Investigation into the death of a man whilst in the custody of HMP Swansea in September 2010

Report by the Prisons and Probation Ombudsman for England and Wales

October 2011

This report considers the circumstances surrounding the death of the man at HMP Swansea on 18 September 2010. The man was found hanging in his cell shortly after 6.00am. He had been in prison for just two days and it was his 22nd birthday.

I offer my sincere condolences to the man's family and all those who knew him. I am sorry that my report has been delayed and I regret the distress which this may have caused.

The investigation was conducted by one of my investigators on my behalf. I would like to thank the governing governor and his staff for their co-operation. I also extend thanks to the member of staff, who liaised with my office. In addition, I thank the clinical reviewer, who conducted a review of the man's clinical care. He was appointed by the Healthcare Inspectorate Wales.

After breaching the conditions of his Community Order, the man received a custodial sentence on 16 September 2010, and was taken to HMP Swansea. He had harmed himself once before, five years earlier, but members of staff did not have any reason to believe that he posed a risk of harming himself again. The man used drugs including heroin regularly and on 17 September was prescribed medication to manage withdrawal. On the night of 17/18 September, he told an officer that he was finding the withdrawal difficult. He died later the same night.

This is the sixth self-inflicted death at Swansea since 2004, when my office began investigating all deaths in prison custody. Before the man's death, the previous such death occurred two months earlier in July 2010.

My investigation has looked into the health screening completed at the time of the man's arrival at Swansea, the management of his drug withdrawal, the emergency response, liaison with his family, and the overnight staffing arrangements. I make ten recommendations.

This 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.

Thea Walton
Acting Deputy Ombudsman **October 2011**

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SUMMARY

1. The man was sentenced to a Community Order on 13 August 2009. After failing to comply with the requirements of the order, he was returned to Swansea Crown Court on 16 September 2010 and sentenced to eight months imprisonment.

2. The members of staff responsible for the man at court noted on his person escort record (PER) that he had “a problem with drugs”, and had harmed himself five years earlier. As a result of this, he had scars on his forearm. However, the escort staff did not think he had any thoughts of harming himself, and considered that he appeared positive and even jovial.

3. The man arrived at HMP Swansea at 4.55pm. He had given members of staff no cause for concern during the journey from the court to the prison. He had a first reception health screening (a basic health assessment for all new prisoners) with a nurse, who noted that he was prescribed anti-depressants, had seen a psychiatrist as a teenager, and had harmed himself five years earlier. She also wrote that the man told her that he was not considering harming himself and felt “absolutely fine” at the time of the interview.

4. In terms of drug misuse, the nurse noted that the man used heroin and benzodiazepines daily, methadone occasionally, and cannabis. He used heroin intravenously, and told the nurse that he had used the drug earlier that day. The nurse did not think the man was suffering from any symptoms of drug withdrawal at the time of the interview.

5. During the admissions process, the man also saw a senior officer, who completed a cell sharing risk assessment (CSRA). This is designed to identify whether a prisoner might pose a risk to a cellmate if he were to share a cell. The officer noted a number of issues (the man was convicted for a violent offence, and had been involved in a fight during a previous sentence) but assessed him as a low risk of harm to others. He also made a note of the man’s previous self-harm, but said that he had no current thoughts of harming himself.

6. Following the admissions process, the man moved to B wing, the first night and induction unit at Swansea. He had a first night interview with an officer, intended to explain the rules and regulations of the prison, to allay any fears and to help prisoners feel at ease. The members of staff who saw the man on 16 September told my investigator that they did not have any concerns about self-harm, and he presented as calm, mature, friendly and happy. He was placed in a shared cell on B wing.

7. The next morning, the man went to an appointment with a doctor, who prescribed anti-depressants and a number of medications for withdrawal from drugs. Primarily, he was prescribed a seven day course of lofexidine, a medication used to alleviate the symptoms of heroin withdrawal. The doctor also thought that the man seemed happy and relaxed, with no physical symptoms of drug withdrawal.

8. On the same morning, the man saw an officer from the safer custody team, which is responsible for the management and prevention of self-harm and suicide in the prison. The man was not seen because of any specific concerns; all new prisoners at Swansea are seen so that they can discuss any areas of concern and receive information about the avenues of support available. The officer did not have any concerns about the man.

9. The man attended an induction board around midday on 17 September. All new prisoners attend an induction board and meet representatives from various areas of the prison, such as offender management, drugs and alcohol services, and the chaplaincy. The senior officer who facilitated the induction board had no concerns about the man and said that he presented as relaxed, open and honest.

10. The man made three short telephone calls the same afternoon. Like all other prisoners, he was locked in his shared cell from 5.30pm.

11. At 11.34pm, the alarm in the man's cell was activated. When an officer responded, the man asked for paracetamol, saying that he was withdrawing from drugs and had a headache. The officer explained that he could not administer medication or unlock the cell, and advised him to see a member of healthcare staff the next morning. At 1.25am on 18 September, the cell alarm was activated again. The same officer attended, and the man said he could not sleep. He again asked for paracetamol and the officer repeated his earlier advice.

12. The cell alarm was activated a third time at 6.07am. Officer A, who was responsible for B wing during the night, went to the cell, and found the man's cellmate in a state of distress. The man was hanging from a ligature that had been attached to the cell's window bars. The officer used his radio to call for assistance, and other members of staff arrived within seconds. The officer cut the ligature and, with Officer B, commenced cardio-pulmonary resuscitation (CPR). Paramedics arrived at the prison six to eight minutes after the radio message asking for urgent assistance. The resuscitation attempts were unsuccessful, and at 6.20am the paramedics declared that the man had died. It was the morning of his 22nd birthday.

13. I have investigated issues around the first reception health screening, the management of the man's withdrawal from drugs, the emergency response on 18 September, liaison with the man's family, and overnight staffing arrangements. I make ten recommendations.

THE INVESTIGATION PROCESS

14. One of my senior investigators was appointed to conduct the investigation on my behalf. Notices of the investigation were sent to the prison for distribution and display, giving staff and prisoners the opportunity to contact my investigator with any relevant information.

15. My investigator visited HMP Swansea to open the investigation on 23 September 2010. He met the prison's liaison to my office, and the head of healthcare. In addition, my investigator met two members of Swansea's Independent Monitoring Board (IMB). He also visited the reception area and B wing.

16. During the opening visit, my investigator checked the release date of the man's cellmate and asked that he was not transferred to another prison so that he could be interviewed as part of this investigation. However, the man's cellmate successfully appealed against his sentence and was released before my investigator returned to the prison to conduct interviews. No release address was given. On 10 November, my investigator wrote to the man's solicitor but received no response.

17. The prison liaison officer sent my investigator copies of documents relating to the man's short time at Swansea. In addition to the paper documents, there was a CD containing audio recordings of the three telephone calls that the man made on 17 September.

18. In order to aid his investigation, my investigator obtained the following:

    - Documents from Wales Probation Trust about the community sentence that the man was serving prior to his imprisonment. (My investigator also spoke to the man's offender manager in the community, on 22 February 2011.)
    - A report from the investigation officer from Reliance Custodial Services (RCS) about he man's detention at court and transfer to prison on 16 September 2010.
    - The patient record from the Welsh Ambulance NHS Trust relating to the emergency response on the morning of 18 September.

19. My investigator returned to Swansea to conduct interviews on 4 and 5 November 2010, 2 December 2010, and 11 February 2011. He interviewed 11 members of staff. The interviews were recorded and transcripts are included as annexes to this report. He also spoke to (but did not formally interview) the prison chaplain, the prison's family liaison officer, and the prison doctor who treated the man on 17 September 2010.

20. My investigator attempted to interview the nurse who worked overnight and responded to the medical emergency on 18 September. An interview was scheduled for 2 December 2010, but the nurse was unable to attend. The interview was rescheduled for 11 February 2011, but again she could not attend. My investigator then wrote to the nurse with a number of questions,

but due to sick leave she was unable to respond. As a result, it has not been possible to gain first-hand information from the nurse in order to inform this report.

21. One of my family liaison officers (FLOs) wrote separately to the man's mother and father to explain the purpose of my investigation and provide them with an opportunity to raise any issues or questions about the care that the man received in prison. My FLO did not receive any responses to these letters. The man's mother and father each received a copy of the draft version of this report. They did not raise any further issues or questions in response.

22. The Healthcare Inspectorate Wales (HIW) appointed a clinical reviewer to conduct a review of the man's care whilst in custody. The purpose of a clinical review is to examine the medical care that a prisoner received in custody, which should be an equivalent standard to what might have been expected in the community. The clinical reviewer consulted the man's medical records to inform his review. On 2 December 2010, the clinical reviewer and his colleague conducted interviews with my investigator. The clinical reviewer's colleague conducted a further interview with my investigator on 11 February 2011. He also had access to the transcripts of the interviews that my investigator conducted with other members of the prison's staff. His findings are summarised within this report and the full review is included as an annex.

HMP SWANSEA

23. HMP Swansea is a small prison that primarily serves the courts of south and west Wales. It can hold up to 422 remand, unsentenced and sentenced adult male prisoners. There are three residential units, a segregation unit, and an induction unit.

24. The induction unit (B wing) is where prisoners can spend up to two weeks after arriving at Swansea. An induction programme is intended to help prisoners understand their rights and responsibilities, and help familiarise them with the prison setting and regime. During their induction, prisoners meet representatives from various departments within the prison.

