PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Cardiff in September 2013

Our Vision

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

This is the investigation report into the death of a man, who was found hanging in his cell at HMP Cardiff in September 2013. He was 42 years old. I offer my condolences to his family and friends.

Healthcare Inspectorate Wales reviewed the clinical care which the man received at the prison. The prison cooperated fully with the investigation.

The man had alcohol problems and was arrested after allegedly assaulting and making threats to kill his mother. While he was in police custody, he was taken to hospital to be treated for alcohol withdrawal symptoms after having a fit. He was remanded to HMP Cardiff. The next morning he was found to have hanged himself in his cell.

The investigation has found that reception staff at the prison did not properly consider all of the man's known risk factors. Instead, as I have previously found at Cardiff, they relied too much on his personal presentation. He was experiencing his first night in prison, had never been in prison before and was withdrawing from alcohol. He had been charged with violent offences against a family member, a risk factor which I have highlighted in two recent investigations of deaths at the prison. In response to these deaths, the prison had introduced a new suicide and self-harm screening form, but this was not completed properly and did not identify the evident risks. I am concerned that reception staff had not been fully briefed or trained in its use and to understand its importance. A separate suicide risk assessment used by healthcare staff in reception did not appear adequate to assess risk in the prison context. Although there is a dedicated first night unit at Cardiff, there are no additional safety checks for new arrivals during the night, even for those like him who are withdrawing from alcohol. These are all matters which have been identified in previous investigations into deaths at HMP Cardiff and I am seriously concerned that insufficient action appears to have been taken as a result.

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.

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

CONTENTS

SUMMARY

1. The man was arrested on 17 September 2013. He was charged with assault, threats to kill and possession of an offensive weapon. The incident involved his parents and sister while he was under the influence of alcohol. He spent two days in police custody, during which time he was taken to hospital to be treated for alcohol withdrawal symptoms.

2. A few days later the man appeared at court and was remanded to HMP Cardiff. During the reception procedure, he was assessed by a reception healthcare assistant and a reception officer. Despite a number of risk factors which should have indicated that he was at risk of suicide and self-harm, they were satisfied with his mood and behaviour and did not begin suicide and self-harm monitoring. The healthcare assistant completed a clinical suicide risk assessment tool which did not identify any concerns. A recently introduced reception suicide screening form was not completed properly and omitted to record that he was charged with violent offences against family members. The new form had been introduced as a result of recommendations arising from our previous investigations into deaths at the prison where the raised risk of suicide in prisoners charged with violent offences against family members had not been identified.

3. The healthcare assistant completed an alcohol withdrawal assessment with the man and his score prompted a nurse to give him 10mg of diazepam to treat mild to moderate withdrawal symptoms on his first night. Although it was noted that he should share a cell, he remained alone in a double cell on the induction unit as there was no other identified non-smoker on the unit to share with him. He was locked in his cell shortly after arriving on the unit and he was not checked again at any time during the night.

4. The next morning, an officer found the man hanged in his cell. Although there were clear signs that the man had been dead for some time, two nurses believed they were required to attempt resuscitation as they were not formally qualified to verify death. When paramedics arrived, they pronounced his death.

5. The investigation has shown that more training is needed to help reception staff at the prison understand risk factors and assess the likelihood of suicide and self-harm. There is also a need for better cooperation and communication between officers and healthcare staff in reception to help ensure that risk factors are not overlooked. We were concerned about the suitability in a prison setting of the clinical suicide risk assessment, which did not identify the man as posing any risk to himself.

6. When assessing the man's risk of suicide and self-harm, the reception staff relied too much on his personal presentation rather than his known risk factors. He was charged with violent offences against his family, was withdrawing from alcohol and this was his first time in custody. They overlooked a warning from court staff and information from the police appears to have gone missing. We consider that suicide and self-harm prevention procedures should have been implemented and he should have been monitored during his first night in prison, especially as he was withdrawing from a dependence on alcohol. We also consider that he should have had a

shared cell. Our investigation also found that Cardiff's alcohol detoxification guidelines for the healthcare staff do not reflect current practice and require updating.

