PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in December 2012 at HMP Cardiff

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report into the death of a man at HMP Cardiff in December 2012. The man was found hanging from bed sheets attached to the window bars in his cell. He was 38 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. Healthcare Inspectorate Wales (HIW) conducted a review of the man's clinical care in custody. HMP Cardiff cooperated fully with the investigation.

The man was not assessed as at risk of self-harm or suicide when he was remanded to HMP Cardiff on 4 December, charged with a violent offence against a close family member. Previous healthcare records showed that the man had undergone detoxification from drugs and alcohol and had been seen by HMP Cardiff's mental health team in 2011, but these records were not accessed. Prisoners on the wing said that the man asked an officer on the evening he died, if he could share a cell, but the officer allegedly refused without explanation. It has not been possible to establish for certain whether or not an officer turned down such a request, but leaving him alone left him without the support of a cell mate. Just before 6.00am the next morning, the man was found unresponsive in his cell. As there were signs of rigor mortis, staff did not attempt resuscitation.

I am concerned that there is no system to retrieve records of a prisoner's previous experience of custody in HMP Cardiff. Without that information, the assessment of the man's risk could not be complete. While we cannot know whether this would have affected the outcome, too much reliance appears to have been placed on the man's personal presentation when assessing his risks and needs. In particular – and in line with local and national suicide prevention guidance - more weight ought to have been placed on the nature and circumstances of the man charge of domestic violence, which is a known risk factor in the assessment risk of suicide or self-harm.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2014**

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SUMMARY

1. The man was arrested on 3 December for an alleged false imprisonment and assault against his elderly father. He spent the night in police custody during which no concerns were raised. On 4 December, the man appeared in court and was remanded to HMP Cardiff. He arrived at Cardiff with a number of risk factors highlighted on his records, which were discussed with him in reception. Officers considered that there was no cause for concern.

2. As part of the initial health screen, the reception nurse carried out a routine questionnaire which did not identify the man as depressed. He told the nurse he had no problematic drug use, although the man had previously been in Cardiff three times in 2011, and had undergone an opiate and alcohol detoxification each time. He had been referred to the mental health team on two of those occasions. The nurse was not aware of this information.

3. The man spent the first two nights in custody in a single cell while his cell sharing risk assessment form was completed. An officer interviewed him and determined that he was not a risk to other prisoners and was suitable to share a cell.

4. There is little recorded about the man over the next two weeks, and officers said that he gave them no cause for concern. On 17 December, his cell mate was moved to another cell. Other prisoners said that the man asked an officer if he could share a cell, but was refused. The officer has denied this and this matter is currently subject to an internal Prison Service investigation. The man remained alone in the cell.

5. At 5.58am the next morning, the man was found hanging by bed sheets from the window bar of his cell. Cardiopulmonary resuscitation was not carried out as there were clear signs of rigor mortis.

6. We are concerned that important information about the man's needs remained archived in the prison until this investigation took place. The assessment of his risk in reception placed too much weight on his presentation rather than known risk factors, such as the nature of his alleged offence and his relationship to the victim. While we do not know for certain whether the man asked for a shared cell we believe it is important that officers understand that any request by a prisoner to share a cell should be appropriately considered as an indicator or possible risk.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was informed of the man' death on 18 December 2012. The investigator issued notices to staff and prisoners at Cardiff informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

8. Healthcare Inspectorate Wales (HIW) conducted a review of the man's clinical care and received copies of relevant medical and prison documents and the interview transcripts.

9. The investigator interviewed seven officers at Cardiff on 5 and 6 February 2013. She also interviewed a prisoner at HMP Parc on 14 February. The investigator kept the deputy governor informed of emerging findings.

10. The investigator contacted the man's legal representatives by email and liaised with the investigating police officer during the course of the investigation.

11. The investigator informed HM Coroner for Cardiff and Vale of Glamorgan District of the investigation and a copy of the report has been sent to her.

12. One of the Ombudsman's family liaison officers, contacted the man's sister to explain the purpose of the investigation. She explained that the man had psychotic symptoms, possibly schizophrenia and wanted to know whether the man's mental health was assessed and if he received any mental health or suicide prevention support. She said the man was dependent on drugs and questioned why he was located in a cell with an alleged drug dealer and when his cell mate moved out of his cell.