25. Healthcare services at Swansea are predominantly provided by a team of nursing staff. A registered nurse conducts health assessments with all newly arriving prisoners, who are then offered an appointment the following day with a doctor and a nurse for a more detailed health screening. The nurse conducting the initial health screening can provide certain medications from an approved list if they are required immediately, for example to alleviate drug or alcohol withdrawal symptoms.

26. A doctor holds a surgery in the prison from 8.30am to 11.30am, seven days a week. An on-call service is provided on weekday afternoons, and a similar out of hours service can be used by nurses both overnight and at weekends. The prison provides 24 hour nursing cover, with one nurse remaining on duty throughout the night.

27. Swansea does not have a dedicated detoxification unit, neither is there an inpatient unit. However, prisoners experiencing particularly acute drug or alcohol withdrawal symptoms can be admitted to one of two ‘crisis beds’ in the healthcare unit.

Performance

28. HM Chief Inspector of Prisons, inspected Swansea in February 2010. In her report, published in April the same year, she described Swansea as “an impressively safe place, underpinned by excellent staff-prisoner relations”. Regarding prisoners’ arrival at Swansea, HM Chief Inspector of Prisons noted that “staff were supportive and caring, and prisoners were given a range of information about available services”.

29. HM Chief Inspector of Prisons noted that the first night and induction processes were well organised and flexible, providing good support for new prisoners. The induction unit was described as having a “decent environment, good procedures and positive staff attitude”. However, some members of prison staff said the unit sometimes felt more like a detoxification wing than an induction unit, due to the number of prisoners withdrawing from drugs and alcohol.

30. In terms of Swansea's management of drug-dependent prisoners, HM Chief Inspector of Prisons noted that a good level of care was provided. There were, however, no designated cells to allow unrestricted observation during a prisoner's initial stabilisation and detoxification.

31. When commenting about suicide prevention, the HM Chief Inspector of Prisons wrote that Swansea's senior managers showed a strong commitment to supporting prisoners at risk from suicide and self-harm, and went on to say that "good attention was given to increased risks in the early days of custody".

32. The Independent Monitoring Board (IMB) is made up of volunteers from the community in which the prison is located. IMBs must satisfy themselves as to the humane and just treatment of people held in custody, and they report to the Justice Secretary annually. At the time of writing, the most recently published report for Swansea covered the period May 2009 to May 2010. The IMB noted that prisoners arriving in the prison's reception area had their needs assessed, with "medical and drug issues … dealt with appropriately and swiftly". Regarding the induction unit, the IMB wrote:

> "The regime on this wing is specifically designed to introduce prisoners to the routines and regimes of prison life in a very supportive way. It is a small wing, staffed by experienced officers who are very diligent and committed."

Previous deaths at Swansea

33. My office has been responsible for investigating deaths in custody since April 2004. Prior to the man's death, I have investigated five other self-inflicted deaths at Swansea. These deaths occurred in 2004, 2005, 2007, 2009 and July 2010. The three most recent self-inflicted deaths took place on the induction unit and involved hanging by ligature, as was the case with the man.

34. Following my investigation in 2009, I made, amongst others, recommendations relating to:

    - The referral of prisoners for substance misuse assessments.
    - Ensuring that defibrillators are taken to medical emergencies.
    - The development of a protocol between the prison and the South Wales Police about informing a prisoner's relatives of his death.

35. Following my investigation in July 2010, I made, amongst others, recommendations relating to:

    - Requesting an ambulance in an emergency situation.
    - Reviewing the arrangements for members of staff permanently working overnight.
    - Ongoing liaison with the prisoner's family following the death.

36. I return to all of these issues as part of this report.

KEY EVENTS

37. The man was convicted of assault at Swansea Crown Court on 13 August 2009. On 14 September, he was sentenced to a community order. It involved 18 months supervision by the probation service, a two month curfew, and six months living at an approved location. For the residential requirement, he went to Ashley Court, a project in Devon run by the Amber Foundation, an organisation which aims to help unemployed and homeless young people gain skills for obtaining and keeping employment and accommodation. He stayed in Devon for six months before returning to Swansea.

38. On 21 April and 21 May 2010, the man did not go to appointments with his offender manager (probation officer). His offender manager wrote a statement of fact for the court on 24 May, confirming that the man had breached the terms of his order. She wrote a more detailed breach report on 13 July and said that the man had returned to Swansea as soon as his six month residential requirement in Devon had expired. This was despite additional funding that would have allowed him to remain there for a further six months. The man's offender manager went on to say that the man had "subsequently relapsed and returned to substance misuse". He had also failed to attend appointments with the local criminal justice integrated team (CJIT) to discuss the provision of a prescription for a substitute for illicit drugs, and had been discharged from their service. In concluding her report, she said she had no other option but to suggest that the man's order was revoked and that he should be re-sentenced.

Thursday 16 September

39. My investigator, my investigator, obtained a report completed by an investigation officer for Reliance Custodial Services (RCS). RCS is the private company responsible for the remand cells at Swansea Crown Court and escorting prisoners to prisons including HMP Swansea. The man was due to appear at Swansea Crown Court for the breach of his Community Order on the morning of 16 September. The investigation officer reported that the man arrived after midday and, at 12.30pm, was remanded into RCS's custody to await his hearing at 2.00pm.

40. The investigation officer for RCS reported that Prison Custody Officer (PCO) A "questioned the man on any risks that he might have". The man told PCO A that he had a problem with drugs. This was recorded on the person escort record (PER), but no further detail was given. PCO A noticed that the man had scars on his forearm that appeared to be a result of self-harm. The man said he had harmed himself five years earlier, but had no such issues currently. This information was also recorded on the PER.

41. PCO B told the investigation officer from RCS that the man said he wanted to go to prison so that he could stop using drugs. The PCO said the man "appeared very jovial" and she had no concerns about his wellbeing.

42. The man was taken from the detention cells to the courtroom at 2.02pm. He was escorted by PCO C, who told the investigation officer from RCS that the man said he wanted to go to prison in order to “sort himself out”. The man also told PCO C that he had “done okay on a course in Devon” but had started using drugs again after he returned to Swansea.

43. The man was sentenced to eight months imprisonment and returned to the court cells at 2.20pm. He was checked by RCS staff at 2.40pm, 3.10pm, 3.40pm and 4.15pm. No concerns were reported. At 3.55pm RCS staff received the man’s warrant for imprisonment, and at 4.30pm he boarded an escort vehicle with five other prisoners being taken to HMP Swansea.

44. The escort vehicle stopped at Swansea Magistrates’ Court to collect one additional prisoner. It arrived at HMP Swansea at 4.55pm. PCO D, the escorting officer, reported to the investigation officer that none of the prisoners on the vehicle reported any concern about the man during the journey.

45. When he arrived at Swansea, the man underwent a first reception health screen. This is a basic medical assessment for all new prisoners, and can lead to referrals to other medical services. Nurse A completed the health screening with the man. She noted that he was prescribed sertraline (an anti-depressant) but could not remember whether his dose was 40mg or 50mg daily. The nurse did not record any concerns about the man’s physical health or alcohol intake.

46. In terms of drug misuse, Nurse A recorded on the initial health screening form that The man spent £20 per day on heroin, and had used the drug earlier that day. He reported occasional methadone use and said that he had last used it two or three days earlier. Additionally, he reported daily use of 50mg benzodiazepines, last used the previous day, and cannabis use. The nurse did not record on the form the frequency of the man’s cannabis use, but recalled during interview with my investigator that he said that he used it on most days.

47. The man told Nurse A that he used heroin intravenously. She said during interview that she explained the importance of using clean needles, and recalled that he understood this. The man told the nurse that he had received a vaccination for Hepatitis B whilst serving a previous sentence at HMP Parc. She also checked that his injection sites were clean and free from infection. Nurse A recalled that the man told her that he wanted to stop using drugs. He had recognised this for some time but found it difficult to do so.

48. My investigator asked Nurse A whether she thought the man was suffering from any drug withdrawal symptoms. She said:

> “There was no sign of withdrawal; he was quite relaxed about the fact that he’d used that day. He didn’t even ask me for medication, which is a thing that people who have used drugs usually do. He didn’t ask me for medication, he felt absolutely fine. He was quite settled, he was quite pleased in a way, which sounds absolutely bizarre, said he was quite

happy that he'd come into prison because he knew it was a good place to get clean because his focus was he wanted to give up. He felt that it wasn't a negative thing coming in here, he was just wanting me to put him down for detox and to give him the help he needed, he was really keen for that."

49. The man supplied a urine test, which showed a positive result for opiates (a possible indicator of heroin use), methadone and benzodiazepines.

50. The first reception health screening document includes a section about mental health. Nurse A noted that the man was diagnosed with attention deficit hyperactivity disorder (ADHD) as a teenager after seeing a psychiatrist. She also recorded that he was prescribed antidepressants. In terms of self-harm, the form provides three boxes to indicate no self-harm, self-harm in prison, and self-harm in the community. Nurse A did not tick any of these boxes but confirmed during interview that at least one of them should be ticked. Underneath, there is a space to write details of the "most serious and most recent" form of self-harm. Nurse A wrote: "5 yrs ago sliced arm (anger). One and only time." During interview, she was unable to recall much more about the conversation, other than to say that the man had convinced her that he had acted in anger and felt "absolutely fine now".

