Investigation into the circumstances surrounding the death of a man at HMP Swansea in August 2007

Report by the Prisons and Probation Ombudsman for England and Wales

August 2009

This is the report of an investigation into the circumstances of the death of a man in August 2007 at HMP Swansea. The man was found with a ligature around his neck attached to the top of the window in his cell. Prison staff and paramedics attempted resuscitation, but were unable to revive him. I would like to offer my sincere condolences to the man's partner and family and all those touched by his death. I must also apologise for the delay in issuing the final version of this report. I deeply regret any further distress this may have caused.

The investigation was undertaken by my colleague. Both she and I would like to thank the Governor and her staff for their cooperation during the course of our inquiries. Not for the first time, I must also thank the appointed doctor, Healthcare Inspectorate, for her clinical review.

The man had been released on licence in March 2007 after a ten year sentence. In spite of intentions to get a job and settle down, he found it difficult to adjust to life outside prison and was recalled to prison on 8 August. He was in Swansea for just four days before he died.

Research and my own investigations have drawn attention to the increased risk of suicide and self-harm amongst those recalled to prison. I am concerned about opportunities that were missed to obtain more information both from the man and from those involved in his care in the community.

I make eight recommendations, largely relating to the management and assistance of recalled prisoners and to information sharing.

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Prisons and Probation Ombudsman **August 2009**

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SUMMARY

The man was released on licence from HMP Channings Wood in March 2007 after serving ten years in prison. Two of those years had been at HMP Swansea.

Three months after his release, he made an attempt on his life and received psychiatric treatment.

In August 2007, the man was distraught when informed his licence was being revoked. His partner contacted his probation officer to complain. She warned that, if he was returned to custody, he was likely to kill himself. This information was recorded on the probation database.

The man was recalled to Swansea prison on 8 August 2007. The accompanying police officers had completed the Prisoner Escort Record (PER), confirming that he was a current suicide risk and concerns had been raised by his partner. On reception, he said he was disappointed to be back in prison.

At the reception board the following morning, the man said he was concerned about the reasons for his recall. The probation officer later explained the reasons to him after examining the database and speaking to his home probation officer. The probation officer also told the Senior Officer (SO) about the concerns expressed by the man's partner.

The SO found it difficult to believe that the man would harm himself, and thought this out of character. He asked the chaplain to see the man for a second opinion and she found no cause for concern. He had told the Chaplain he was worried about his partner and concerned that he could not get through to her on the phone. The SO mistakenly thought that the man's partner had phoned into the prison probation department, and to alleviate his concerns he told him this. He seemed relieved but over the next few days continued to try to contact his partner, becoming increasingly concerned that she might have ended the relationship.

At around 11.00am on 12 August, while the man's cellmate was at church, an officer noticed that a towel was obscuring the observation panel in the cell door. The officer entered the cell and found him hanging with a ligature made from bed sheets around his neck, attached to the top of the window. Staff and paramedics attempted to save him, but without success.

Following the man's death, all contingency plans were followed thoroughly and considerable attempts were made to locate his family to break the news. Staff and prisoners were offered support.

The investigation found that a number of opportunities to explore the man's state of mind were overlooked. For example, the PER form was not passed to medical staff and his GP and psychiatrist were not contacted. Thus, prison staff were not fully aware of his psychiatric state, his prior attempt at suicide, or his drug use.

The man was a private individual, and did not share his intentions with anyone in the prison. However, staff were over-reliant on their previous knowledge and relationship with him in assessing his state of mind.

I make a number of recommendations. These include the need for improvements in information sharing on the risk of suicide and self harm, and raising awareness of the risks relating those recalled to prison.

THE INVESTIGATION PROCESS

1. I appointed one of my colleagues to lead the investigation on my behalf. On her initial visit to HMP Swansea, she met the Governor, members of the local committee of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). She was also given a tour of the prison, including the cell where the man died. Notices were issued to both prisoners and staff in Swansea inviting anyone who might have information relating to him to make themselves known to the inquiry.

2. My investigator and one of my family liaison officers visited the man's partner and contacted his sister to discuss the investigation and ascertain any particular family concerns or questions. The man's sister and partner were seriously concerned about the reasons for his recall and his treatment from outside agencies. It is beyond the remit of this investigation to comment on these latter matters. However, my investigator did contact the man's GP, probation officer and the police to gather more information regarding his vulnerability as well as the context of his time in the community and subsequent imprisonment. The man's partner also asked for more information on how the man died, and when he had last been seen and checked. These issues are covered in detail in this report.

3. The investigation team interviewed prison staff and prisoners at Swansea, both formally and informally. The team examined the man's prison record, medical records and a series of prison documents.

4. A doctor from the Healthcare Inspectorate conducted a clinical review of the provision for the man's healthcare needs whilst in HMP Swansea. The clinical reviewer and my investigator conducted some joint interviews of clinical staff. Once the investigation was complete, my investigator provided feedback to the Governor.