13. The man's family received a copy of the draft report. They commented there was a factual inaccuracy at paragraph 30, which has been amended. The prison considered our draft report and recommendations, which they have accepted. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report

HMP CARDIFF

14. HMP Cardiff is a local prison, predominantly serving the Welsh courts and the South West of England. It holds approximately 800 adult sentenced and remanded male prisoners.

Her Majesty's Inspectorate of Prisons (HMIP)

15. The report of the most recent inspection of HMP Cardiff in February 2013 had not been published at the time of issuing this draft report. In interim feedback, the Inspectorate recognised that Cardiff had improved systems to identify and support prisoners charged with or convicted of violent offences against a family member. This was in response to emerging findings from our investigations into recent deaths at the prison, including that of the man's.

16. At the time of the previous inspection in June 2010, the Inspectorate found that Cardiff provided an essentially safe environment. Following a number of deaths at the prison, the Inspectorate noted that suicide prevention work had been given an appropriately heightened focus. Early days in custody were assessed as satisfactorily managed, although reception staff struggled to deal with the high number of prisoners.

Independent Monitoring Board (IMB)

17. Every prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who monitor standards to help ensure prisoners are treated fairly and decently. In its latest annual report for September 2011 to August 2012, the IMB noted that deaths in custody were still a major factor at the prison. Although the mental health team were reported to be under strain, the IMB were pleased that a mental health awareness training day was planned to attend to increase staff awareness.

Previous deaths at HMP Cardiff

18. Since 2010, there have been five self-inflicted deaths at Cardiff, including the man. Four out of the five deaths involved prisoners who were charged with offences involving violence against a family member. We have been told that the prison has since introduced a new system to manage this risk factor.

KEY EVENTS

Previous custody

19. The man spent two months at HMP Cardiff from January to March 2011. During this time, he underwent detoxification for alcohol and drugs (opiates and unprescribed benzodiazepines) and was prescribed an antidepressant. At a mental health referral meeting on 15 February, the man was referred for a psychiatric assessment, but was released before it took place.

20. The man was remanded to Cardiff again on 2 September 2011 and told a nurse that he had seen a doctor recently for depression and was receiving mirtazepine. He also said he used heroin most days, benzodiazepines once or twice a week and crack cocaine occasionally, so he was referred to the doctor. On 7 September, during a mental health assessment, the man said he had had a breakdown three years earlier and was being treated by community mental health services, but did not attend many appointments. The man was released on 9 September.

21. When he was remanded to Cardiff again on 19 September 2011, the man explained the extent of his drug and alcohol use and he was referred to the doctor who arranged another clinical detoxification. There is no record that he was referred for a mental health assessment, received mental health support or was prescribed antidepressants. The man was released on 5 October.

December 2012

22. The man was arrested at 1.15am on 3 December 2012 for an offence of unlawful imprisonment and assault against his father. It was recorded in the police custody record that the man refused to answer questions and stormed out of his interview. A police risk assessment identified no issues of concern.

23. The two duty solicitors who represented the man at the police station and in court said he engaged well, understood the advice he was given and did not seem to have any problems. On 4 December 2012, the man appeared at Pontypridd Magistrates' Court and was remanded to HMP Cardiff.

24. The police completed a Person Escort Record (PER) and identified the man's risk factors as suicide or self-harm; physical or verbal abuse; violence or risk to others; hostage taker; conceals weapons or other items. (The PER form accompanies prisoners on all journeys from and between prisons. It serves as a communication tool about risks a prisoner poses on escort or transfer.) In the suicide or self-harm section, it is recorded that the man had "no attempts in custody but broken glass, spoon and lighter found hidden in clothing in past". Under the medical risk section it was recorded that the man said he had suffered from depression in 2011.

