cellmate, who was an old acquaintance. On B wing, Senior Officer (SO) A completed an 'Immediate Action Plan' as part of the ACCT process. He wrote that the man was moving to a cell on the drug recovery wing for detoxification, medication and monitoring and would be living with a supportive prisoner. The man was given a PIN number to allow him to make telephone calls and was told how to contact the Samaritans and use the Listeners (prisoners trained by the Samaritans to provide support for other men in distress).
30. The man told SO A that he had no intention of deliberately harming himself. The SO wrote instructions to staff on the front cover of the ACCT document reminding them how often to check the man. He set the frequency of observations as three meaningful conversations with an officer in the morning, afternoon and evening. Wing staff were required to make an entry in the document every two hours during the day about the man's activity and behaviour, and night staff were to check him every time they moved about the wing. (Night staff have to press a sequence of cell bells around the wing at predetermined intervals which vary each night. These are recorded and demonstrate that staff are monitoring the full extent of the wing).
31. Officer B, knew the man from a previous sentence at HMP Cardiff, and spoke to him later when he attended the medication hatch on B wing. The man told him that he wanted to read but had poor eyesight. Mental Health Nurse B and Officer B found him a pair of reading glasses to use. The officer told the investigator that the man was polite, pleasant, articulate and positive and collected two books to read.

Sunday 10 June

32. The next morning, 10 June, Nurse B assessed the man. He wrote in his clinical record that the man had an alcohol misuse problem, was withdrawing

and was having difficulty sleeping. The man told the nurse that he sometimes heard voices and experienced delusions, and drank alcohol to try to block these out. He said that the voices encouraged him to harm himself, but he knew they were not real and tried to ignore them. The nurse booked an appointment for the man to attend the alcohol clinic on 9 July, the next available routine appointment.

33. Nurse B referred the man to the Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS) team. (There is a CARATS team in each prison to help prisoners who misuse drugs or alcohol.) The nurse completed a substance misuse assessment tool and recorded that the man misused alcohol, benzodiazepines and cannabis and drank one and a half litres of vodka each day (approximately 60 units of alcohol). The nurse scheduled daily detoxification monitoring.
34. Nurse B noted that the man had a history of depression and self-harm. The man said he had not had any suicidal thoughts since arriving in prison, but he sometimes thought that he would be better off dead. The nurse made an entry in the man's ACCT document, noting that he was tearful and in a very low mood. The nurse also recorded that the man would benefit from chaplaincy support but was getting on well with his cellmate.
35. Nurse B completed Patient Health Questionnaire (PHQ) 9 to assess the man's mood and level of depression. He scored the man at 16, meaning that his depression was moderately severe and required immediate treatment. Because the man was already known to the CMHT in Barry, the nurse referred him automatically to the prison's mental health in-reach team for them to request his notes from the CMHT. He also referred the man to the Lighthouse primary care mental health team in case he was not deemed sufficiently unwell for a permanent place on the in-reach team's caseload. The nurse booked an appointment for the man at the Lighthouse clinic on 21 June.
36. A prison doctor then assessed the man who said that he abused cannabis and diazepam and had done so within the last three days. He told the doctor that he had withdrawal symptoms including back pain, sweating, insomnia and auditory hallucinations. The man reported that he had recently attempted to harm himself, prompted by his partner's own self-harm. He said that he did not have any current suicidal thoughts as he was too worried about his partner. The doctor recalled that the man talked about his partner throughout the consultation, became tearful and upset and was unable to continue. The doctor told the clinical reviewer that he did not come across this sort of distress very often. The doctor reassured the man that he could see Nurse B afterwards. The doctor planned to confirm the man's ongoing treatment with his local GP surgery before he prescribed any mental health medication, but he re-prescribed diazepam (for his withdrawal symptoms), ibuprofen and paracetamol. He wrote in the clinical record that ACCT self-harm monitoring should continue. He did not make an entry in the ACCT document itself.