HMP SWANSEA

5. HMP Swansea is a category B local prison that holds adult males remanded into custody from the courts as well as convicted and sentenced prisoners.

6. The prison was completed in 1861. It has remained largely unchanged since then, although D wing has had accommodation added and the reception, kitchen and visits area have been re-built. Considerable refurbishment of existing accommodation areas is currently underway including a new pedestrian gate, healthcare and the re-establishment of B wing as a residential unit.

7. HM Chief Inspector of Prisons last conducted a full inspection of Swansea in April 2005. She found one of its distinguishing features to be the good relationship between staff and prisoners, often based on familiarity as many prisoners were repeat offenders. However, she noted that there could be a danger that good relationships become comfortable and collusive. There was also a need to ensure that robust systems existed to ensure the care of those not known, or whose problems are not visible, to staff.

8. During the inspection, HM Chief Inspector of Prisons found that reception was efficient and staff engaged positively with prisoners. Prisoners were positive about their treatment in reception, with responses above the benchmark figure for other local prisons – 81 per cent of respondents said they were treated well or very well in reception, against the benchmark of 55 per cent. Reception was clean and well organised. Staff worked efficiently and prisoners did not spend long periods there.

9. First night procedures were handled well and 78 per cent of prisoners said that they felt safe on their first night – significantly higher than other local prisons. There were good and supportive first night interviews but not enough to do during induction. Generally, the prison relied on good relationships rather than systems to support safety. The prison was performing reasonably well against this test.

10. At the time of my investigation, considerable work was under way to improve reception and induction procedures. The policies relating to these areas were undergoing review.

11. There is an observation hatch in each cell door that can be opened from outside the cell. This is to allow staff to check on prisoners. Prisoners should not obstruct the view of these observation hatches, although it can become a mainstream feature of prison culture to do so unless staff are both vigilant and robust.

KEY EVENTS

12. The man served a long prison sentence between October 1997 and March 2007. He spent time at a number of prisons, including HMP Swansea where he had been housed from September 2003 until October 2005. Whilst at Swansea, he had become a trusted prisoner, and earned the role of orderly in both reception and the induction units. He was also a Listener (a prisoner trained by Samaritans to provide confidential emotional support to fellow prisoners in distress). He had a good relationship with staff on the unit, and was unhappy to be moved.

13. In October 2005, the man transferred to HMP Dartmoor. He went to HMP Channings Wood on 3 February 2006, until his release on licence on 9 March 2007.

14. On release, the man lived with his partner near Swansea. He had hoped to find work, get married and settle down, but found it difficult to adjust to life outside prison and suffered with depression. The man's general practitioner (GP), kindly provided my investigator with a summary of her contact with him. She saw him soon after his release to reissue his medication: citalopram 20mg daily (anti-depressant), propranolol twice daily (to help calm nerves/a beta-blocker), cimetidine 400mg daily (for heartburn) and nitrazepam 10mg at night (for insomnia). He agreed to a trial of omeprazole instead of the cimetidine in an attempt to help relieve the heartburn.

15. The man visited his GP again on 4 April 2007 and told her he had been drinking to excess and using illicit drugs. He said he was forgetful, acting out of character and unable to sleep. The GP referred him urgently to the psychiatric team. A week before his appointment with the psychiatrist, the man went to hospital having deliberately overdosed and cut his wrists. He was sent to a different hospital to have his wrist lacerations treated, but discharged himself before this could be done.

16. On 3 May, the man was assessed by a psychiatry specialist registrar, at the psychiatry outpatient clinic. He diagnosed "adjustment reaction," along with mild to moderate depression and anxiety.

17. The following week, the man visited his GP. As the doctor had not yet received the letter from the psychiatrist she was unable to prescribe the suggested medication. The man felt quite positive at this time. He was due to start a forklift driving course which he hoped would help him find employment. Four days later he was seen by one of the GP partners, and again admitted to illicit drug use. He was given a prescription to start new medication, an anti-psychotic (quetiapine), at an increased dose as instructed by the psychiatrist. He was given only one week's supply due to his previous overdose attempt.

18. On 11 June, the man returned to request another month's medication. He had finished the forklift driver's course, and was hoping to pass a health and safety exam later in the month. He denied illicit drug use, but had stopped the medication suggested by psychiatrist as it made him drowsy. Nearly three

weeks later, he collected another month's medication early as he was planning to go and visit his family. He said he had passed the exam and was looking for work.

19. On 16 July, the man told his GP that he had thrown his medication down the toilet as he thought it was making him feel worse. He asked for a new prescription. He felt low but did not express any suicidal ideation. He was concerned no one would offer him a job as he had a prison record. The man had not attended his psychiatry appointment at the end of June and therefore had been discharged from their care. The GP was aware, from the man's partner, that he had been taking illicit drugs – mainly smoking heroin.