25. The man arrived at Cardiff at about 2.00pm. A Senior Officer (SO) was managing the prison's reception, and the records show that she saw the man when he first arrived at the prison, but she said she could not specifically

recall him. SO Steed started the cell sharing risk assessment (CSRA) and wrote 'drugs, weapons, violence, harassment, mental health issues, concealer, thoughts of deliberate self-harm in past, biter'. (A CSRA is used to assess the risk of violence that a prisoner would present to other prisoners when sharing a cell.) The SO circled 'false imprisonment' on the form, but indicated that he had no history of it. As reception staff could not access the man' previous convictions, he was located in a single cell until the CSRA was reviewed the next day.

26. At his initial health screen, the man told a mental health nurse that he had no mental health issues, he had not used drugs for the previous month, he had been in Cardiff before and he had no self-harm history. The mental health nurse concluded that there was no reason for the man to see a doctor and deemed him fit for normal location and work in the prison. SystmOne, the computerised medical record used across the Prison Service, was introduced at Cardiff in February 2012 and medical records that predated the computer records were archived. There was no system for retrieving previous records from the archive, and the man's records from 2011 remained archived until the investigator requested them for the purpose of this investigation.

27. The mental health nurse completed a secondary health screen in reception which included a routine depression scale questionnaire. The man did not give any indication that he was suffering from depression. The mental health nurse then completed the healthcare section of the CSRA and assessed that the man was not an increased risk to share a cell. At interview, he said he could not specifically recall the man, or whether he had seen the PER, but said his views would not have changed if he had seen it. The mental health nurse recorded that the man did not have a drug or alcohol problem and said he did not want to engage with Counselling, Assessment, Referral, Advice and Throughcare Services. (CARATS provides support to prisoners with substance misuse needs.)

28. The reception officer also said he could not specifically recall the man, but recorded on the CSRA that he had explained the cell sharing risk assessment, and the man had no concerns. The officer noted that the man was not to speak to the victim of his alleged offence. The man was taken to a single cell on the induction wing.

29. On 5 December, another officer reviewed the man's CSRA. She spoke to him for about ten minutes about his alleged offence and described him as talkative and polite. The officer concluded that the man could share a cell without posing a risk to a cell mate.

30. There are two entries on the man's case notes on 5 December. The chaplain recorded that the man said that he was coping and he did not have any self-harm issues. Later, an officer wrote that the man had refused to have an induction because he had been at Cardiff in November 2011. (This is the last entry in his record.)

31. On 6 December, the man moved from the induction wing to a shared cell on F wing. There was no security information to suggest that his cell mate was involved in dealing drugs on the wing.

32. The man appeared at court via video link on 11 December. His case was adjourned until 22 January 2013, and his solicitor said that the man gave him no cause for concern.

33. On 12 December, the man moved to cell F3-08 for 15 minutes, then moved to cell F2-07 for twenty minutes before finally being moved to cell F3-14 with a different cell mate. The reason for the succession of quick moves was not recorded and F wing officers could offer no explanation. On 17 December, the man's cell mate was placed on the basic regime because of misuse of telephone accounts. As prisoners on the basic regime are not allowed televisions he was moved to another cell. At 5.26pm, the man pressed his cell bell. It is not recorded who answered the bell or why the man rang it.

34. A prisoner in the cell diagonally opposite the man's cell, said that he heard a heated exchange at about 7.00pm so asked his cell mate to turn off the television. The prisoner and his cell mate looked through the observation panel on their cell door to see onto the wing. The prisoner said that he heard the man ask the officer for a cell mate because he did not like being on his own. He said that the officer swore at the man and dismissed his request for a shared cell. A prisoner in the cell next to the man, said that he heard the officer say "you have no fucking human rights, just get your head down" when prisoners were being locked in their cells at 7.00pm. The prisoner who shared a cell with the other prisoner, said he heard the officer talking to the man when prisoners were being locked in their cells at 7.00pm, but could not hear what was said. The prisoner said that he asked the man if he wanted any tea or coffee passed through to his cell, but he said he was fine.

35. The officer told the investigator that he was working on the man's landing on F wing between 7.30am and 7.30pm, but it was not his usual landing. He said he did not speak to the man that day. There was no CCTV footage to clarify events. The roll check paperwork shows that the officer signed for the 7.30pm roll check on the man's landing, so the officer would have at least gone to his cell to check he was there that evening.