37. Nurse B checked the man again who then saw Nurse C. The man was prescribed thiamine (vitamin B1), vitamin B, omeprazole (used to treat acid reflux) and re-prescribed metoclopramide to treat his alcohol withdrawal.
38. At 12.40pm, SO A saw the man again as part of the reception process. He said that that he had taken an overdose the previous month after he and his partner suffered a bereavement. He said that he was not having any thoughts of self-harm. Shortly after 2.00pm, he telephoned his partner again.
39. At about 3.00pm, Officer C carried out an ACCT assessment interview with the man, who said that he was taking medication for anxiety. He told the officer that he was hearing voices telling him to harm others. He said that the voices were worse at night. He told the officer that he felt low and anxious and that the voices were not helping his mood. The man told the officer that he was worried about his partner because of their bereavement. He explained that he had taken an overdose three and a half weeks earlier and was unsure if he had intended to take his life. He indicated that he was not having any suicidal thoughts, but seemed ambivalent when asked whether he wanted to carry on living.
40. The man told Officer C that, as long as he could keep in contact with his partner and hear her voice, he would be able to cope. They agreed that the man would benefit from staying in touch with his partner, sharing a cell with his current cellmate and seeing the Lighthouse team.
41. The man asked to speak to his partner and Officer C took him to the wing office and telephoned his partner. The officer gave her information about visiting and she agreed to speak to the man. After the conversation, Officer C thought that the man seemed relieved and his mood much improved. The man had no credit on his phone account, so the officer arranged for £12 credit to be added.
42. SO A (the ACCT case manager) then held the man's first ACCT case review with Nurse D (Nurse B had left the prison for the day) and Officer C. Nurse D told the investigator that the man was calm, cooperative, talkative and kept good eye contact. He did not observe any shakes or tremors.
43. The man's mood was low. He again explained the bereavement. He said that the voices he heard were worse at night. Nurse D made sure that the man knew how to use the Listener scheme and gave him advice about how to speak to his family and friends in a calmer way. (Listeners are prisoners trained by the Samaritans to support others in distress.) They planned what he might say during telephone conversations to stay calm.
44. The man said to the staff at the review that it would help if he went to Cardiff Magistrates' Court in person for his next hearing on 14 June, rather than appearing by videolink. He hoped he would then go to HMP Cardiff from court.

45. Under 'Triggers / warning signs to prompt immediate review', SO A wrote 'Loss of contact with partner / breakdown in relationship.' The man said that he did not want to die and had no current intention of harming himself. However, because of the number of risk factors, the SO recorded that the likelihood of further deliberate self-harm was raised. The same frequency of ACCT checks was maintained after the review.
46. SO A recorded four issues on the man's ACCT care map: mental health assessment, alcohol issues, current cell sharing (his cell mate was considered to provide beneficial support) and contact with his partner. The next ACCT review was scheduled for 14 June.

Monday 11 June

47. The next morning, 11 June, Nurse C saw the man again. He said that he was not sleeping, was experiencing stomach cramps and was hearing voices. The man told the nurse he did not have any thoughts of deliberate self-harm.
48. That morning, the man attended an induction board and spoke to the reverend (the Church in Wales prison chaplain) about his concern for his partner and their recent bereavement. The reverend telephoned the man's partner on his behalf and subsequently let the man know. The man also saw a member from the CARATS team as part of the routine induction process.
49. Nurse E contacted the man's local community GP surgery, confirmed that he was prescribed propranolol and omeprazole and prescribed these two medications the same day. Between about 4.15pm and 4.30pm that afternoon, the man telephoned his partner three times.

Tuesday 12 June

50. At about 9.45am on 12 June, Nurse B checked the man who said that he was feeling okay in spite of his withdrawal symptoms. He told the nurse that he did not have any thoughts of deliberate self-harm but had some troublesome thoughts. He was worried about his partner, who thought she might be pregnant. The nurse told the man that an appointment with the primary care mental health team had been booked.
51. At 10.40am, the man telephoned his partner. At about 2.00pm, he asked to visit the chaplaincy to discuss his bereavement problems. At about 2.30pm, Officer D spoke to the man about the telephone numbers he was authorised to call. He said the man seemed anxious but calmed down after a long conversation. The man telephoned his partner at 2.40pm for ten minutes. He called her again at 3.55pm for a further five minutes.