20. Three days later, the man's partner visited the GP. She said the man had stopped taking all drugs and was suffering badly from withdrawal symptoms. She explained that he was desperate to stop taking heroin, but could not get an appointment at the local drugs and alcohol addiction unit until the following week. The man was too unwell to visit the surgery, so the GP prescribed medication to help abdominal pain (co-codamol and tramadol), cramps (buscopan), nausea (cyclizine) and agitation (diazepam).

21. The man visited his GP again on 1 August. He said he had managed one week without taking any illicit drugs, but had then called round to see a friend and relapsed. He was desperate to stop taking drugs, but was finding it difficult to get help. He explained he had visited the local drug and alcohol addiction centre, but after the second interview the police had visited his home. They had been informed by the drug and alcohol centre counsellor that the man had been aggressive towards his partner and that she might be at risk. (His partner stressed that she had never felt threatened by him.) The GP agreed to re-prescribe the medication to help with withdrawal. She also emphasised that, if he felt suicidal, he must get help either from the GP surgery or the local hospital. The next day he went to the local hospital and was assessed by the psychiatric team.

22. The man's partner told the GP on 7 August that the man had been arrested. His partner was concerned he might try to take his own life and had passed on these concerns to the police and his probation officer.

23. The man's supervising probation officer told my investigator he was aware that the man's brother had taken his own life. He might have overdosed shortly after that (1990), but he had not indicated any further thoughts of suicide or self-harm. The supervising probation officer knew that the man had been a Listener in prison and did not suspect that he would be likely to commit suicide. He was also aware that his GP had referred him to psychiatric services to treat his depression, but he had spoken little of this.

24. The supervising probation officer told my investigator that the man had been arrested in July 2007 and bailed for possessing heroin. The supervising probation officer did not know that he used drugs. He therefore viewed this as an isolated incident and referred him to the local drug agency. The man also

received a final warning letter, advising him that further non-compliance would result in recall to prison.

25. Following the information given about the man's allegedly aggressive behaviour, the Probation Service decided that he should be recalled to prison. He was upset when the supervising probation officer phoned to tell him the news. Soon after, his partner phoned the supervising probation officer to protest at the decision. She said she was concerned about his safety and that he might harm himself. The supervising probation officer recorded this information and marked the man as a potential suicide risk on the probation service database (CRAMS) which would be accessed by probation staff in prison.

26. The man was arrested for a further offence. He spent three days in police custody and during this time his licence was revoked. Police told my investigator that he saw a doctor and nurses on several occasions while he was in custody. When asked specifically whether he was having suicidal thoughts, he said no, but admitted he had tried to harm himself many years previously. The man told police he was taking medication for depression. He also said that he was addicted to heroin, so the police doctor prescribed relevant medication.

8 August

27. On 8 August, the man was taken to Swansea prison. Police had completed the Prisoner Escort Record (PER) on which the prisoner's previous and current risk is recorded. He was considered to be vulnerable in three categories - violent, drugs/alcohol and suicide/self-harm. Further information was added regarding suicide/self-harm: "18.6.07 arrested for possession of class A; 17.6.07 offended on bail; 17.6.07 wife says has been feeling down and suicidal." The man had his medication with him.

28. The PER form initiated by the police was given to escort staff and then passed to another SO. This SO told my investigators that he knew the man as a bubbly character from his previous sentence. He said that he examined the PER form and asked him how he was. He felt he had let himself down but gave no indication that he was feeling particularly low. The SO had previous experience of the man and thought he was alright.

29. Various staff met the man to complete the reception procedures. Most remembered him well. An officer carried out the Cell Sharing Risk Assessment with him. He told my investigators that, during their conversation, the man said he was upset with the Probation Service and his recall. He asked if it would be possible to work as an orderly in reception as he had during his previous sentence. The officer explained there were already two prisoners working there and he seemed to accept this.

30. The officer completed section one of the Cell Sharing Risk Assessment to indicate what information relating to the prisoner has been received. In the man's case, this had been the PER and the warrant. He then completed

section two which requires an assessment of the risk he might pose to others. The officer wrote that the man had not abused drugs, had no concerns about drugs and did not anger quickly.

31. A nurse undertook a reception health screen with the man. He disclosed that he had been seeing his doctor for depression, and had an outstanding appointment with a psychiatrist the following day. The man also said he had stayed in a psychiatric hospital in March 2007. He had some grazes and bruises which he said he had received during his arrest, but told the nurse he had no concerns regarding physical health. When asked, he denied using drugs and said he drank alcohol socially.