51. The form states that when any of the questions about seeing a psychiatrist, receiving medication for mental health problems, or attempting self-harm are answered 'yes', the prisoner should be referred for a mental health assessment. Although all three of the questions received a 'yes' answer in this case, no mental health referral was made. During interview, Nurse A said her understanding was that professional judgement should be used to decide whether or not to refer a prisoner for a mental health assessment, rather than it being an automatic process.

52. Following the question about previous self-harm, the first reception health screening asks the following question:

> "For some people, coming into prison can be difficult and a few find it so hard that they may consider harming themselves. Do you feel like that?"

53. There are two possible answers: no and yes. Nurse A ticked the 'yes' box. Underneath, there is a space for the member of staff completing the form to record their "impression of the prisoner's behaviour and mental state". Nurse A did not write anything in this box. Underneath, there is a box to tick "if nil of note". This box was ticked. During interview, Nurse A said:

> "I've obviously ticked the wrong box; obviously meant to be 'no'. If I do tick 'yes' as a general rule, I would have written why I'd ticked 'yes' in the box below. I also would have opened up an ACCT [the Prison Service's process for supporting and monitoring prisoners thought to be at risk of self-harm or suicide] because if I had concerns about someone I wouldn't allow them to leave reception without being on an open ACCT and without noting it on other documentation."

54. My investigator asked Nurse A if she was absolutely clear that the man did not say that he felt as if he might harm himself. She went on to say:

> "I'm absolutely clear because he was looking to the future and he was hoping to come, he wanted to come off drugs, he wanted to be clean, he wanted to progress further on in his life. So he was positive about being in prison and he was positive about what he wanted to get from the experience."

55. Nurse A indicated on the form that the man had said he wanted an appointment to see a doctor. On the last page of the health screening, Nurse A indicated that she was referring the man to see a doctor because of his substance misuse and because he had requested it.

56. My investigator asked Nurse A whether medication was available for prisoners arriving at Swansea in the evening, when a doctor was not on duty. She said that nurses have a list of medications that can be used to cover a prisoner's first night or weekend in custody, until they are able to see a doctor. This includes medication to alleviate the symptoms of withdrawal from drugs. Nurse A explained that there is a specific form to assess the level of withdrawal and whether a prisoner needs medication on his first night. However, on this occasion she did not use the form or prescribe any medication, as the man had used heroin earlier that day and did not appear to be suffering from any withdrawal symptoms.

57. A cell sharing risk assessment (CSRA) was completed in Swansea's reception area shortly after the man's arrival. The primary purpose of the CSRA is to identify whether a prisoner might pose a risk to a cellmate if he were to share a cell. Sections 1 and 2 of the form were completed by Senior Officer (SO) A. These sections relate to various issues that might indicate a risk in terms of cell sharing. SO A noted that the man had been convicted of a violent offence and that he said he had previously been involved in a fight at HMP Parc. He noted that the man had abused and was dependent on drugs. Although the SO reported that the man had not previously been subject to the ACCT process, he wrote:

> "PER indicates self-harm five years ago and drug issues. States no intent of DSH [deliberate self-harm], is fully aware of all the support available to him. Polite and respectful. Has drug issues."

58. He assessed the man as a low risk of harm to others when sharing a cell. This meant there was no indication or evidence of risk to others, and that the man was suitable to share a cell.

59. Section 3 of the CSRA is completed by a member of healthcare staff. In this case, it was Nurse A. She assessed the man as low risk, and indicated that no concerns had been raised following the self-harm assessment. She wrote: "Drug user. No meds given, used this AM. Will be okay until tomorrow."

60. SO A made entries into the electronic contact log, which is part of the P-NOMIS computer system. (The P-NOMIS system is used in all public sector prisons in England and Wales.) The first entry was made at 5.56pm. SO A wrote:

> "Seen on reception. Previous custodial exp[erience]. PER warning and self-harm marks on forearm. No intent of DSH [deliberate self-harm], is fully aware of all the support services available to him. Polite and respectful, should settle quickly."

61. In a further entry at 6.01pm, he wrote:

> "States has drug issues, advised of CARAT [Counselling, Assessment, Referral, Advice and Throughcare, a drugs service available in prisons] support and help."

62. SO A also used the P-NOMIS computer system to raise a self-harm 'alert' for the man. This meant that any member of staff looking at the man's computer record would be able to see that there were concerns about self-harm. SO A noted: "States previously self-harmed by cutting his forearm in 2003/4."

63. During his interview with my investigator, SO A recalled that:

> "Scott came over very well during interview. As I've already mentioned he was polite, he was respectful, he knew a little bit about prison because he'd previously been to Parc. I had sort of explained to him that perhaps Swansea was slightly different, that we do sort of tend to talk to people more here and he was quite happy with that, he acknowledged that. He came over as somebody who may well have had a drug problem but he didn't look as if he was withdrawing at all or detoxing at all, he was quite relaxed, quite sort of well humoured and I had no concerns about him. And in fact in one of my comments I actually wrote 'should settle quickly' because he came over as somebody that would probably benefit from all the help and the support that he was likely to get."

64. SO A said that he discussed the man's previous self-harm with him, but that the man gave him no reason to suspect that he presented a risk to himself at the time of his arrival into Swansea. The SO told my investigator:

> "When he left me I'd absolutely no concerns about the self-harm. Yes, there was a history of self-harm and he was quite honest about it. He said that it was five years ago and he had absolutely no intentions of harming himself. And he was aware of all the help that was available; he knew that he could press a buzzer and talk to people and he gave me absolutely no indication really that there was going to be an issue."

65. After completing the admissions processes such as the first reception health screening and CSRA, the man moved to B wing. This is the first night and induction unit at Swansea, where prisoners spend up to two weeks. During this time, prisoners complete an induction programme designed to help them

understand the prison regime. All prisoners have a first night interview with a member of the unit staff when they arrive. The man had his interview with Officer C. Officer C made an entry in the electronic contact log at 7.23pm. He wrote:

> "First night interview with the man who appeared open and honest during assessment and stated he was previously charged with a racial offence but stated he is not a racist. He also stated no issues at present or intentions of self-harm and was fully aware of the support here at Swansea. Although first time in custody as an adult he should settle without too much problem. Given a pack of tobacco and a PIN phone credit [to allow him to make telephone calls from the unit payphone]."

66. During his interview with my investigator, Officer C said he conducted first night interviews to explain the rules and regulations of the prison, relieve any fears and help prisoners feel at ease. He said he tended to ask lots of questions and tried to build up a rapport, so that he could hope to "pick up a picture of the individual to see how they are in relation to whether they are safe or unsafe".

67. Officer C recalled that the man presented as calm, mature and friendly. He said that he asked him about self-harm and suicide, and was satisfied that there was no reason for concern. The officer explained to my investigator the various actions that he could take if he thought someone was at risk (such as the ACCT process and/or location in a cell with a reduced number of possible ligature points) but did not think this was necessary for the man. When the man left the first night interview, Officer C had no concerns about his ability to cope in prison or his risk of self-harm or suicide.

68. Following his first night interview with the man, Officer A also wrote in B wing's observation book. This is a document available to staff on the unit, and it is where the details of significant events on the wing are recorded. Officer A's entry related to the man's arrival on B wing. He described the man as "upbeat" and said there was no indication of a risk of self-harm or suicide.

69. The man was located in cell B4-09 with another prisoner.

Friday 17 September

70. The next morning, 17 September, the man saw the prison doctor. The doctor completed a 'doctor's assessment' form, which has sections relating to relevant family history, previous medical history, mental condition, and general health. The doctor did not write anything in the section about relevant family history. Referring to previous medical history, the doctor wrote that the man had used heroin intravenously for four years, with some use of methadone, cannabis and street valium. He wrote that there was "nil else" of note. In terms of mental condition, the doctor wrote that the man had no history of psychiatric contact, but was taking tablets for depression. In the section about general health, the doctor noted that the man was prescribed 50mg sertraline daily.

71. The prison doctor prescribed a number of medications for the man. These were recorded on his prescription and administration chart, a clinical document to record the medications prescribed and given to prisoners. He was prescribed sertraline, diazepam (for benzodiazepine withdrawal), quinine sulphate and metoclopramide (to alleviate the symptoms of withdrawal from heroin).

72. The man was also prescribed a seven day course of lofexidine, a medication used to alleviate the symptoms of heroin withdrawal. This detoxification programme was recorded on a separate chart used only for that purpose. It shows that the man was due to receive lofexidine four times daily for the first five days, then twice daily for the last two days. The chart shows that he collected this medication at lunchtime, in the afternoon and in the evening on 17 September. (No morning dose was prescribed on the first day.)

73. When speaking to my investigator, the prison doctor said he was with the man for around ten minutes. He recalled that the man presented as quite happy and relaxed throughout. He did not seem concerned, worried, confused or depressed, and appeared well, with no physical symptoms of drug withdrawal.

74. The head of healthcare at Swansea, told my investigator that a secondary health screening - a more detailed medical assessment than that conducted on the first night - would ordinarily take place for prisoners the morning after their arrival. However, on 17 September, a large number of new arrivals and a shortage of available healthcare staff meant that the man did not have his secondary health screening. Although the man saw the doctor and was prescribed medication, the more detailed drug and alcohol assessment that would normally be undertaken at the secondary health screening was not completed. The head of healthcare told my investigator that, when prisoners are not offered a secondary health screening the day after their arrival, they will be offered an appointment for the next working day. As 17 September was a Friday, the earliest appointment offered would have been Monday 20 September.