7. Although sadly it was too late to save the man, we are concerned that officers did not follow the required procedures for a medical emergency. This meant that healthcare staff attending did not bring the required emergency equipment and an ambulance was not called immediately. Finally, we think that healthcare staff need guidance on the circumstances when it is appropriate not to perform cardiopulmonary resuscitation. We make seven recommendations as a result of the investigation.

THE INVESTIGATION PROCESS

8. Notices were issued to staff and prisoners at HMP Cardiff about the investigation. No one responded. The investigator and a colleague visited Cardiff on 25 September. They collected copies of the man's clinical and prison records and visited the reception and induction units. On 22 and 23 October, they interviewed seven members of staff. They gave verbal feedback and written feedback to the Governor about the initial findings of the investigation. The investigator subsequently interviewed three other members of staff by telephone.

9. Healthcare Inspectorate Wales reviewed the man's clinical care at the prison.

10. The local Coroner has been sent a copy of this report.

The man's family

11. Our family liaison officer contacted the man's parents and wife to explain the investigation process. They had no specific questions for the investigation to take into account. His parents and his wife had no comments to make about the draft report. They all requested copies of the final report.

HMP CARDIFF

12. HMP Cardiff is a city centre prison holding around 800 men. Like the man, many of the prisoners come from the local courts on remand. There is a nurse on duty 24 hours a day. Prisoners arrive in the reception area where they are seen first by a healthcare assistant and an officer. There is a qualified nurse for additional healthcare support and first night prescribing. Newly-arrived prisoners do not normally see a GP until the next day. Prisoners move to the induction unit where they can speak to an insider, who is an experienced prisoner able to offer advice. They spend their first night on the induction unit and complete their induction the following morning. There is no CCTV monitoring on the induction unit.

Her Majesty's Inspectorate of Prisons

13. HM Inspectorate of Prisons (HMIP) last carried out an inspection of Cardiff in March 2013. Inspectors found that Cardiff was busy and overcrowded and noted that the population was very transient with many prisoners serving only short sentences. HMIP found that reception and first night assessment procedures were thorough and that new arrivals benefitted from talking to Insiders (trained prisoner peer mentors.) However, they were concerned that there were insufficient safety checks on prisoners on their first night.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. The IMB 2012 annual report noted that the prison had made changes to its reception and induction processes after feedback from HMIP and the appearance of the units had been altered to make them more welcoming.

Previous deaths

15. Including the man's, there have been nine deaths at Cardiff since 2012. Of particular relevance are the self-inflicted deaths of three men in June, November and December 2012. All the men had committed offences against family members, a factor that the Prison Service recognises can increase the risk of suicide and self-harm. We recommended in all three reports that staff should take account of all known potential risk factors and triggers when assessing a prisoner's risk of suicide.

16. The prison accepted the recommendations and introduced a new self-harm screening form for use in reception from 8 July 2013. The man had been charged with violent offences against a family member but this was not noted on the screening form despite a prompt for this information.

17. Our recent investigations also highlighted the importance of newly-arrived prisoners sharing cells during their induction period. The prison assured us that sufficient accommodation would be made available in the first night centre and that all prisoners who needed to share a cell would be allocated one unless they were a risk to others. Despite this, the man spent his first night in prison alone in a double cell.

18. Our investigation into the death at Cardiff in June 2012 revealed a failure to take fully into account a self-harm warning form which arrived with the prisoner, and problems with the arrangements for men withdrawing from alcohol when they arrived. There are similar issues in the man's case.

Assessment, Care in Custody and Teamwork (ACCT)

19. Assessment, Care in Custody and Teamwork (ACCT) is a Prison Service-wide process for supporting and monitoring prisoners thought to be at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary review meetings involving the prisoner.

KEY EVENTS

20. The man had developed an alcohol misuse problem in the year leading up to his arrest. He had never been to prison before. According to his family, he had previously threatened to take his own life, which they had warned the police about.

21. The man was arrested in the early hours of Tuesday 17 September 2013, after threatening his parents and sister with a knife while under the influence of alcohol. He was charged with assaulting his mother, making threats to kill her and possession of an offensive weapon.