32. In response to questions about suicide and self harm, the man said he had taken an overdose many years before, but this had been outside of prison. He said he had no current concerns and was aware of the support available to him. The first reception screen nurse referred him to the doctor and for a mental health assessment. She also recorded the medication he had with him: propranalol (beta blocker), buscopan (stomach cramps), tramadol (opiate painkiller), cimetidine (antacid) omeprazole and citalopram. The first reception screen nurse had not seen the PER form at the time of conducting the healthscreen.

33. From reception, the man was taken to the first night centre. The first night centre officer said that he appeared agitated and wanted to know if another named prisoner was on the wing. He was concerned there might be some ill feeling between them relating to the charge the other prisoner was facing, and said he felt threatened by his presence. The first night centre officer spoke with the other prisoner who was very quiet about this and he feared there could be a problem between the two prisoners. The officer and the man discussed the matter with the SO and secured the other prisoner's agreement to move to another wing.

34. The man told the first night centre officer that the reason for his recall was nonsense and he thought it would be dropped by the police. The police told my investigator that it was likely he would have faced charges for offences unrelated to his recall.

35. On their first night in custody, prisoners have a first night interview to identify and resolve any problems they might have on their first night. The first night centre officer began a first night interview which was continued by his colleague. According to the first night centre officer, the main issue raised was that of the man and the other prisoner being on the same wing. The man said he was not a drug user and the first night centre officer saw no indication that he was withdrawing from drugs. He felt he was a "big strong man … strong of mind and in body". He said that he seemed more likely to support others emotionally than require it for himself. He had not known the man to suffer depression, but knew from his previous time at Swansea that he could sometimes become a little paranoid.

36. The first night centre officer said that the man had completed much of the induction programme and there was little need for him to do it again. He arranged for him to have his pin phone numbers authorised so that he could make telephone calls.

37. That evening, the man phoned his partner twice but there was no answer. He then phoned his mother. During the call he clearly felt aggrieved about being back in prison. He told his mother he might be out in May. She tried to reassure him and said she would send some money.

From 9 August

38. In the morning of 9 August, the man attended a reception board chaired by the SO and attended by the probation officer, the chaplain and a CARAT's worker (Counselling Advice Referral and Throughcare - a drugs service).

39. The SO told my investigators that they discussed why the man was in prison. His understanding was that he was in prison for breaching his licence. He was also facing other charges, but thought it unlikely he would face prosecution. The SO introduced the other members of the board who, in turn, explained the service they could provide and how they could be contacted. The man was concerned about his recall. He thought it had been unfair and wanted to speak to the supervising probation officer. The probation officer offered to contact the supervising probation officer to establish the reasons for recall. Aside from this, the man raised no other concerns during the reception board.

40. About an hour after the board, the man approached the SO to request a transfer to another prison. He told him that he had problems with another prisoner. He thought there was a "contract out" on him and felt threatened. The SO was surprised at this, as he told my investigator he thought that the man was far better equipped than the other prisoner to handle himself and cope. The SO agreed to look into the matter, and completed a Security Information Report (SIR).

41. Following the reception board, the probation officer looked on the probation database, CRAMS. She saw that the supervising probation officer had explained the reasons for recall to him, and that his partner had been concerned that the man might harm himself. The probation officer and the supervising probation officer had a telephone conversation which largely centred on the man's recall. The supervising probation officer said he had never had concerns that the man might self-harm but thought it prudent to alert prison staff.

42. In the meantime, the man saw the healthcare officer for a second healthscreen. His blood pressure was higher than normal at 133 over 98 (a normal reading for a man of his age is 120 over 80), and his pulse was quite rapid at 98 beats (normal resting rate is 70 beats). He was noted to have an injury to his head and arm, two loose teeth and sore ribs on his right side. It

was also noted that he had been seeing a hospital psychiatrist. The healthcare officer felt that the man was cheerful, but not his normal self.

43. As a matter of routine, the man also saw the medical officer, who noted the medication he had been prescribed outside of prison and that he was being seen by a psychiatrist. The medical officer considered him to be calm and friendly during interview, and he did not consider it necessary to perform a mental health assessment at that time. The medical officer was content that a routine mental health assessment, to be performed between 7-14 days later, would suffice. There is no evidence that prison staff contacted the man's community psychiatric nurse, psychiatrist, or GP to obtain his latest medical history. Neither did they contact the hospital to notify them that he would not be attending his appointment that day.

44. Between 9.00am and 4.15pm that day, the man attempted to telephone his partner 11 times without success. He phoned his mother at 2.00pm. He sounded tearful and said he was "worried sick" about his partner.

45. The probation officer returned to the wing to explain to the man the reasons for his recall. She then told the SO about the concerns of the man's partner that he would kill himself. At the time, the SO thought that the man's partner had phoned the probation department in the prison to provide that information. The SO told my investigator he was surprised as he never thought he was likely to harm himself. He then asked the chaplain to speak to him for a second opinion.