75. At 11.07am on 17 September, Officer D made an entry in the computerised contact log. She wrote:

> "Seen by Safer Custody, all avenues of support explained. Discussed his PER warning regards his self-harm, states no current thoughts or intentions. Currently detoxing from drugs, otherwise okay, confident of coping."

76. Safer custody is the department responsible for the management and prevention of self-harm and suicide in the prison. During interview with my investigator, Officer D explained that prisoners at Swansea are seen by someone from safer custody the morning after their arrival, to discuss any concerns that they might have and to advise them about the avenues of support available to them. The officer did not meet the man because specific

concerns had been identified, but because he had arrived at Swansea the previous evening and this is the prison routine.

77. In addition to creating an entry on the P-NOMIS computer system, Officer D completed a ‘safer custody initial interview/risk profile’ form. This covers various topics, the first of which relates to a prisoner’s history of suicide attempts. The officer mentioned the warning on the man’s PER about self-harm five years earlier. She recalled during interview that the man did not talk about the incident in much detail and seemed to be embarrassed by it. She asked him if he had any current thoughts of self-harm or suicide, and he said that he did not. The officer told my investigator that she informed the man about various support networks which were available to him. These included telephone contact with the Samaritans, and the use of Listeners (prisoners trained by the Samaritans to offer a confidential support service). The officer explained that, additionally, all prisoners have a telephone number printed on the back of their identification card. This is the number for the safer custody answering service. Prisoners leaving a message on the answering machine could expect to be seen by a member of the safer custody team within 24 hours.

78. The form completed by Officer D also included a section about drug and alcohol issues. In this section, she wrote: “Heroin, withdrawing. Seen doctor, on lofexidine. No alcohol issues.” During interview, the officer said the man had told her he “was coming off heroin and he was withdrawing and he did say he was struggling with his detox”. She advised the man to give his medication time to work, and she told my investigator that he did not look physically ill.

79. On the section of the form relating to attitude and behaviour during the interview, Officer D wrote: “Confident of coping. All avenues of support explained.” She told my investigator that the man said he was from the local area, had a family support network outside prison, and expected to receive visits. He did not seem apprehensive about his sentence, and did not intend to appeal against it. A further box on the form related to any other concerns that were raised. The officer noted that the man had previously been in a fight with his cellmate at Parc. She told my investigator that she advised him to speak to members of wing staff if he had any problems with cell sharing, rather than resorting to violence.

80. At the bottom of the form, Officer D was required to indicate whether or not she had opened a safer custody file for the man. During interview, she explained that such files are opened for prisoners who need additional support during their initial period in custody. These prisoners are seen regularly by safer custody staff. They need not necessarily present a risk of self-harm or suicide.

81. Officer D did not have any concerns about the man, and so she did not open a safer custody file. She told my investigator that “the way he portrayed himself to me, he was confident and coping, he was happy, especially as a young offender”.

82. SO B made an entry into the electronic contact log at 12.07pm. He wrote that an induction board had been completed for he man. The SO explained to my investigator that all prisoners attend an induction board the morning after they arrive at Swansea. Prisoners attend individually and meet a panel of representatives from various areas of the prison, such as offender management, drugs and alcohol services, and the chaplaincy. The purpose of the induction board, according to the SO, is to "look at any anxieties, any issues, any concerns" that prisoners have, and address them or make appropriate referrals for further support. He told my investigator that the time taken to complete the induction board depends on the individual prisoners and the needs they may have. In terms of the man's induction board, the SO said:

> "I don't believe it took very long, from what I remember he was very relaxed, open, honest. I remember him being cheery, quite smiley. He came across [as though] he didn't have any problems."

83. As part of his entry in the computerised contact log, SO B wrote: "First adult custodial sentence. PER warnings for drugs and self-harm. Has been referred to CARATS. Full support network explained." The SO told my investigator that he spoke to the man about self-harm and noticed that he had marks on his arm. However, he did not think the man gave any cause for concern, and repeated that he was "actually quite smiley and cheery as if he didn't have any problems". In terms of referral to the CARAT team, the SO could not recall whether a representative from the service was present at the induction board, and there is no evidence of a written referral to the team. However, the man's induction paperwork indicated that an 'introduction to CARATS' was given on the same day.

84. SO B said that he had no concerns about the man, who gave him no reason to believe that he posed a risk in terms of self-harm or suicide.

85. At 2.22pm, Officer C made an entry in the electronic contact log, explaining that the man had been introduced to a member of the chaplaincy. During interview, the member of the chaplaincy explained that he had met the man as part of the aforementioned induction board. He was unable to recall the man specifically, but from his written records noted that the man was one of 12 new prisoners to attend the board on the morning of 17 September. He had written that the man was of no fixed address in the community, used drugs, had contact with probation services, had family who he expected would visit him, and had previously harmed himself. Whilst he was unable to remember the interview itself, he told my investigator that "if there were any areas that stood out … I would have made comment on the information sheet".

86. Prisoners use the personal identification number (PIN) telephone system to make outgoing calls. All such calls are recorded, though they are not usually monitored at the same time as they are placed. The man made three

telephone calls on 17 September. Having been provided with a CD of these recordings, my investigator listened to the telephone calls.

87. The first call was placed at 4.21pm to a mobile telephone number. The man spoke to a woman who did not identify herself. The man explained that he was in Swansea prison, but it was difficult to make out what the other person said. It was a short exchange; the entire telephone call (including the time before it was answered) lasted 46 seconds.

88. At 4.24pm, the man made a second call to the same mobile number. He spoke to a different woman, and explained that he wanted to speak to someone else. The woman told him that the person he wanted to speak to was asleep. He asked the woman to tell the other person that he was in Swansea. This was, again, a brief exchange, with the call lasting 36 seconds.

89. The man's third telephone call was made at 4.26pm, to a different mobile number. He spoke to a man and said he was in Swansea. The man gave his cell location, and the man said he would try to "throw some stuff over". The man said that he would call back later. This call lasted one minute and three seconds.

90. There is no further information contained within the man's prison record to indicate anything about the remainder of the afternoon and the evening of 17 September. The published regime for B wing indicates that prisoners spend much of the afternoon completing the induction programme or associating with other prisoners. An evening meal is served at 5.00pm and, on Fridays, prisoners are locked in their cells from 5.30pm for the night.

Overnight on Friday 17/Saturday 18 September

91. Overnight, Swansea, like other prisons, operates with reduced staffing numbers. The night orderly officer is in charge of the prison and is accompanied by an assistant orderly officer. One officer is responsible for patrolling A, C and E wings. One officer patrols B wing, and another officer patrols D wing. A nurse remains on duty throughout the night and is usually based in the prison's central area.

92. Officer B began work at 8.00pm on 17 September, although his shift did not formally begin until 8.45pm. Overnight, he was responsible for patrolling A, C and E wings. During interview with my investigator, he explained that the gates to each wing from the central area remain unlocked during the night, so that the members of staff on duty have access to them. Other than the orderly officer, the overnight staff do not carry keys. They have a cell key, sealed in a pouch on their utility belts, for emergency use.

93. Every cell has an alarm bell, activated by a button inside the cell. Pressing the button activates a light on the landing above the cell, and also triggers a light and audible warning in the prison's central area. The times at which the cell alarm is activated and subsequently cancelled by a member of staff are automatically recorded by a computer system. Officer B recalled that, around

midnight, a light indicated that the cell alarm for B4-09 had been activated. The computer system showed that the alarm was activated at 11.34pm. He could not recall whether he was on B wing or in the central area at the time. However, he remembered that Officer A, who was responsible for patrolling B wing, was completing some work on the computer. Officer B therefore responded to the cell alarm. The system recorded that he reset the cell alarm, at the cell, at 11.35pm.

94. Officer B told my investigator that he opened the observation panel at cell B4-09. He recalled that the man was standing in the cell, wearing tracksuit bottoms and no shirt. His cellmate was awake and lying on the bottom bunk. The man told Officer B that he was withdrawing from drugs and had a headache. He asked for paracetamol. The officer told my investigator that he explained to the man that he could not administer any medication, nor could he unlock his cell during the night. He asked the man if he had seen the doctor, and the man confirmed that he had done so, and had taken his medication. The officer advised the man to see someone from healthcare the next morning.

95. During interview, Officer B recalled that the man did not appear distressed. He said the man was calm and reasonable, and seemed to understand that he could not administer medication or open the cell. He also said that the man's cellmate was talking to and reassuring him.

96. Officer B recalled that around an hour later, the cell bell for B4-09 was again activated. The computer system recorded the time of this alarm as 1.25am on 18 September. The officer responded (at 1.26am), and again found the man saying that he could not sleep and asking for paracetamol. The man's cellmate was still awake and lying on the bottom bunk. The officer reiterated what he had said earlier. He recalled that the man said, "It's okay, I'll just ride it." The officer told my investigator that it was common for prisoners on B wing, during their first few days in prison, to sound their alarm bells overnight complaining of withdrawing from drugs.