22. The man was held at a police station. He had a fit while in police custody and was taken to hospital to be treated for alcohol withdrawal. As a result, the interview and charging process was extended and he spent two nights in police custody. He was given an anti-rip suicide prevention suit at the police station and was checked every half-hour. He told police officers that he had no thoughts of suicide and self-harm. A police doctor examined him and assessed him as a low risk of suicide and self-harm.

Events leading up to the incident

23. A few days later, the man was taken to Magistrates' Court. A police officer wrote on the person escort record (PER – which accompanies all prisoners when they move between police stations, courts and prison) that he had made threats to kill his mother, suffered from depression and was alcohol dependent. He also circled to indicate that a suicide and self-harm warning form was enclosed. The Independent Police Complaints Commission (IPCC) has completed its own investigation as a matter of routine because he died less than 24 hours after leaving police custody. The police officer who wrote on the PER told the IPCC that he had stapled an additional piece of paper to the inside front cover of the PER, which apparently became detached before the PER reached the prison. It is apparent from the photocopy of the PER that there were four staples on the front cover. The officer told the IPCC that this piece of paper was a printout of information containing similar information to the handwritten PER, indicating that he was a high risk to his elderly mother, had threatened to kill her, was alcohol dependent and suffered from depression. This paper was not found in his prison file after he died and we do not know when it became detached.

24. The man was remanded into custody. His case was committed to Crown Court, with his next appearance scheduled for 26 September. Court staff completed a form entitled "Notification to the Governor of HMP Cardiff". This document indicated that he had made threats to kill and simply stated the words 'self-harm' in the prisoner risk / vulnerability section. The accompanying charge sheet from the court outlined three charges against him: assaulting his mother, threatening to kill her and carrying an offensive weapon. Prison reception staff received both documents with the PER.

25. The man arrived at HMP Cardiff at about 3.20pm. Sixteen new prisoners came through reception that day. An officer booked him in at the reception front desk which she estimated took between five and ten minutes. She checked his PER and court warrant and then wrote on his cell sharing risk

assessment (CSRA). (The CSRA is used to determine whether someone would present a risk of violence to another prisoner in a shared cell.) She recorded on the CSRA that his alleged offences were making threats to kill and domestic violence. She added the names of his victims, that it was his first time in custody and that he misused alcohol. She said she had been instructed by the safer custody manager always to record offences of domestic violence on the CSRA, in order that the reception officer who subsequently completes the induction interview with the prisoner can see this information.

26. Because the 'Notification to the Governor' form named three members of the man's family as witnesses to his alleged offences, the officer informed him that he would not be allowed to speak to these family members for the time being. He told her that he had no suicidal thoughts. She told the investigator that he was quiet and cooperative and not visibly distressed. She did not consider that Assessment, Care in Custody and Teamwork (ACCT) monitoring was needed. (ACCT is the Prison Service suicide and self-harm prevention procedure.)

27. A healthcare assistant then assessed the man in the reception area. She saw the PER, the court warrant detailing his charges and the CSRA which had been part-completed by the officer. When she was interviewed, the healthcare assistant did not recall having seen the Notification to the Governor form which the court staff had completed.

28. The healthcare assistant said she shared a joke with the man when she first called him into the office because she had mispronounced his surname. He told her that he was on remand and had not been to prison before. She asked about suicide and self-harm and he told her that he had not previously attempted to harm himself in the community and did not have any suicidal thoughts at that time.

29. Although the healthcare assistant had looked at the PER and the court warrant, she said she did not notice that his victim was a family member with the same surname. She therefore did not record the man's offence as one of domestic violence. Has she done so, the electronic clinical record would have automatically advised that this raised the risk of suicide and self-harm.

30. The healthcare assistant recorded that the man was dependent on alcohol and suffered from depression, but was not taking any medication in the community for this. He told her that he was currently prescribed medication for high blood pressure.