46. The chaplain noticed the man was not as cheerful as he had been during his previous time in custody. They chatted for about 20 minutes. He said he was concerned because his partner was not answering her phone. The chaplain explained that it was not uncommon for loved ones of prisoners to take a little time to adjust and advised him to give his partner some time. He looked unkempt, and the chaplain suggested if he tidied himself up that might help him feel brighter.

47. After their conversation, the chaplain went to the wing office. She told the SO that the man had been concerned about his partner. The SO then spoke to him in the office. The man said he was concerned that his partner might do something "daft". The SO reassured him that his partner had actually phoned to check that he was okay (his interpretation of the message from probation). The SO told my investigator that, on receiving this information, the man totally changed and seemed far more relaxed. He also said that the subject of killing himself had been raised and he had reassured him he would not do anything. The SO told my investigator that the man said "What me do anything silly, I'm not going to do anything silly". The SO said it was as if the man thought the idea ridiculous.

48. Just after 4.00pm, the man phoned his mother again. He said:

> "I saw the chaplain right, so that I could see about [partner]. And she's been in touch; she's been worried about me. So there's got to be a fault,

there's got to be, the number must be wrong. But I can't understand why she hasn't phoned you … she thinks I tried to harm myself."

The man reassured his mother that he had not harmed himself.

49. On 10 August, the man made three attempts to contact his partner. On 11 August, he tried a further three times, following which he phoned his mother. In this call, he was concerned his partner might have ended their relationship. He spoke to both his mother and father, trying to think of ways of reaching his partner. He came out for association on the wing, used the phone and was seen collecting medication from the treatment hatch. He spoke to staff, but generally kept himself to himself.

50. The man's cellmate had not been in prison before, and told my investigator that he had been supportive and easy to talk to. The man was fairly quiet but they chatted and played cards to pass the time. The man told his cellmate he had already served eight years in prison and was unhappy to be back; he hated being in prison.

51. The man also told his cellmate he was very worried about his partner. He said that, some time before, his partner had said she would not be able to cope if he was returned to prison. As he could not get hold of her, he was trying to think of others who knew her and would be able to go and check. When he was told she had phoned into the prison, he seemed greatly relieved but was confused as to why he could not get through to her.

52. The cellmate said that the man was physically well. He had a healthy appetite, and even finished his cellmate's dessert when he could not manage it. His cellmate described the man as always looking man sad. He did not mention feeling threatened or worried by other prisoners, but thought he might be in prison for about six years to see out the rest of his sentence and possibly have further time added.

12 August

53. An officer unlocked the man's cell at about 8.30am on the morning of 12 August so that he could use the phone. He said in interview that the man seemed all right and expressed no problems. At 8.48am, he tried to phone his partner. There was no answer. At about 10.00am, the officer who unlocked the man's cell went back to the cell to see whether the man and his cellmate wanted to go to church or outside for exercise. He said no, but his cellmate decided to go to church.

54. The exercise period finished at about 11.00am. Another officer went up to the fourth floor landing and began to unlock the cell doors so the prisoners could go straight back into their cells. As he walked past the man's cell, he noticed the observation panel was open but the view was obscured from the inside by a towel. He tried to open the door in order to ask him to remove the towel, but realised it had been barricaded by an item of furniture (a locker). He managed to push the door open several inches and saw that he had a ligature

around his neck made from knotted bed sheets and tied to the top of the window at the back of the cell.

55. The first officer on scene called for his colleague, who was a little further up the landing. Between them they pushed the door open and moved the locker. The first officer on scene held the man around the waist to take the weight off the ligature, and his colleague used his anti-ligature knife to cut through the sheet. They moved the man to the middle of the cell, laid him flat and began cardio pulmonary resuscitation (CPR).

56. The officer's colleague shouted to a nurse and a third officer, who were on the landing below, to come quickly. As they reached the cell, the nurse went to get the emergency first aid kit. The third officer took the nurse's radio and called for urgent assistance and an ambulance. The nurse, a PO and the first officer on scene continued CPR.

57. Within minutes, two further arrived with the "first responder kit" which has a defibrillator machine (a device that delivers a measured electrical shock to the heart). One nurse applied the defibrillator pads to the man's chest. The defibrillator indicated to continue CPR until the paramedics arrived at 11.23am. The first officer on scene estimated that they conducted CPR for about 40 minutes before the paramedics declared the man had died. The prison doctor attended and confirmed the man's death at 12.15pm.

58. Following the man's death, contingency plans for a death in custody were activated. Staff attended a debrief and were offered support. The news was broken to other prisoners and they too were offered support.

59. The Governor went to see the man's partner at her home to break the news of his death, but she was not there. Once they had returned to the prison, concerns were raised about her safety and the Governor alerted the police. The police found out she was in hospital and went to tell her what had happened. The Governor later visited her.