Wednesday 13 June

52. Nurse B checked the man at about 10.00am, when he complained of cramps in his legs and stomach. The nurse thought that the man seemed sombre

and tired, but he again said that he did not have any thoughts of self-harm or suicide. The nurse planned to review him the following day.

53. At 11.00am, the man visited the chapel and spent about 45 minutes talking to the reverend about his bereavement issues. Officer B spoke to the man about what he was reading. The man said that he had read four books since Saturday and that he would tell the officer about his current book once he had finished it.
54. The man telephoned his partner for four minutes at 11.50am. After she hung up, he immediately called her back at 11.54am for a further ten minute call. Officer E and Officer F noticed the man became upset during the call. The association period had ended and prisoners were collecting their meals and medication and returning to their cells. Officer F had to ask the man repeatedly to end his telephone call. Eventually, the man hung up, but then punched the metal hood covering the telephone several times. He was emotional and tearful.
55. Officer F told the man to stop damaging the booth took him into the landing interview room to calm down and gave him a cigarette. The man stopped crying and told the officer that his partner had suffered a bereavement and wanted to leave him. The officer told the investigator that he advised the man against putting too much pressure on his partner. The officer made an entry in the ACCT document at 12.00pm, recording that the man had become very upset. He planned to check him again after lunch.
56. After he calmed down, the man collected his meal and was locked in his cell over lunchtime. His cellmate told the investigator that the man was upset with himself for assaulting his partner by giving her a black eye. He recalled that the man's telephone conversations with his partner seemed to become increasingly more fraught during the five days he was in prison. During the lunchtime lock up, the cellmate heard the man tearing his bed sheet. He asked the man what he was doing, and he replied that he was making the sheet shorter in order to tuck it in properly. The cellmate told him not to do anything stupid. He did not report this incident to staff.
57. At about 2.30pm, Officer F took the man to the staff rest room and the officer telephoned his partner and explained to her that the man was going to take some time out to gather his thoughts. The officer said that the man was sorry for putting pressure on her and they all agreed that the man would not telephone her again for 24 hours because the calls were upsetting them both. The officer told the investigator that the man's partner thanked him for the call and agreed that the man could call her the next day. The officer recalled that, afterwards, the man seemed more emotionally stable.
58. Despite this agreement, at 3.51pm the man telephoned his partner again. Officer E and Officer F noticed him using the telephone. The man said he was calling his mother, but a monitoring check indicated that he was speaking to his partner again. Officer F said he planned to challenge the man about

this the next day. Officer E made an entry in the ACCT document at 4.00pm. Officer F finished his shift at 5.30pm.

59. Shortly after 6.00pm, Officer B and Officer E unlocked prisoners for evening association. Officer E said that the man seemed noticeably more settled and relaxed to begin with, but he telephoned his partner at 6.14pm for three minutes. They argued, spoke about the end of their relationship and the man said that he was going to go and kill himself. The man's partner hung up, and he immediately called her back for a further minute's conversation. He was running out of credit. He asked his partner if she loved him and she said that she did not.
60. SO A (in charge of B and C wings that day) and Officer B told the investigator that this association period was difficult to manage as the prisoners were unusually rowdy and noisy. About 20 prisoners from B2 and B3 landings were gathered on B3 landing, where the pool tables are, and there was some tension because of an alleged theft of tobacco from a cell. As the drug recovery wing had only been established for ten days the SO said the regime had yet to settle down and he was worried there might be a fight.
61. At 6.35pm, the man asked Officer B to let him back into his cell to use the toilet because he had an upset stomach. Officer B did not think this unusual as the man had mentioned this problem, apparently caused by his alcohol withdrawal. The officer was unaware of the man's most recent telephone calls to his partner. The officer let the man in his cell and left the door unlocked and very slightly ajar. He told the investigator that the man dashed for the toilet as soon as he entered the cell. At about 6.40pm, Officer E made an entry in the man's ACCT document, noting that Officer B had taken the man back to his cell.
62. Officer B then spent the rest of the association period patrolling the landing to monitor the other prisoners. He told the investigator that he had to speak to a prisoner on B4 landing about cell sharing for about 15 minutes and had to warn five prisoners on B4 landing to calm down. The disruptive behaviour then moved from B4 to B3 landing and Officer B and SO A spoke to the most difficult prisoners in the wing office about their behaviour.
63. As he was dealing with the problems, Officer B heard the man shout out, 'What's going on?' He said the man peered out of his cell door through the observation panel, rather than opening the door and coming out onto the landing. A little later, at about 7.00pm, when the officer was talking to prisoners about their behaviour, he saw the man again through the observation panel in his cell door. He was wearing his reading glasses and gave Officer B a 'thumbs up'.
64. Just before 7.25pm, a prisoner from the cell next to the man asked Officer B if he could get something from his cell. When the officer went to open the neighbouring cell he noticed that the observation panel on the man's cell door was partially obscured by paper. He looked inside and saw the man. At first, it seemed as if he was sitting on the toilet. Then Officer B realised that the