36. In his police statement, the officer said that he was given a verbal handover by the departing officer on F wing when he started his shift that evening at 7.30pm and the man was not mentioned. At about 7.40pm, he checked the man as part of the routine roll check. He said he could not remember what the man was doing at this time but he had no concerns.

37. On 18 December, at 5.45am, the officer began the routine morning roll check. The Operational Support Grade (OSG) who was also working on F wing started to check other landings. At 5.58am, the officer reached the man's cell. When he opened the observation flap, he said he saw the man standing at the back of the cell facing the window and seconds later noticed bed sheets hanging from the top of the window. Immediately, he called a 'code blue' over

his radio and the OSG arrived from the landing below seconds later. (A code blue is an emergency code which indicates that someone has stopped breathing and requires urgent medical assistance.) The control log recorded the time as 5.58am and an ambulance was called at 5.59am. The officers went into the cell and said that they saw signs of rigor mortis and realised that the man was dead.

38. The officer could not cut through the sheets which were tied too thick for his anti-ligature knife. A SO who was in charge of the operation of the prison that night, said he was at the prison gate when he heard the code blue and estimated it took him about five minutes to get to the man's cell, where staff were still trying to cut through the sheets. The SO went to get scissors which were locked in the tool cabinet on the landing below, but could not open the cabinet and returned to the cell, arriving at the same time as a nurse. The mental health nurse had been in the healthcare unit when he heard the code blue and went to F wing.

39. When the mental health nurse reached the cell, he found that the man was still suspended, there were no signs of life and rigor mortis had set in. The SO and the mental health nurse supported the man while the officer climbed onto a pipe and released the bed sheet from the window bar. They placed the man on a blanket on the floor. Paramedics arrived at 6.25am and the man was pronounced dead at 6.32am.

40. The Governor and the chaplain broke the news of his death to the man's father and sister at their home at 10.00am. The prison offered to pay reasonable funeral costs and the chaplain led the funeral service on 11 January at the request of the man's family.

Support for prisoners

41. The Governor issued a notice announcing the man's death, and expressing his condolences. The notice told prisoners of the support available from officers, the chaplaincy and Listeners (prisoners trained by the Samaritans to provide confidential support for other prisoners).

Support for staff

42. A hot debrief was held to support those involved in the emergency response. The officers and nurse were offered the support of the staff care team.

ISSUES

Previous records

43. In the clinical review, HIW concludes that there was no evidence that the man was suffering from a mental illness, presented with any risk, or had any intention to harm himself or commit suicide for the two weeks he was at Cardiff. The man's previous medical records highlighted that he had suffered from depression, had been prescribed antidepressants, was referred for a psychiatric assessment, and to community mental health services for mental health support. The man spoke about his substance misuse, and went through clinical detoxification for drugs and alcohol three times.

44. When SystmOne was introduced in Cardiff in February 2012, all previous medical records were archived. There is no system to retrieve the archived information, so relevant historic medical information is not used to help assess prisoners arriving at Cardiff who have been there before. As a local prison, Cardiff receives a large number of returning prisoners who might previously have received treatment at the prison before. It is surprising that there is no system to ensure that all relevant medical information being held by the prison is retrieved to inform the assessment of a prisoner's needs.

45. HIW concludes that, although information about the man previous history might have impacted on the prison's decisions about the most appropriate pathway for him, there was no evidence to suggest that anything more could have been done to foresee or prevent the man's death. The man's family were concerned that his ongoing mental health and substance misuse needs were not addressed in prison. The man told staff that he had no such needs but reception staff who assessed his mental health and substance misuse needs did not know the extent of his history or previous treatment at the prison, so this highly relevant information did not form part of their assessment or decision-making.

The Head of Healthcare should ensure that prisoners' relevant previous medical records inform the assessment of their needs in reception.

Assessment of risk

46. The man arrived at Cardiff with a number of risk factors on his escort record, relating to his alleged violent offence against his father. PSI 64/2011 highlights that prisoners charged with a violent offence against another person, especially against family members are at an increased risk of suicide. This is reflected in Cardiff's suicide prevention policy, where it is required that the person completing the initial health screen is aware of the suicide and self-harm risk associated with prisoners charged with violence towards a family member. Despite these provisions in national and local guidance, there is no evidence that anyone spoke to the man about the alleged offence or his victim in reception. He was spoken to in depth about the offence by the officer but this was for the purpose of the cell sharing risk assessment form and his suitability to share a cell and not to assess his risk to himself.