60. In the meantime, staff examined the man's phone records to locate members of his family. The Governor then telephoned his parents. His family were grateful for the support offered by the prison family liaison officer.

ISSUES

The man's time in the community

61. It is clear that the man found it difficult to adjust to life outside prison. He suffered from depression and could not find employment. He was under the care of a psychiatrist and had attempted to take his life. He also used illicit drugs.

62. The man's partner said he had become distressed when told of his recall over the phone. She told his probation officer that, if returned to prison he would kill himself. The man's probation officer recorded this information on the probation database.

Prisoner Escort Record

63. Prison Service Order (PSO) 1025 "Communicating Information about Risks on Escort or Transfer – The Prisoner Escort Record" reads:

> 1.2. It is essential that when a prisoner is moved from police station, court or prison to court, prison, hospital or other destination those responsible for the prisoner are made aware of any risks or vulnerabilities. In particular it is essential that known risks of escape, assault, suicide or self harm or harassment are communicated to others into whose custody the prisoner is passed; to protect prisoners, staff and the public. It is also essential that any new risks that develop during a movement are recorded and flagged up for others.
>
> 1.4 Whenever a prisoner is received from the custody of others for, during or on completion of a movement the risk and vulnerabilities identified by the previous custodian should be noted and acted on; to protect the prisoner and other prisoners, staff and the public.

64. The man's PER contained information about his attempted suicide in June and his partner's concerns that he would harm himself.

65. There is no requirement to open an Assessment, Care in Custody and Teamwork (ACCT) document (used to support and monitor those at risk of suicide and self-harm) if a suicide/self-harm marker is ticked on a PER form. Indeed, many staff told my investigator that it was common for a suicide flag to be marked but these are often historic events without a current risk. However, there is an obligation to acknowledge and explore the information and pass it on to others.

66. The SO who passed the initial PER said he saw the suicide marker had been ticked and spoke to The man:

> "He seemed ok, I did read the PER where it highlights warnings but knowing him of old I had a little chat with him, well I suppose I had quite a bit of a chat with him really and he gave me no indication whatsoever."

67. My investigator asked what they had discussed, and the SO who passed the initial PER replied:

> "How was he doing, what was he doing back that type of thing, what happened that type of thing I think, normal general chit chat … [the PERs] do give you the warning signs, but as I spoke to him I had obviously seen this and he gave me no indication that he was feeling that bad really but he was down and he felt he had let himself down by being back in prison really and I put it down to that and as I said having previous experience of him I thought he was ok."

68. Paragraph 3.2 of PSO 2700 "Suicide and self harm" requires:

> "Reception staff must alert appropriate staff in the prison to any risks identified on the PER, eg healthcare and security staff, duty governor/orderly officer."

69. The SO who passed the initial PER told my investigator that a copy of the PER is placed in the prisoner's core record which is taken to the induction unit. He said that in his experience he had not known a PER to be passed to the reception nurse. The first reception screen nurse also said she did not see the form. Had she seen the PER, she would have probed the man further about self-harm and suicide.

70. In itself, this may not have had a bearing on the man's death. He was a private man, and did not choose to share his thoughts freely. However, the first reception screen nurse had other information regarding his medication and limited psychiatric history. Taken together, this might have led to more in-depth discussion and probing. This was a missed opportunity.

The Governor should ensure adequate systems are in place to ensure important information from PER forms is communicated to staff responsible for the prisoner concerned, in particular healthcare staff. Staff should be reminded of the reasons why this is important.

71. The PER form was passed to the induction unit. The SO had the form with him at the reception board the day after the man's arrival.

Communication of risks raised by the man's partner

72. When the probation officer checked the database for information regarding the man's recall she saw the note that his partner was concerned that he would kill himself if he returned to prison. The entry in the database reads:

> "… she said he had tried to commit suicide yesterday, I noted he was at home and apparently well. I also agreed to notify the prison authorities of his suicide risk when he is back in custody … She ended the conversation by stating I would have his death on my hands."

73. The probation officer spoke to the supervising probation officer, but this was largely about the reasons for the man's recall. The supervising probation officer said he had not known the man to be a suicide risk but thought he should communicate the concerns raised by his partner.

74. The information from the database was passed to the SO verbally. Given the wording on the database was very strong, it might have been better conveyed by showing him the actual entry. In spite of this, the SO was clear that the man's partner had been concerned that he might try to harm himself. The SO felt he knew the man well. He had seen him at the reception board, and had helped him explore the possibilities of a transfer. He was confident that he would feel able to approach him with a problem. The SO recalled that, during his previous time in Swansea, he had been an orderly and a Listener and had communicated well with staff. He therefore was shocked by the concerns raised. When told, his response was:

> "… there was a couple in the office at the time and I looked at them and said [the man] you are joking aren't you, well that is what we have been told … I said well I can't believe he would do anything … but we'll get a second opinion."