man was hanging at the back of the cell. He had tied a strip of bed sheet around his neck with the other end tied to the bars on the window at the back of the cell.

65. Officer B went into the cell. The man's cell mate was just behind him and also saw the man hanging. The officer shouted for assistance, then went to the back of the cell. A cupboard was blocking his way and there were books on the floor. He held the man under his arms to support his weight, but at first could only hold him from an awkward angle because of the cupboard. The officer then managed to get closer to support the man's weight fully. He could get no response from the man. Officer E heard the commotion and went into the cell.
66. SO A and SO B (the orderly officer in charge of the prison) were on B2 landing at the time, speaking to a prisoner who was alleged to have stolen the tobacco. They heard raised voices, went up the stairs to B3 landing and saw a group of prisoners gathering at the man's cell. SO A told the investigator that it was not immediately clear what had happened. As they reached the cell, Officer E ran out and pressed the general alarm bell. Although members of staff at the scene were carrying radios, the emergency was not announced using the standard code system across the radio network.
67. SO A and SO B went into the cell and helped Officer B to support the man. While Officer B continued to hold him under his arms, SO A used his cut-down tool (a specially designed knife) to cut through the bed sheet about six inches above the knot. Officer B then gave the man a fireman's lift and passed him to SO Davies. The officers had difficulty in lowering the man onto the floor because of the confined space and the cupboard. However, they managed to lay him on his back, his head nearest the door and feet nearest the window.
68. SO B then immediately went downstairs to the treatment room on B2 landing, ten seconds away, to call for healthcare staff. In the cell, Officer B tilted the man's head, checked his airway, put his head next to his mouth to check for breaths, looked for rise and fall in his chest, checked his mouth for blockages and tried to obtain a response. He began chest compressions as the man was not breathing.
69. Nurse F (a registered general nurse) and Healthcare Officer (HCO) were both close by in the treatment room. When the HCO first heard the general alarm, he went upstairs to B3 landing but it was not immediately apparent where the problem was. He began locking prisoners away and then heard SO B shouting for a member of healthcare staff. The HCO went to the man's cell, saw the officers giving chest compressions and ran back downstairs to the treatment room to get equipment. SO B found Nurse F in the treatment room and told her to bring the emergency response bag because there had been a hanging.
70. The Physical Education Instructor (PEI) (who was trained in cardiopulmonary resuscitation, or CPR, and the use of defibrillators) was also close by between

A and C wings when he heard the general alarm. He was also not sure where the incident was, but was directed to B3 landing by an officer at the treatment hatch. He met prisoners coming down the stairs onto B2 landing and began locking them up, thinking that a fight was taking place on B3. He then heard SO B shouting for medical assistance, went to B3 landing, entered the man's cell and took over chest compressions from Officer B.