47. Police recorded on the man's PER that there were "no attempts in custody but broken glass, spoon and lighter found in clothing in past" next to the suicide and self-harm marker. Reception staff said that they discussed this with the man but did not consider it to be an indication that he was at risk of suicide or self-harm at that time. These items are associated with substance misuse but there is no evidence that either the police or the prison considered this risk factor or discussed it with the man.

48. We investigated another self-inflicted death at Cardiff in December 2012, where the prisoner had also been charged with a domestic violence offence. We found that staff attached too much weight to the presentation of the prisoner in reception and did not attach sufficient weight to this known risk factor when considering the risk of suicide and self-harm. Although we understand that the prison have introduced a system to manage this risk, we repeat the recommendation we made in that report:

The Governor and Head of Healthcare should ensure that staff take account of all known potential risks and triggers when assessing a prisoner's risk of self-harm or suicide.

Request to share a cell

49. Some prisoners reported hearing an exchange between the officer and the man the night before he died but there is no corroborated account of what was said. One said that the man asked to have a shared cell. The officer told the investigator that he had not spoken to the man that day but that does not accord with the prisoners' accounts. The officer recorded the roll check for that landing at 7.30pm so he would at least have seen the man in his cell. The deputy governor explained that if a prisoner told an officer that he did not want to be alone, the officer should discuss this with the prisoner and raise this with the duty manager and arrange for him to be in a shared cell if he thought the prisoners needed the support of a cell mate.

50. As the officer's account differs from the prisoners, and there is no other evidence available, it has not been possible for this investigation to establish exactly what happened that evening. The prisoners' concerns were fed back to the deputy governor and, at the time of issuing this draft report, an internal Prison Service investigation was being held. If the man had indicated that he needed to share a cell, we would have expected the officer to have discussed the matter with him, considered whether an ACCT needed to be opened to support him and, as the deputy governor suggests, raised the issue with the duty manager. Unfortunately, we cannot be sure what happened in this instance, but it would appear to be a sensible learning point to remind officers how they should respond to such requests when they occur and we therefore make the following recommendation:

The Governor should ensure that any request by a prisoner for a shared cell is given appropriate consideration and that this includes the possibility of opening an ACCT if further support is needed.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners' relevant previous medical records inform the assessment of their needs in reception.

2. The Governor and Head of Healthcare should ensure that staff take account of all known potential risks and triggers when assessing a prisoner's risk of self-harm or suicide.

3. The Governor should ensure that any request by a prisoner for a shared cell is given appropriate consideration and that this includes the possibility of opening an ACCT if further support is needed.

PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

Action Plan: Andrew Hawkins – HMP Cardiff

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners' relevant previous medical records inform the assessment of their needs in reception.	Not Accepted	At present the infrastructure is not in place to enable access to every patient's medical records on reception into prison, currently there are not IT systems in place in the community to facilitate this. This is a nationwide issue for the NHS. Given this, and to utilise healthcare resources appropriately, we have developed a protocol to identify those patients that must have their past medical records accessed.	1st July 2013	
2	The Governor and Head of Healthcare should ensure that staff take account of all known potential risks and triggers when assessing a prisoner's risk of self-harm or suicide.	Accepted	Following further investigation into trigger points, and in an effort to ensure risk is managed and minimised effectively, a self harm screening tool has been developed. The tool is attached to the first night induction booklet and offers specifically trained staff a further insight into the risk of self harm posed by the prisoner. It identifies known triggers whilst still maintaining professional discretion.	8th July 2013	

3	The Governor should ensure that any request by a prisoner for a shared cell is given appropriate consideration and that this includes the possibility of opening an ACCT if further support is needed.	Accepted	All requests for shared cells made by prisoners at HMP Cardiff would in the first instance alert staff that the prisoner in their care may require extra support. Reasonable consideration should be given to the request. If it is felt that the prisoner is in need of support this could be offered in the form of a cell mate but should always trigger assessment for further support in the form of an ACCT.	21st June 2013	