97. During interview with my investigator, Officer A explained that he was working on B wing overnight on 17-18 September. He was aware that Officer B had responded to the cell alarms, but said he had no reason to be concerned about the man's wellbeing. Shortly after 6.00am, he was preparing to begin the morning roll check on B wing. (A roll check is a physical count of the prisoners on a wing within a prison. Roll checks take place at specified times during the day and night, and members of staff must sign to confirm that the numbers are correct.) He said that he was on B4 landing, about to look into cell B4-01, when he heard the cell alarm and saw the light illuminate above cell B4-09. The computer system recorded the time of the cell alarm as 6.07am.

The emergency response

98. Officer A said he went immediately to cell B4-09. The computer system recorded that the alarm was reset at 6.08am. The officer recalled that when

he arrived at the cell and opened the observation panel, he could only see the man's cellmate, who was at the door with his face in the observation window. The officer said the cellmate looked pale, distressed and disorientated, and was asking to be let out of the cell. He told my investigator that he knew something was wrong, and used a switch outside the cell to turn on a light inside. At this point, the cellmate moved to one side, and the officer saw the man in what he described as a "semi-suspended state" from a ligature that had been attached to the cell's window bars.

99. Describing what he could see through the observation panel, Officer A said:

> "I was aware he was clothed, he was wearing prison, I remember seeing the blue T-shirt. I remember his head being at a very obscure angle and basically the situation he was, he wasn't standing and he wasn't kneeling. It's hard to describe. It's in a position basically where his knees were off from the vertical and he was suspended forward, his body was pitched forward, taut against the ligature and he looked in a very distressed, a very, very severely distressed state so the first thing I did then I gave an urgent message call over the radio."

100. Officer A said that after he used his radio to request urgent assistance, he broke the seal of his emergency cell key pouch and put the key into the cell's door lock. He did not open the cell immediately, and waited for other members of staff to arrive. The officer recalled that, seconds after his first radio message, he received a reply from the prison's control room (where all radio messages are relayed). As this message was difficult to make out, he repeated his request for urgent assistance. At the time of this message, Officer A saw that two members of staff, Officer B and Nurse B, had arrived on the wing two floors below him and were making their way upstairs to B4 landing.

101. Officer B told my investigator that he was about to start the roll check on A wing when he heard the urgent message from Officer A over the radio. (Although messages are sent and received via the prison's control room, the radios are set to 'talk-through' mode at night, meaning that every member of staff can hear all the messages.) He ran to B wing, arriving on B2 landing (effectively the ground floor) less than 30 seconds after hearing the radio message. He recalled that when he reached B3 landing, he made eye contact with Officer A one floor above him, who then unlocked, opened and entered cell B4-09.

102. When he went into the cell, Officer A ushered the man's cellmate under his arm and out of the cell as he made his way to the back of the cell, where the man was suspended. Officer B then ushered the man's cellmate to SO C, who had arrived on the wing having heard the urgent radio message. The SO locked the man's cellmate in an empty cell and returned to cell B4-09.

103. Officer A reached the man and took his weight whilst using his anti-ligature knife (a piece of equipment carried by all prison officers) to cut the ligature. He and Officer B then lowered the man to the floor and manoeuvred him into

an accessible position so that resuscitation could be attempted. Officer A recalled that the man felt cold and stiff, and looked very pale.

104. Another member of staff, Officer F, arrived at the cell as the other officers were lowering the man to the floor. He had also heard the urgent radio message. He told my investigator that when he arrived, Nurse B was at the cell in addition to SO C and Officers A and B. The SO took Officer F to the gate area so that he could escort the paramedics to the cell when they arrived.

105. Officers A and B began cardio pulmonary resuscitation (CPR). Officer A explained to my investigator that the man's jaw was stiff and he could not open his mouth enough to perform mouth to mouth breaths. Instead, he administered breaths to the man's nose. Officer B performed chest compressions. Nurse B directed the resuscitation effort, ensuring that the officers performed cycles of 30 chest compressions and two breaths, and used her radio to liaise with ambulance control. When SO C arrived back at the cell (having taken Officer F to the gate), he recalled that the resuscitation effort was ongoing. Nurse B took over chest compressions from Officer B when he began to tire. The resuscitation attempts were continuous until paramedics arrived.

106. My investigator obtained the patient record from the Welsh Ambulance Services NHS Trust. The time of the 999 call was not recorded, although the ambulance crew noted that the vehicle was mobile at 6.13am and arrived at the prison one minute later, at 6.14am. Officer F and SO C (who had again left B wing and gone to the gate) escorted the paramedics to the man's cell. Officer A recalled that the paramedics cut the man's T-shirt and attached a heart monitor to his chest. The patient record shows that this was a three-lead electrocardiogram (ECG), a machine designed to check the heart's electrical activity. No signs of life were found and, at 6.20pm, the paramedics declared that he had died. It was the morning of the man's 22nd birthday.

Events after the emergency response

107. When he was relieved by the paramedics, Officer A opened the man's cellmate's cell to check on his wellbeing. He recalled that the man's cellmate was very shaken and was shivering. He gave the man's cellmate a blanket and some sweetened tea to drink. He opened the cleaner's cell (the cleaner was a trusted prisoner on the wing), awoke the cleaner and explained the situation. Officer A then put the man's cellmate in the cell with the cleaner, so that he was not alone. He provided him with a pack of tobacco, and then later moved him to C wing to share a cell with a Listener. Listeners are trusted prisoners trained by the Samaritans to offer confidential support to other prisoners in distress.

108. Prisoners on B wing who asked what had happened were told. A notice to all prisoners, informing them of the man's death, was issued later the same morning.

109. A ‘hot debrief’ was held around 9.00am. This was attended by all members of staff involved in the emergency response. It was an opportunity to discuss what had happened, and for the prison’s senior management team to check on staff welfare and provide information about the avenues for support.

110. The undertakers did not arrive at the prison until 11.45am. When they did arrive, the two members of staff were not equipped to carry the man from the prison. Two prison officers offered to do this. Prisoners on B wing remained locked in their cells until early afternoon, when the man was taken from the prison. A notice was subsequently sent to them, thanking them for their co-operation. That afternoon, two Listeners were provided to B wing to offer support to prisoners.

111. A service for the man was held in the prison chapel on 19 September. On 21 September, a member of the prison’s Independent Monitoring Board (IMB) visited the man’s cellmate. He told her that he had received excellent support from Listeners and members of staff.

Liaison with the man’s family

112. When speaking to my investigator the prison chaplain, said the police had insisted that they should tell the man’s family about his death. The prison chaplain the man’s mother at 10.00am on 18 September to provide further information and offer support. He told my investigator that he gave as much information as he could, though the man’s mother was understandably very distressed. The prison chaplain was with the man’s mother and her partner for around 45 minutes. He subsequently visited the address of the man’s father, though he was not at home.

113. The following day, 19 September, the prison chaplain visited the man’s father, who was at home with another son. He told my investigator that the man’s father had questions about withdrawal from drugs and whether this was properly managed by the prison.

114. On 22 September, a prison liaison officer was appointed to the man’s family. He contacted the man’s mother and father to provide further information and support. On 24 September, several members of the man’s family visited the prison. They saw the man’s cell, met members of the senior staff, and collected his belongings.

115. The man’s funeral took place on 30 September and was conducted by the prison chaplain. Swansea’s Governor attended the funeral.

ISSUES

The first reception health screening

116. Nurse A completed the health screening with the man shortly after his arrival at Swansea on 16 September 2010. There were a number of errors and omissions. A question about previous acts of self-harm had three response boxes (no self-harm, self-harm in prison, self-harm in the community) and at least one of them should have been ticked. Nurse A wrote the details of the man's previous self-harm in the section that asked for the "most serious and recent form". However, because she did not tick any of the boxes, it was unclear whether this act of self-harm occurred in prison or in the community.

117. A further question on the reception health screening asked:

> "For some people, coming into prison can be difficult and a few find it so hard that they may consider harming themselves. Do you feel like that?"

118. Nurse A ticked the 'yes' box. In the space underneath, which asks the member of staff completing the form to record their "impression of the prisoner's behaviour and mental state", she did not write anything. She ticked a box to indicate that there was "nil of note". During her interview with my investigator, Nurse A was very clear that she had ticked the 'yes' box in error, and that the man had not told her that he felt as if he might harm himself. She went on to say that, had she ticked the 'yes' box knowingly, she would have indicated why she had done so in the space provided on the form.

119. During interview, Nurse A presented as professional and credible, with a good recollection of her meeting with the man. She was able to recall in detail the way in which he presented, and she was clear about the reasons about her having no concerns for his wellbeing. Whilst the nurse did not indicate whether the man's previous self-harm occurred in the prison or the community, she provided a summary of what happened. The intended 'no' response to the question about feelings of self-harm is more consistent with the rest of the health screening, and it does appear to be a genuine mistake. However, it is important that such forms are completed correctly and the information given is accurate, particularly when addressing matters as serious as self-harm.

120. I have no reason to believe that administrative errors are endemic at Swansea, and so I do not make a formal recommendation. However, the head of healthcare may wish to consider this section of my report and reiterate to healthcare staff the importance of accuracy and attention to detail.

121. The first reception health screening has questions about seeing a psychiatrist, receiving medication for mental health problems, and attempting self-harm. It states, in bold lettering, that when any of these three questions are answered 'yes', the prisoner should be referred for a mental health assessment. Nurse A indicated that the man had previously seen a psychiatrist, was prescribed medication for depression, and had previously harmed himself. She therefore

answered yes to all three questions, but did not refer him for a mental health assessment.