71. Nurse F and the HCO arrived a few seconds later with an oxygen cylinder, the emergency response bag and defibrillator. (Once attached to a patient, a defibrillator can deliver an electric shock to reset his heart rhythm, but only if an irregular heart rhythm is found.) As soon as she arrived, Nurse F asked for an ambulance to be called. SO B radioed the control room and requested an emergency ambulance.
72. During interview, Officer B and SO A could not remember cutting the torn bedsheet from around the man's neck. However, Nurse F recalled that the material was lying loosely across the man's neck when she arrived. With the HCO's assistance, Nurse F tilted the man's neck and checked his throat was clear. She then inserted an artificial airway and gave him oxygen using a mask and bag. Nurse F supported the man's neck and held the mask in place while the HCO pumped the bag. The PEI continued to perform chest compressions.
73. The PEI and Nurse F then attached defibrillator pads to the man's chest. The machine twice advised the staff that it could not find a heart rhythm and they therefore should not shock the man. The staff continued CPR for about ten minutes until the paramedics arrived, alternating 30 compressions to two breaths.
74. The man began to vomit, so Nurse F used a handheld suction unit to clear his airway, but this was inadequate for the task. The HCO returned to the treatment room to get an electronic suction unit, which Nurse F then used to try to clear the man's airway. Although not fully effective, this unit worked better.
75. While the staff were trying to help the man, the reverend and Officer G looked after the man's cellmate, who was very upset. Other officers began locking up prisoners to clear the landing.
76. Paramedics arrived at the prison and were escorted to the cell by SO B at about 7.42pm. The duty governor arrived at the prison at about the same time, having been notified of the emergency. The defibrillator had been attached to the man for ten minutes and 41 seconds when the paramedics arrived. The paramedics asked staff to move the man onto the landing. The PEI and Nurse F did this while supporting the man's head and neck. Nurse F performed chest compressions on the landing. The paramedics managed the man's airway and attached their own defibrillator. This then detected a shockable heart rhythm, so they shocked the man and gave him adrenaline. The paramedics tried to insert an airway but were unable to. They continued

to perform CPR, but the man did not recover and the ambulance crew pronounced him dead at 7.59pm.

77. The man left a long suicide note in his cell, addressed to his partner in which he indicated that he intended to hang himself.
78. During the evening, officers reviewed prisoners subject to ACCT self-harm monitoring. One was moved to spend time with a Listener and another was given access to Listeners and a mental health nurse. The duty governor spoke to some prisoners who had been particularly affected. The man's cellmate moved to a cell with two other prisoners overnight. An additional officer was brought in to work on the drug recovery wing that night to monitor the wellbeing of the prisoners. The reverend and Officer G (both members of the care team) checked the welfare of the staff involved.
79. The duty governor individually debriefed Officers E and B, Nurses F and HCO, SO A and PEI. He checked on their welfare and offered the services of the care team. However, he did not hold a formal hot debrief meeting with all the staff involved together to allow them to raise any immediate issues. The Governor arrived and was briefed by the duty governor.
80. At 9.40pm, the reverend and a lay chaplain, went to visit the man's relatives to break the news of his death. He had named his mother as his emergency contact and his partner as his next of kin. They arrived at the man's mother's home at 11.00pm and were met there by deputy governor. There was nobody at home and the man's mother's mobile telephone was switched off. They then went to the man's partner's home, arriving at 11.20pm. They broke the news to her and left an hour later, at 12.20am.
81. The man's mother was on holiday, but the reverend was able to contact her by telephone at 9.10am the next morning, 14 June. Unfortunately, comments about the man's death had been posted on a social networking site, prompting concerned friends to telephone the man's mother. Consequently, she was already aware of the news when the chaplain called. Staff at Swansea held a memorial service for prisoners to attend in the chapel that afternoon.
82. The man's father was a serving prisoner at a different prison. He liaised with a senior manager at the prison, and the reverend spoke to the coordinating Church of England chaplain. The senior manager informed the man's father of his son's death on 15 June. Members of the chaplaincy subsequently supported the man's father.
83. The man's funeral was held on Wednesday 4 July. The man's father, the lay chaplain and another colleague attended. A critical incident debrief was held at Swansea on the same day for the staff involved in the emergency.
84. The toxicology results in the post mortem report showed that the man had not consumed any alcohol or an overdose of drugs before his death. The blood and urine tests showed:

- traces of cannabis either taken previously or recently (there is no further information about when the man took cannabis either inside or outside prison)
- traces of mirtazapine (antidepressant) ingested previously rather than recently
- traces of omeprazole ingested previously rather than recently
- a benzodiazepine derivative of either chlordiazepoxide or diazepam (both prescribed for alcohol withdrawal)
- low concentrations of propranolol, metoclopramide, ibuprofen and paracetamol consistent with his prescriptions