75. The SO asked the chaplain for her view of the man. The chaplain told my investigator that she had not been made aware of the concerns regarding suicide, so did not ask him about this. At no time during their conversation did he raise the subject, neither did she feel he was at risk of self-harm. When the chaplain had finished talking to the man, she told the SO that he was concerned about his partner. The SO called the man to the office and told him, as he believed to be the case, that his partner had phoned in to report her concern about him:

> "… he just totally changed and he said. 'When did she phone in?' and I said, 'Well today.' 'Who did she speak to?' 'Probation.' 'Oh God, thank God for that, I was really worried about her.' And he just changed he was back to being [the man]. And I said, 'Well, what about it then [the man]? What about you have we have got to be worried about …? Are you going to do anything silly?' And he just gave me that look like, it is difficult to explain it really unless you knew the bloke."

76. The SO had seen the PER form and was also privy to information from the probation officer. He acknowledged the information, consulted another colleague, and spoke briefly to the man about it. The SO made a judgement that the man was not at risk of suicide at that time.

77. I am disappointed that the man was not questioned at the reception board about the suicide marker on his PER. Furthermore, the information from the probation database should have been conveyed to reflect the strong manner in which it was written. It appears that the SO's view had been tempered by the fact that he knew the man well, and that he did not present any signs or concerns. A colleague who was asked for a second opinion concurred with his judgement.

78. The man had seen a number of experienced staff and health professionals in the police station, and on a one to one basis in Swansea. None thought he presented a risk to himself.

79. Staff were clear what to do when they had concerns regarding self-harm. My investigator examined the last nine ACCTs that had been closed, including some that had been opened in reception and induction. They had been opened for a number of reasons such as prisoners feeling low and needing extra support, and it was certainly not the case that staff waited for an explicit act of self-harm to occur before they intervened. Many case reviews, largely those chaired by the SO, were relevant and meaningful. However, all too many of the ACCT reviews had not been completed by a multi-disciplinary team including those that led to closure of the ACCT.

80. During interview after the man's death, the SO said that, even with the benefit of hindsight, he still felt that at the time he spoke to the man there were no signs that gave him cause for concern.

81. The SO did not copy the information from probation into the wing observation book. He felt that recording it in the book would have indicated sufficient concern to merit opening an ACCT, but this was not necessary. In my view, a different approach could have been taken. It might have been better to have written an entry describing what had happened, pointing out that he did not feel it warranted opening an ACCT at that time, but that staff should be aware of the situation.

The Governor should remind all staff of the importance of recording relevant matters in the wing observation book.

The prison's assessment of the man

82. Many staff who were interviewed spoke fondly of the man. They remembered his character and felt they had a good understanding of him. However, he had not been in Swansea for nearly two years. In the time he had been released, he had attempted suicide, become a drug user and suffered depression. Staff were not aware of these factors and, arguably, viewed him as the same familiar character they had known before.

83. There are a number of known risk factors for those who self-harm in prison. PSOs 2700 and 0500 are absolutely clear that prisoners released on licence who are recalled to prison are vulnerable. The man was used to HMP Swansea, he knew the regime and staff, and knew who to ask for help. However, he felt angry about his recall and faced a number of difficulties. He did not know if he was facing further charges, and how long he would spend in prison. He was concerned about his partner. He had struggled outside of prison to find work, and might have felt he had failed and that his future was bleak.

In line with PSO 2700, Swansea should put in place a strategy to respond to the needs of recalled prisoners.

84. Prison Service Instruction 16/2006 states that:

> "Reception and First Night staff must be alert to the significant risk of suicide/self-harm that recalled prisoners present. Not only may the recall itself have increased the suicide/self-harm risk, but this may be intensified if the prisoner has had difficulties contacting family or if they are in a state of intoxication or withdrawal or otherwise in need of healthcare support."

85. Whilst relationships between staff and prisoners are one of the acknowledged strengths of HMP Swansea, I am concerned that staff may have placed too much emphasis on their prior knowledge of the man and not fully appreciated his change of status and circumstances. Accordingly, on reception and subsequently they may not have given him the full level of questioning, time and support that they might offer a new prisoner.

The Governor should remind staff of the increased risk of self-harm and suicide by those recalled to prison.

Healthcare

86. The initial healthscreen was completed to a good standard. My investigator was told that at the second healthscreen arrangements are made to contact prisoners' GPs and relevant outside specialists.

87. However, there is no evidence that staff contacted the man's CPN, psychiatrist, or GP to obtain his latest medical history. These clinical professionals had information regarding his mental state, suicide attempt and drug use. I endorse the following recommendation made by the clinical reviewer:

Healthcare staff should make every effort to contact a prisoner's GP or community care worker to obtain information on recent treatment so that continuity of care can be maintained.