122. During interview, Nurse A explained that her understanding was that professional judgement should be used to decide whether or not to refer a prisoner for a mental health assessment. She went on to say that if she referred every prisoner who had previously self-harmed or had been prescribed anti-depressants, there would not be enough nurses to deal with the referrals.

123. I appreciate Nurse A's position, and I acknowledge that she is a registered mental health nurse. However, on many occasions, first reception health screenings are completed by registered general nurses, who do not necessarily have an insight into mental health needs. In any case, the health screening form is unambiguous, and states that 'yes' answers to the relevant questions should prompt an automatic referral for a mental health assessment.

The head of healthcare should remind all healthcare staff to follow the instructions on the first reception healthcare screening. Prisoners should automatically be referred for a mental health assessment when it is indicated by answers given at the first reception health screening.

Managing the man's withdrawal from drugs

124. The first reception health screening provides the first opportunity for a member of the prison's healthcare team to make an assessment of drug misuse and withdrawal. Swansea's health screening process allows nurses to administer certain medications, including those intended to manage drug withdrawal, for up to 72 hours. Within this period, prisoners attend an appointment with a doctor and the medication is reviewed. Prisoners often arrive from court during the evening, when no doctors are working in the prison. Allowing nurses to issue medications from an approved list ensures that prisoners can receive help with drug withdrawal without delay.

125. Nurse A asked the man a number of questions about drug misuse and noted the answers on the initial health screening document. She chose not to prescribe any medication for the man. During interview with my investigator, The nurse showed a clear understanding of the circumstances in which medications could be administered. She could also recall in detail the reception screening with the man. Nurse A comprehensively outlined what she would look for in assessing drug withdrawal, and confirmed that the man did not appear to be withdrawing. He told Nurse A during the reception screening that he had used heroin earlier that day.

126. Following the investigation of a death at Swansea in 2009, I recommended that prisoners suspected of drug misuse should be referred for full substance misuse assessments. Nurse A referred the man to the doctor, and indicated that one of the reasons for the referral was substance misuse.

127. On 17 September, the morning after he arrived at Swansea, the man saw the prison doctor, who completed a hand-written form about the appointment. The form did not contain a great deal of detail about what was discussed, although the doctor prescribed a number of medications which are discussed below. A form specifically relating to substance misuse remained uncompleted in the man's clinical record. During interview, the head of healthcare explained that this form would normally be completed during a secondary health screening, administered by a nurse the day after a prisoner's arrival. On this occasion, staff shortages meant that the secondary screening was not completed. The head of healthcare said that it would have been completed on the next working day.

128. Nurse A made it clear that she was referring the man to the doctor as a result of his drug misuse issues. Whilst the man was not afforded a secondary health screening with a nurse, he did attend his appointment with the doctor, when his substance misuse issues were discussed. However, there was no evidence in the man's clinical record of a referral to an ongoing prison-based drugs service, such as the CARAT team.

129. The NHS document 'Clinical Management of Drug Dependence in the Adult Prison Setting' was published in 2006. It relates specifically to prisons in England. The Head of Healthcare said during interview that, whilst Swansea does not necessarily receive the same funding for drug dependent prisoners as its English counterparts, the principles of the NHS document are applied wherever possible. One of the issues covered is the management of drug withdrawal and, in particular, the medications that should be prescribed. The authors acknowledged the "considerable unease" around the use of methadone maintenance programmes in prisons, but went on to say that "through careful evaluation and study, it has become apparent that this intervention within a prison setting can lead to important harm reduction benefits". Methadone is a controlled synthetic opioid that can be legally prescribed as a substitute for illicit opiates such as heroin.

130. The NHS document suggests the prescribing of methadone or buprenorphine (a semi-synthetic opioid) when prisoners first arrive in custody. Specifically, the authors state:

> "Opiate-dependent prisoners should be stabilised on licensed opiate substitute medication for a minimum of five days to enable withdrawal symptoms to be adequately controlled. This period also permits time for input from professionals from both within the community and the prison to inform a decision on whether to proceed to detoxification or maintenance, taking into account the wishes of the patient. Detailed assessment and care planning should be developed over this five-day stabilisation phase."

131. When prisoners have gone through the initial stabilisation phase, they should be offered a detoxification programme. The NHS document states that prisoners may choose to complete detoxification using a non-opiate medication such as lofexidine.

132. The man admitted to regular heroin misuse, and the drug test administered at the initial health screening on 16 September gave a positive result for opiates. The next day, he was prescribed a number of medications, most notably lofexidine on a seven-day detoxification programme.

133. During interview with my investigator, the Head of Healthcare confirmed that lofexidine was the medication used at Swansea for drug detoxification, and that methadone was not used. The clinical reviewer in his review of the man's clinical care, described the medication prescribed as "appropriate". However, the NHS document is clear that synthetic opioid medication, such as methadone, should be used for at least the first five days to help with withdrawal symptoms and stabilisation.

134. I understand that the NHS document applies only to prisons in England. However, the conclusion reached was that an initial stabilisation period using methadone offers the most effective and safe treatment for drug dependent prisoners. There is no reason why this approach would yield different results simply because prisoners are located in Wales. The importance of early and effective interventions cannot be understated. The 'National Study of Self-Inflicted Deaths in Prison Custody in England and Wales from 1999 to 2007', written by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness' and published in April 2011 states:

> "Drug dependent self-inflicted deaths were significantly more likely to occur within 28 days of reception compared with other self-inflicted deaths, indicating the need for efficient and effective detoxification programmes at reception into prison."

135. It would seem that, by implementing different arrangements, prisons in Wales – in this case, specifically Swansea – may be providing an inferior service to their English counterparts. I am concerned that the last three prisoners to die at Swansea did so after only a few days in the prison. The National Offender Management Service (NOMS) must ensure that Swansea, and indeed other prisons in Wales, has drug intervention arrangements are effective, safe, and in line with best practice.

The National Offender Management Service (NOMS) should urgently review the arrangements for managing drug dependent prisoners, with a view to implementing the fundamental principles contained in the NHS document 'Clinical Management of Drug Dependence in the Adult Prison Setting' into prisons in Wales.

136. Overnight on 17/18 September, Officer B twice visited the man's cell in response to the cell alarm. On both occasions, the man said that he was withdrawing from drugs and asked for paracetamol. Officer B explained to the man that he could not administer any medication. He did not, however, record this information anywhere or report it to anyone.

137. During interview, Officer B said that he would not go out of his way to report such an occurrence to the nurse on duty during the night, and went on to

explain that it was commonplace for prisoners to complain of drug withdrawal and ask for medication such as paracetamol during the night. HM Chief Inspector of Prisons has previously noted that some members of staff at Swansea said the unit sometimes felt more like a detoxification wing than an induction unit, due to the number of prisoners withdrawing from drugs and alcohol.

138. The NHS document 'Clinical management of drug dependence in the adult prison setting' covers the subject of withdrawal and, specifically, its effect on sleep. The authors stated that:

> "Insomnia is one of the most common symptoms of opiate, alcohol and benzodiazepine withdrawal. Protracted sleep loss has a detrimental effect on thought, mood and behaviour. Insomnia should therefore be regarded as a potential risk factor for self-harm and suicide."

139. The overnight period of 17/18 September was the man's second night in custody. There was no evidence of protracted sleep loss. However, he told Officer B that he was not able to sleep on that particular night, and complained about withdrawing from drugs. Whilst I appreciate that it may not be unusual for staff on the induction unit to respond to such complaints, I would expect the information to be recorded and conveyed to the nurse on duty. No intervention, whether medical or not, was offered in response to the man's complaints, other than to advise him to seek medical attention the next morning.

140. In his clinical review, the clinical reviewer recommended that the governing Governor should review the arrangements for administering pain relief medication at night. I believe that the arrangements for dealing with prisoners who complain of drug withdrawal symptoms overnight should also be reviewed.

The Governor and head of healthcare should review the procedure for administering pain relief overnight.

The Governor and head of healthcare should review the arrangements for prisoners who complain of drug withdrawal symptoms overnight.

The emergency response

141. Overall, the response was swift. Officer A responded promptly to the cell alarm, and used his radio to ask for urgent assistance when the nature of the situation became clear. He broke the security seal to access his emergency cell key and placed it in the lock ready for use, but he did not open the cell immediately.

142. During a number of investigations, I have found confusion amongst members of prison staff concerning when they can enter a cell alone, particularly during the night. In January 2010, eight months before the man took his life, the Chief Operating Officer of the National Offender Management Service

(NOMS), issued guidance to all prisons about this issue. He explained that all prisons must have a local security strategy (LSS, an instruction from the governing Governor relating to a policy at a particular prison) which clearly states what members of staff should do "if faced with a potentially life-threatening situation when there are no other staff in the immediate vicinity". The sample LSS included in his guidance stated the following:

> "Where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff may enter the cell on their own."

143. It goes on to state that:

> "Staff have a duty of care to prisoners and to themselves and to other staff. The preservation of life must take precedence over security concerns but night staff should not take action that they feel would put themselves or others in unnecessary danger."