ISSUES

Clinical care

85. Healthcare Inspectorate Wales (HIW) completed a review of the clinical care the man received in prison. They consider that all those involved in his care acted professionally and appropriately. HIW are satisfied that the doctor prescribed appropriate medication and that healthcare staff acted appropriately in contacting the man's community GP to confirm his medication and then reviewing his prescriptions. They consider that, for the most part, the relevant assessments and referrals were completed during the first and secondary health screenings.
86. However, HIW note that the man reported experiencing auditory hallucinations and hearing aggressive voices to both Nurse B and Officer C on Sunday 10 June. Although the man was referred to the mental health team for an appointment on 21 June and staff were seeking his notes from the CMHT, there is no evidence of an assessment to determine if he required antipsychotic medication in his early days in custody. We make the following recommendation based on HIW's findings:

The Head of Healthcare should ensure that prisoners who report auditory hallucinations are assessed and prescribed medication if appropriate.

Assessment, Care in Custody and Teamwork (ACCT) self harm monitoring

87. The man was subject to ACCT self harm monitoring as soon as he arrived at Swansea. Nurse A immediately identified that he needed support. The care map completed by SO A clearly outlined the different ways in which the man would be offered help to improve his mood.
88. The doctor saw the man on 10 June and made an entry about the consultation in his clinical record. However, he did not make an entry in the man's ACCT document about his mood. Although Nurse B saw the man on three different days, and made good quality entries in the clinical record, he only made an entry in the ACCT document on the first occasion. He agreed during interview that he should have made an entry in the ACCT document each time. He told the investigator that, in future, he would make an entry reflecting any visit to a patient in their ACCT document as well as in their clinical record. The entries in the ACCT document must of course respect patient confidentiality, but should inform wing staff that a medical professional has seen the prisoner and whether there are any concerns about their safety. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff record their interactions with prisoners subject to ACCT monitoring in the clinical record and the ACCT document.

89. On 13 June, Officer F spoke to the man because he was upset after talking to his partner on the telephone when she had told him she wanted to leave him. We think that Officer F helped the man in a sensible, supportive and proactive way. He offered him advice, calmed him down and telephoned the man's partner on his behalf. However, we consider that the news of the apparent breakdown in his relationship should have triggered a further ACCT review.
90. Prison Service Instruction (PSI) 64/2011 (Management of prisoners at risk of harm to self, to others and from others) states:
- '[Staff present at the first case review must] agree what events / signs or increased risk (if any) will be watched out for and will trigger further action and / or an immediate case review. These must be noted on the inside front cover of the ACCT plan.'
91. The 'Trigger/warning signs to prompt immediate review' recorded by SO A in the man's ACCT document was 'Loss of contact with partner / breakdown in relationship'. Despite the man's upset after the telephone call and his disclosure of his deteriorating relationship with his partner, there was no ACCT case review held on the afternoon of 13 June and the frequency of observations was not increased. Officer F told the investigator that he was aware of the trigger information which SO A had written in the ACCT document. However, he explained that the man seemed calmer and happier after they had had a discussion and called his partner. They agreed that the man would not call his partner again for 24 hours so they could both calm down. Officer F told the investigator that the man did not mention having any suicidal thoughts.
92. Later in the afternoon, Officer F realised that the man was once again telephoning his partner. He planned to address the matter with him the next day, although this further call was evidence that the man had not followed his advice and was still keen to talk to his partner, and likely to cause himself more distress. The officer told the investigator that, when he finished his shift at 5.30pm, he felt that he had calmed the man down and that he was no longer in the sort of distress that might trigger an immediate review. He was satisfied that the situation had been handled appropriately and even in retrospect he did not believe there was a need to have a case review or increase the frequency of observations.
93. SO A told the investigator that he would have expected the telephone call which initially prompted Officer F to sit down with the man on 13 June to have triggered a review, because the man's distress was directly related to difficulties which he was having in his relationship. The SO also praised the officer's handling of the man's distress and he pointed out that the ACCT document was due to be reviewed the following day, 14 June.
94. HIW note in their clinical review that there was no evidence available to staff on 13 June that the man was having suicidal thoughts and to that extent the man's death was neither foreseeable nor preventable. They think it likely that

the man's death might have been an impulsive act resulting from his telephone conversations.