88. During consultation about the draft report, solicitors acting on behalf of the man's partner raised concern over the quality of the assessment by the prison doctor. They felt that he was not fully informed about the man's history and there was no care plan in relation to his future care. The solicitors passed my investigator a copy of the hospital records from two hospital's mental health records. My investigator in turn passed these records to the clinical reviewer and asked for comment regarding these issues. She maintains that a core issue is the need to make efforts to contact with clinical services outside of the prison to ensure continuity is maintained. However, she concluded "I am unable to tell whether knowledge of information from the man's GP and hospital records would have changed the subsequent actions of Prison Healthcare staff".

89. The clinical reviewer's background makes her qualified to judge the care the man received. I agree that this is particular cause for concern. Without the previous knowledge to inform the present, staff could not make a judgement based on the facts. I cannot stress the importance of information being sought to inform decisions on prisoners health and well being.

90. Furthermore, there is no evidence either that staff contacted the man's GP or the hospital to notify them that he would not be attending his appointment on 9 August and to reschedule it. I agree with the clinical reviewer:

Healthcare staff must liaise with external NHS practitioners if prisoners are not able to keep appointments to ensure these are rescheduled for the ultimate health benefit of the prisoner.

91. After considerable delay, HMP Swansea was able to provide my investigator with an electronic pharmacy print-out to show that the man had been prescribed medication. However, the prison could not locate his prescription chart. Staff said they remembered seeing him at the medication hatch, but without the prescription chart I have been unable to verify whether he was collecting his medication. The following recommendation is intended to ensure that such a situation does not recur:

Healthcare staff should ensure that prescription charts are kept safely and securely in a designated place.

Drugs

92. Outside of prison, the man began using illicit drugs. He had spoken to his GP about this and had tried to stop on several occasions. He had also sought help for his drug use through a drug agency and had even enquired about a potential methadone prescription.

93. While in police custody, the man admitted he was a heroin user. In contrast, he did not mention drugs in prison. In fact, he actively denied having recently used them. I can only speculate why this may have been. It may be that he was aware that being a drug user might curtail some activities in prison, or he might have wanted to present a positive image of himself. Alternatively, he might have felt this was a private matter and one that he did not wish to discuss. Certainly it was not raised as an issue, and no one who dealt with him, including the clinical staff and CARATs worker, thought he was actively detoxing from drugs. Drug withdrawal, even at the latter stages, can impact on mental health.

Threats

94. When the man came into prison, he was concerned about the presence of another prisoner on the wing. Both men had allegedly been involved in the same offence. Officers spoke with the other prisoner and were of the opinion he was annoyed with the man. Accordingly, he was moved to another wing.

95. My investigators interviewed the prisoner concerned. He said he was originally annoyed with the man, but would not have taken issue with him. He said they had been mates outside of prison and had always got on. He said he never made threats towards him and was shocked by his death. He did not think that he would take his own life.

96. The man had told staff of his concern that there might be trouble for him in Swansea, and had requested a transfer to another prison. This had been approved. His cellmate said that the man had never mentioned to him that he was either concerned or felt threatened by other prisoners.

Recent developments

97. At the time of investigation, Swansea was revisiting the safer custody agenda. It is worth noting that a considerable plan of work was pending, including a dedicated unit to support a greater number of vulnerable prisoners. A revised induction plan was also being introduced, together with improvements in reception and first night procedures. There is a positive plan for the future. I trust the lessons from the man's death can be used to enhance this framework.

Crisis management

98. When staff found the man, they acted appropriately and professionally in a stressful situation. Swansea operates a "first responder system". This is where a number of staff from various departments, but largely discipline staff, are trained in first aid and the use of defibrillators to ensure there is always someone trained who is on duty. This is good practice that I would like to see rolled out to all prisons, or at least to all local prisons.

RECOMMENDATIONS

The Governor should ensure adequate systems are in place to ensure important information from PER forms is communicated to staff responsible for the prisoner concerned, in particular healthcare staff. Staff should be reminded of the reasons why this is important.

The Governor should remind all staff of the importance of recording relevant matters in the wing observation book.

In line with PSO 2700, Swansea should put in place a strategy to respond to the needs of recalled prisoners.

The Governor should remind staff of the increased risk of self-harm and suicide by those recalled to prison.

Healthcare staff should make every effort to contact a prisoner's GP or community care worker to obtain information on recent treatment so that continuity of care can be maintained.

Healthcare staff must liaise with external NHS practitioners if prisoners are not able to keep appointments to ensure these are rescheduled for the ultimate health benefit of the prisoner.

Healthcare staff should ensure that prescription charts are safe and secure in a designated place.

GOOD PRACTICE

The first responder system, which ensures an adequate number of staff are on duty trained in basic life support, including the use of defibrillators, is an example of good practice.

The Prison Service accepted all of the recommendations