144. Swansea's governing Governor issued LSS 2.77 in July 2010, some six months after the chief operating officer of NOMS issued his own guidance. This refers to the opening of cells during the night, and includes a section on emergency situations. Section 2 of the document states that when a member of staff is satisfied that there is a "potential or actual threat to the safety of life", he or she must inform the communications room of the situation and the intention to enter the cell, and then enter the cell to deal with the situation.

145. In this case, Officer A did not go immediately into the cell. It was clear from his interview with my investigator that he believed there was a threat to the safety of life. However, he was also concerned for his own personal safety and the security of the prison, particularly as someone else (the man's cellmate) was in the cell. When other members of staff arrived on the wing only seconds after his radio message, Officer A opened the cell even before they reached him.

146. The LSS is clear that "safety of life is paramount", but also states that members of staff should not take action that they feel would put them in unnecessary danger. I do not criticise the members of staff involved in the emergency response on this occasion. They went inside the cell and commenced CPR quickly. However, during interview, members of staff suggested there were no circumstances that would involve them entering a cell alone. Officer A said: "I wouldn't enter that cell until I knew [Officer B] was visible." Officer B said: "You wouldn't enter a cell on your own, especially in a patrol state."

147. The guidance issued by the chief officer of NOMS and Swansea's LSS on the matter are clear that members of staff can and should enter cells alone when there is immediate danger to life. In another situation, opening a cell rather than waiting for other members of staff to arrive could be crucial. Whilst there is no indication that Officer A unnecessarily delayed the emergency response,

or that it affected the outcome for the man, staff at Swansea should be reminded that they are able to go into the cells in life threatening situations.

The Governor should re-issue local security strategy 2.77, and remind all members of staff of the guidance on opening cells during the night.

148. Regarding timings, the computer record shows that the cell alarm was reset at 6.08am. The ambulance crew noted that they arrived at the prison at 6.14am. However, the log kept in the prison's control room timed the initial radio message at 6.17am, and the ambulance arriving at the prison at 6.25am. Although this initially suggests a discrepancy, it can most likely be explained by the use of several different clocks, which were not necessarily synchronised. Regardless of the different timings given, it seems that the ambulance arrived at the prison six to eight minutes after the first radio message requesting urgent assistance.

149. Following the death of a prisoner at Swansea in July 2010, I found that prison officers had waited several minutes for the nurse to arrive at the cell, before an ambulance was requested. My recommendation was that the Governor reminded discipline staff that they should use their initiative and feel able to request an ambulance in emergency situations. In this case, Officer A was unable to recall the exact wording of his radio message after discovering the man. However, the control room log noted that in addition to requesting urgent assistance on B wing, Officer A also asked the control room officer to call the emergency services. I am pleased that in this case, there was no delay in requesting an ambulance.

150. Officers A and B performed CPR. This continued, with Nurse B taking over chest compressions, until the paramedics arrived. The clinical reviewer noted in his clinical review that "a question … remains unanswered [about] why the registered nurse attending the scene did not immediately get involved in the resuscitation of the man". The prison officers involved in the resuscitation attempt had received basic life support training, although not for some time and had not undergone refresher training. As a registered nurse, it is likely that Nurse B had receiving such training more recently. Unfortunately, it was not possible to interview Nurse B during the investigation.

151. With regard to training for members of staff working overnight, I endorse the recommendation made by the clinical reviewer in his clinical review.

The Governor should ensure that members of staff, particularly those working overnight, are offered refresher training in basic life support.

152. Following the death of a prisoner at Swansea in May 2009, I found that a defibrillator was not taken to the cell despite being located nearby. Staff members who were interviewed at that time implied that nurses who were not designated 'first responders' would not be expected to use a defibrillator. However, the clinical reviewer in that investigation thought it was inappropriate to restrict the use of defibrillators to trained members of staff, and provided the supporting views of the Resuscitation Council (UK). I

endorsed the clinical reviewer's recommendation that defibrillators should be taken to all identified or possible cardiac arrests.

153. In this case, my investigator was unable to speak to Nurse B and so I cannot say with certainty whether or not a defibrillator was taken to the man's cell. However, when my investigator asked SO C if there was any emergency equipment, such as oxygen or a defibrillator, at the cell, he said that he did not recall seeing anything of that nature. Certainly, there was no indication from the interviews that a defibrillator had been used. It may be that the initial radio message was not sufficiently clear, and that the nurse was not aware that a defibrillator was required. However, whilst Officers A and B were performing CPR, Nurse C and SO C (for some of the time) were also at the cell and could have retrieved a defibrillator. I therefore repeat my earlier recommendation.

The Governor should remind all staff to take the defibrillator to all identified or possible cardiac arrests.

Nursing cover during the night

154. I investigated Swansea's arrangements for nursing cover overnight after the death of a prisoner in July 2010. At this time, Nurse B worked permanently on night shifts. Her shift pattern involved working seven consecutive nights, followed by seven days off. She was the only nurse in the prison during the night, and frequently the only woman. The nature of her role and the hours that she worked meant that she also risked becoming isolated from her colleagues in the healthcare department. Furthermore, her role during the night meant that, other than emergencies, she had very little prisoner interaction, limiting her opportunity to maintain and refresh her skills. I endorsed a recommendation made by the clinical reviewer that the head of healthcare should review the arrangements for overnight staffing and consider offering rotation to day shifts for permanent night workers.

155. My investigator asked the head of healthcare, about changes that had been made to night staffing arrangements. She explained that the only member of staff to work permanently overnight continued to be Nurse B. (Of the other two nurses working overnight, one was part-time and the other worked a mixture of day and night shifts.) The head of healthcare said that arrangements had been made for Nurse B to work day shifts for two weeks every four months. During these times, she would work in addition to the normal staffing levels, meaning that she was able to attend training courses and take up opportunities for professional development.

156. Whilst I welcome the changes that have been made to the night staffing arrangements, I am not convinced that they are sufficient. A two-week rotation to day shifts every four months equates to only six weeks per calendar year. The remainder of the time is spent working alone overnight. In addition to providing opportunities for development, the head of healthcare must also consider the welfare of staff members overnight. I move on to cover this issue now.

157. Nurse B has attended the three most recent prisoner deaths at Swansea, all within 18 months. Following the death in July 2010, she told my investigator that she did not think that she had been offered adequate support, and that this had also been the case in 2009. The nurse expressed the opinion that there was a perception within the prison that nursing staff were expected to be able to deal with a prisoner's death because it was part of their duties.

158. The head of healthcare told my investigator that, following the previous death, she had introduced a system of an on-call healthcare manager or senior nurse, attending the prison following medical emergencies to offer support. On 18 September, she was herself the person on call. She said that she arrived at the prison around 40 minutes after being contacted, and she felt that Nurse B was offered a great deal of support. The head of healthcare told my investigator that Nurse B felt better supported after the man's death than she had on previous occasions.

159. Unfortunately, my investigator was not able to speak to Nurse B, and so I cannot comment on how she felt about the support that she received. In my report into the previous death, I said that however resilient the nurse, being present at three self-inflicted deaths in 18 months must inevitably take its toll. Although my previous recommendation about reviewing the arrangements for night staffing was rejected, my opinion on the matter has not changed and indeed is now considerably strengthened.

The head of healthcare should further review the arrangements for overnight staffing. In particular, the arrangements should ensure that nurses working overnight are supported properly following incidents that might adversely affect their welfare, such as the death of a prisoner.

Liaison with the man's family

160. The prison chaplain told my investigator that the police had insisted that they should be the ones to inform the man's family about his death. I think that this was most unfortunate, because in most circumstances the prison is better placed to advise the family of the circumstances of the prisoner's death. PSO 2710 covers deaths in custody. Paragraph 4.2 states that the governing Governor must:

> "Arrange notification to the next of kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened."

161. There is detailed supplementary guidance about liaison with bereaved family members. Paragraph 4.7 of this document states that:

> "There are opposing views … but the vast majority believe that the first contact must be made directly by the establishment so that the family recognise that the death is a matter of great concern to the establishment."

162. Following a death at Swansea in May 2009, I found that the police had informed the prisoner's family, contrary to the prison's wishes. I recommended that the governing Governor agreed a protocol with the Chief Constable of South Wales Police concerning this issue. The police also informed the bereaved family after a prisoner died at Swansea in July 2010.

163. As it appears that there remains a problem around informing family members, and there may be difficulty drawing up the protocol, I repeat the recommendation. The Governor may find it helpful to refer to the NOMS Offender Safety, Rights and Responsibility team and the protocol between the Prison Service and the Association of Chief Police Officers. In my experience, every other prison in England and Wales has agreed that the prison is generally responsible for notifying the family of the death although exceptions are made in particular circumstances. I am not clear why an exception is made for deaths at Swansea. In my view the bereaved family should be told of the death by those responsible for their relative's care who can give the most accurate information about the circumstances.

The Governor should ensure that a suitable protocol concerning informing relatives of prisoners who die at HMP Swansea is agreed with the Chief Constable of South Wales Police.

164. Although the police informed the man's family about his death, I am pleased that prison chaplain and his colleague (also from the chaplaincy), visited the man's mother a few hours later, at 10.00am on 18 September. They gave the family more information about the circumstances of the man's death. The prison chaplain and his colleague attempted to visit the man's father, but he was not at home. The prison chaplain alone visited the father the following day.