95. We agree with SO A that Officer F handled the immediate situation well. Nevertheless, the ACCT document should have been reviewed on 13 June. We agree with HIW that there was no clear evidence available to staff that the man was having suicidal thoughts. However, we think they are correct to point to an impulsive decision by the man. As HIW comment in their review, the trigger to prompt an immediate review was very clearly recorded in the ACCT document. That being the case, a review following the telephone conversations should have taken place. We cannot know whether a review or an increase in ACCT observations would have prevented the man taking his own life. We make the following recommendation:

The Governor should ensure that prison staff use the triggers recorded in a prisoner's ACCT document to prompt an ACCT case review where increased risk is identified.

96. The Governor did not accept this recommendation. The prison have pointed out that Prison Service Instruction (PSI) 64/2011 tells staff that the trigger information in an ACCT document should prompt further action and/or an immediate case review. They are satisfied that Officer F took further action and that this was sufficient.
97. The advice in the PSI is confusing, because it contradicts the relevant section of the ACCT document used by officers, which is quite clearly headed 'Triggers/warning signs to prompt immediate review'. There is no mention of 'further action' as an alternative to 'immediate review'.
98. After consideration, we have retained and amended this recommendation in our final report. We also make the following additional recommendation to the Offender Safety Rights and Responsibilities Group (OSRRG) in NOMS:

OSRRG should amend PSI 64/2011 to ensure that it is consistent with the ACCT document.

99. Staff were supposed to make entries in the man's ACCT document at least every two hours during the daytime. However, on the afternoon and evening of 13 June they only made entries at 12.00pm, 4.00pm and 6.40pm. SO A agreed during interview that the frequency of recorded observations on 13 June did not follow his instructions. The final entry in the ACCT document was made by Officer E rather than a direct observation from Officer B who was dealing with the man and would have been better placed to record his mood. The entry was made only 45 minutes before the man was found, so the gap in ACCT observations was not a matter that would have affected the outcome. However, it is important that prison staff comply with the agreed level of observations and record these appropriately in ACCT documents. We make the following recommendations:

The Governor should ensure that staff make entries in ACCT plans in accordance with the requirements on the front cover.

Emergency response

100. When Officer B found the man hanging in his cell, he responded immediately and began CPR before the nurses arrived. HIW are satisfied that the response to the emergency by healthcare staff was professionally handled. However, officers did not communicate by radio using the standard emergency system to initially alert their colleagues to the incident. (Code red indicates a bleeding prisoner, code blue one who has stopped breathing.) Officer E pressed the general alarm instead because it was close to hand. SO B then used his radio to communicate with the control room and request an ambulance.
101. Some interviewees told the investigator that they thought that the general alarm was an effective way of summoning staff, most of whom were nearby. We agree there was no delay in helping the man, but the HCO, SO A and PEI were all confused in the initial moments after the alarm sounded about the nature of the incident and where help was required because it was not properly announced over the radio network. We make the following recommendation:

The Governor should ensure that prison staff use the emergency code system over the radio network to alert their colleagues to an emergency.

102. Staff at the scene of the emergency were spoken to individually by the duty governor and the reverend before they went home. They made sure that the officers involved were safe to drive home, offered to book them a taxi and ensured that they would have somebody waiting for them at home. We are satisfied that the staff were given appropriate support. However, Prison Service instructions require a senior member of staff to hold a hot debrief meeting bringing all of the staff together before they go off duty. As well providing support, this gives the opportunity to identify any immediate learning from the incident that might need to be implemented quickly. We make the following recommendation:

The Governor should ensure that after a death in the prison managers hold a hot debrief meeting in accordance with Prison Service guidance.

CONCLUSION

103. The man spent five days in custody. Staff prescribed appropriate withdrawal treatment, gave him a cell on the drug recovery wing and began self-harm monitoring immediately. He received support from a mental health nurse and the chaplaincy. He telephoned his partner frequently, but on 13 June their calls became argumentative and his partner indicated that the relationship was over. The man became very upset, but an officer was proactive in calming him down. However, the officer did not ask for a review of the self-harm monitoring process or an increase in the frequency of observations. Later on, staff made a reasonable decision in letting the man back into his cell on his own during the association period. When he was found hanging, they acted immediately to try to resuscitate him.

104. The investigation has highlighted some concerns about the use of ACCT self-harm monitoring, in particular the lack of an ACCT review on 13 June. However, some aspects of the ACCT process were managed well. We have also indicated some problems with the emergency procedures, but the resuscitation effort itself appears to have been immediate and well coordinated. In general, we think that the man was offered a good level of care after he arrived at Swansea. Sadly, he seems to have made an impulsive decision to take his own life.

RECOMMENDATIONS

For the Head of Healthcare:

1. The Head of Healthcare should ensure that prisoners who report auditory hallucinations are assessed and prescribed medication if appropriate.

The Head of Healthcare accepted this recommendation and provided the following response:

‘HMP Swansea accepts that prisoners reporting hallucinations of any kind will be assessed and prescribed medication if appropriate. However, in the case of the man, a GP noted hallucinations on the morning of 10/6/12 and he was assessed by a Mental Health Nurse the same day.

‘The man was then referred to the In Reach Team for further assessment by an appropriate specialist however, due to the fact the specialist only attended the prison on a weekly basis, and the man died on 13/6/12, they did not meet. Therefore, although the recommendation is accepted as good practice, HMP Swansea can demonstrate that procedures were followed and timely referrals were made.

‘All other learning points will be discussed with the Local Health Board.’

2. The Head of Healthcare should ensure that all healthcare staff record their interactions with prisoners subject to ACCT monitoring in the clinical record and the ACCT document.

The Head of Healthcare accepted this recommendation and provided the following response:

‘A Standard Operating Procedure for ACCTs and healthcare staff interactions will be produced and issued. Management will ensure that all staff are compliant with ACCT training.’

For the Governor:

3. The Governor should ensure that prison staff use the triggers recorded in a prisoner’s ACCT document to prompt an ACCT case review where increased risk is identified.

The Governor did not accept this recommendation. The prison have pointed out that Prison Service Instruction (PSI) 64/2011 tells staff that the trigger information in an ACCT document should prompt further action and/or an immediate case review. They are satisfied that Officer F took further action and that this was sufficient.

The advice in the PSI is confusing, because it contradicts the relevant section of the ACCT document used by officers, which is quite clearly headed

'Triggers/warning signs to prompt immediate review'. There is no mention of 'further action' as an alternative to 'immediate review'.

After consideration, we have retained and amended this recommendation in our final report. We also make the following additional recommendation to the Offender Safety Rights and Responsibilities Group (OSRRG) in NOMS:

4. **OSRRG should amend PSI 64/2011 to ensure that it is consistent with the ACCT document.**
5. The Governor should ensure that staff make entries in ACCT plans in accordance with the requirements on the front cover.

The Governor accepted this recommendation and provided the following response:

'This has been raised at the safer custody meetings and at the ACCT foundation and case manager training. We have also introduced management checks to ensure compliance.

'A Governors notice to staff will be issued to remind staff of their responsibilities.'

6. The Governor should ensure that prison staff use the emergency code system over the radio network to alert their colleagues to an emergency.

The Governor accepted this recommendation and provided the following response:

'A previous Governor's notice to staff has been reissued on this, including extracts from the updated first on scene contingency plan.'

7. The Governor should ensure that after a death in the prison managers hold a hot debrief meeting in accordance with Prison Service guidance.

The Governor accepted this recommendation and provided the following response:

'Duty Governors and managers have been reminded that they must follow the contingency plans and hold a hot debrief prior to staff leaving the establishment.'

Response from the man's father

The man's father responded to our draft report through his solicitor. He did not agree with the conclusion of our report and thought that the investigation lacked thoroughness. He believes that his son's death was preventable. He thought that mental health staff assessing his son did not take into account all available evidence. More generally, he did not think that information was properly shared among the staff. The man's father thinks that an ACCT review should have been held on the afternoon of 13 June. He described the failure to do this as a 'critical error' with 'catastrophic consequences'. He was also concerned about the emergency response.