165. Paragraph 4.9 of guidance for FLOs (supplementary to PSO 2710) outlines the recommended course of action for initial visits to bereaved family members. It states:

> "Wherever possible, this should be done by a dedicated family liaison officer working alongside the chaplain, or governor or most senior individual available together with the chaplain. No member of staff should be deployed alone."

166. I am pleased that a representative from the prison visited the man's family on the same morning to provide further information. However, as neither the prison chaplain nor his colleague was the dedicated family liaison officer, they should have been accompanied by the most senior member of the prison's management available at the time. For a number of reasons, not least the personal safety of staff members, I do not think that the prison chaplain should have undertaken the visit to the man's father alone.

167. I intend no criticism of the prison chaplain or his colleague who visited the family promptly to provide support, advice and information. I am also aware that trained family liaison officers are not always on duty to conduct initial

visits to bereaved families. The governing Governor must consider timeliness as well as who is appropriate when arranging visits to families. In the absence of a trained family liaison officer, the chaplains were appropriate people to conduct such a visit. However, they should have been accompanied by one of the prison's senior management team.

The Governor should ensure that visits to bereaved family members are conducted by appropriate members of staff, and that members of staff are not deployed alone.

168. The prison family liaison officer was appointed on 22 September. Whilst it was not ideal for four days to elapse before this appointment, I understand that the prison chaplain continued to be the point of contact for the family until the prison family liaison officer took up his role.

169. Following the death of a prisoner at Swansea in July 2010, I noted that the family perceived a lack of communication from the prison and felt excluded from the process. Whilst my investigator has not had direct contact with the man's family, it does not appear that there were such problems in this case. The prison chaplain and the prison family liaison officer reported good relations with the man's family, who visited the prison and met members of senior management. The family also asked the prison chaplain to conduct the man's funeral.

CONCLUSION

170. The man arrived at Swansea on 16 September 2010. He admitted to regular drug use, including heroin. Whilst he had scars on his arms from previous self-harm, the man said he did not have any thoughts of suicide or self-harm at that time.

171. The various members of staff who came into contact with the man had no reason to believe that he posed a risk to himself in terms of self-harm or suicide. He was consistently described as positive, upbeat and even jovial.

172. Despite there being no obvious signs that the man was at risk of suicide, the effect of withdrawal from drugs should not be underestimated. The last three deaths at Swansea have occurred during the prisoner's first days in custody and have involved withdrawal from drugs or alcohol. The man was prescribed medication to manage withdrawal in accordance with Swansea's policies on the issue, though there are wider questions about whether the most effective forms of treatment are being used.

173. There are further issues around the induction unit. Officers said that it was common to respond to complaints of drug withdrawal, and told HM Inspector of Prisons that the induction unit sometimes felt like a detoxification unit. The man complained of drug withdrawal and requested pain relief hours before his death.

174. Whilst I am satisfied that the individual members of staff who came into contact with the man treated him appropriately, I have concerns about Swansea's strategy for addressing drug withdrawal. I therefore recommend that the Governor and head of healthcare work together to review this important area.

RECOMMENDATIONS

1. The head of healthcare should remind all healthcare staff to follow the instructions on the first reception health screening. Prisoners should automatically be referred for a mental health assessment when it is indicated by answers given at the first reception health screening.

   The recommendation was accepted. Refresher training around the reception process will take place for all members of healthcare staff.

2. The National Offender Management Service (NOMS) should urgently review the arrangements for managing drug dependent prisoners, with a view to implementing the fundamental principles contained in the NHS document 'Clinical Management of Drug Dependence in the Adult Prison Setting' into prisons in Wales.

   When this report was issued in draft form, the recommendation was made specifically to HMP Swansea. The responsibility for implementing the recommendation was given to the Governor and head of healthcare. The recommendation was not accepted at establishment level. The response from the prison was as follows:

   > *"The fundamental principle that has been identified as potentially providing an 'inferior service' in relation to the document at HMP Swansea was stabilising a prisoner for the first five days and with methadone prior to lofexidine detoxification. This principle specifically relates to the increased and substantial funding that was made available within the English prison estate to implement the 'Integrated Drug Treatment System' (IDTS) between 2006 and 2007. The additional funding specifically allowed English prisons to provide a drug treatment service specification that incorporated methadone stabilisation during the first days in custody. This highly significant degree of funding provided additional dedicated staffing, as well as refurbishment of the physical environment to accommodate these interventions.*
   >
   > *"Although HMP Swansea and the other prisons in the Welsh estate recognise the increased benefits of being able to provide this additional stabilisation service since the documents published in 2006, the Welsh estate did not benefit from the implementation and funding of IDTS within their establishments. Therefore, the recommendation cannot be accepted on an establishment level, as it implies that it is within the organisational and financial control of the Governor and head of healthcare to implement these interventions but choose not to. This is concerning, as it gives the man's family the impression that HMP Swansea has chosen not to provide a service which potentially could have benefited the man, when this is not the case. If the man had been admitted to any Welsh prison, he would not have been prescribed methadone on entry into custody.*

"HMP Swansea would welcome the implementation of IDTS but, due to a lack of investment of IDTS within Wales, it cannot act on this recommendation on a local level. This recommendation should be directed at a national government level for action within the Welsh estate."

The recommendation was amended to reflect that the same issue exists in prisons across Wales and that the responsibility lies with the NOMS for its implementation. The Chief Operating Officer of NOMS, is currently in discussions with the Welsh Assembly Government regarding drug detoxification arrangements in prisons in Wales. Although a response from the Welsh Assembly Government is expected, no specific time frame has been given about when it might be forthcoming.

3. The Governor and head of healthcare should review the procedure for administering pain relief overnight.

The recommendation was accepted. HMP Swansea pointed out that pain relief has always been available for prisoners overnight. An operational instruction will be issued to discipline staff reminding them of their duty to contact a member of the healthcare team when prisoners request pain relief during the night. The clinical decision of whether or not to issue pain relief medication will be made by the accountable nurse after assessment of the patient.

4. The Governor and head of healthcare should review the arrangements for prisoners who complain of drug withdrawal symptoms overnight.

The recommendation was accepted. A review has taken place and measures taken to improve the access that nurses have overnight to speak to prisoners and administer medication if required. All cell doors on the induction unit have been modified to include an observation hatch.

5. The Governor should re-issue local security strategy 2.77, and remind all members of staff of the guidance on opening cells during the night.

The recommendation was not accepted. The Governor asked for the recommendation to be withdrawn, stating:

"The report states that the response was swift, the LSS has the instructions as per the Chief Operating Officer of NOMS's guidance, and the officers followed that. The PPO report states, 'I do not criticise the members of staff involved.'"

After consideration of this response, I have decided to retain this recommendation. Paragraphs 145-147 of this report make clear that whilst the response was swift on this occasion, a number of staff members did not fully understand, during interview, the circumstances during which they were permitted to enter a cell alone. Such knowledge could prove critical when responding to a situation in the future. For this reason, the LSS should be re-

issued, and the Governor should ensure that members of staff are clear about when they are able to enter cells alone.

6. The Governor should ensure that members of staff, particularly those working overnight, are offered refresher training in basic life support.

   The recommendation was accepted. Emergency first aid courses will be run and permanent night staff in particular will be encouraged to attend.

7. The Governor should remind all staff to take the defibrillator to all identified or possible cardiac arrests.

   The recommendation was accepted. The 'first responder' trainer has been asked to ensure that, as part of training delivery, all staff members in attendance are reminded that they should take a defibrillator if the incident is one of cardiac arrest or possible cardiac arrest. Current 'first responders' have received written guidance.

8. The head of healthcare should further review the arrangements for overnight staffing. In particular, the arrangements should ensure that nurses working overnight are supported properly following incidents that might adversely affect their welfare, such as the death of a prisoner.

   When this report was issued in draft form, the recommendation also made reference to ensuring that the training needs of overnight staff are properly met.

   The recommendation was not accepted and the head of healthcare asked for it to be withdrawn. The head of healthcare specified the amount of training that Nurse B had received, which exceeded that required to maintain her registration as a nurse. The aspect of the recommendation related to training has been withdrawn.

   Regarding support for overnight staff, the head of healthcare asked for the recommendation to be withdrawn, and stated that following a similar recommendation in the previous PPO report, the issue was addressed. The head of healthcare also included a short statement from Nurse B, who stated that the situation had improved and that managers were very supportive.

   After consideration, this recommendation was retained in its amended form. As stated in the report, Nurse B has now responded to the most recent three deaths at HMP Swansea. As it was not possible to interview her during the course of the investigation, I have not been able to satisfy myself that the issue has been satisfactorily resolved.

9. The Governor should ensure that a suitable protocol concerning informing relatives of prisoners who die at HMP Swansea is agreed with the Chief Constable of South Wales Police.

   The recommendation was accepted. A protocol with South Wales Police is being developed to ensure that contact is made appropriately.

10. The Governor should ensure that visits to bereaved family members are conducted by appropriate members of staff, and that members of staff are not deployed alone.

   The recommendation was accepted. The Governor pointed out that the draft version of this report contained factually inaccurate references to the prison chaplain visiting the man's mother alone on Saturday 18 September. This was incorrect, and paragraphs 164-167 have been amended. Nevertheless, the prison chaplain did visit the man's father alone on Sunday 19 September. Neither visit was conducted by a dedicated family liaison officer or a member of the prison's senior management team. The Governor should ensure that visits to bereaved relatives are conducted in accordance with the written guidance.