31. The healthcare assistant assessed the man's alcohol misuse. He said that he had consumed 180 units of alcohol in the previous week. He was mildly nauseous and anxious, had some tremors in his arms and was sweating very slightly. She used the Clinical Institute Withdrawal Assessment of alcohol (CIWA-Ar) template on the electronic clinical record system and scored him 12 for alcohol withdrawal symptoms. This score indicated mild to moderate alcohol withdrawal symptoms. Patient group directions (PGDs) allow a nurse to dispense 10mg diazepam to a prisoner with this CIWA-Ar score on his first night. (A CIWA-Ar score of less than 8 does not require any medication, 8-14 prompts 10mg of diazepam and a score of 15 or more requires 20mg of

diazepam on the first night.) There was no indication that any checks were made to find out what treatment he had received in police custody.

32. The healthcare assistant completed a suicide screening tool with the man using a template on the electronic clinical record. She completed the assessment correctly and his answers to the questions scored him zero. Six is the threshold which indicates a need for further intervention, so she did not refer him for a mental health assessment or open an ACCT document. She said she spent about 20 minutes with him and she had no serious concerns about him. She recalled during interview that he was settled, relaxed, polite and appropriate.

33. For the final reception procedure, an officer completed an induction interview which he said took about 30 to 40 minutes. He had seen the man's PER, warrant and the Notification to the Governor form from the court. The officer asked about some marks on his arm, which he said had been caused when he fell off his bike while riding home when he was drunk. He became upset and tearful when the officer told him that he was not allowed to contact family members named by the court for the time being because they were witnesses to his alleged offence. He said he had wanted to call them to apologise. The officer told the investigator that the man made conversation and kept eye contact, but his arms were shaking a little. He thought that he seemed a little dazed and had a glazed expression.

34. The officer completed a first night suicide and self-harm screen. The first two questions ask whether the prisoner is undergoing detoxification and whether there are any current mental health issues. However, healthcare staff at Cardiff are not involved in completing the form, which they consider was designed principally for officers to complete and not to be a healthcare matter. The officer obtained the answers to these two questions from the man. He wrote that he was undergoing alcohol detoxification and recorded that there were no mental health issues.

35. The officer recorded that there was no current suicide and self-harm warning notice, even though the Notification to the Governor form sent by the court indicated that self-harm was a concern. He recorded that the man said he was not having any current thoughts of suicide or self-harm and that there was no evidence of any previous self-harm.

36. The officer told the investigator that the man had explained to him that he had threatened his mother with a knife when he was drunk after she had poured a bottle of alcohol down the sink.

37. Question six on the suicide and self-harm screening tool asks whether the prisoner's offence gives reason for concern. It gives examples of offences which might raise the risk of suicide or self-harm, including a violent offence committed against a family member. The officer wrote nothing on this part of the form, so it was not complete. He told the investigator that he did not do this because another officer had already written this information on the CSRA. (Although the CSRA is not designed to assess risk of suicide and self-harm.)

38. The officer told the investigator that he was satisfied with the man's mood and behaviour during the interview. He did not consider him to be at risk of

suicide or self-harm so did not therefore begin ACCT monitoring. He did not discuss the possibility of beginning ACCT monitoring with either the healthcare assistant or the other officer.

39. The officer completed the rest of the man's cell sharing risk assessment. He assessed him as a standard risk, meaning that he could share a cell with another prisoner. He said that he would prefer to have a single cell but would be prepared to share with a non-smoker as he did not smoke. On the healthcare section of the CSRA, the healthcare assistant had noted that he should be given a shared cell and sleep on the bottom bunk because he was withdrawing from alcohol.

40. While he was in the room with the officer, the man made a telephone call to a former employer who was also a friend of the family. He was shaky and emotional. The call was not recorded because it was made on the general reception telephone. The officer told the investigator that the man told his friend that he was in prison, that he was sorry for what he had done and asked him to visit. He was not able to make any further telephone calls that day.

41. At about 4.30pm, a nurse saw the man and gave him 10mg of diazepam following his CIWA-AR assessment. She said she looked at the healthcare assistant's entry in the clinical record and the clinical suicide assessment result of zero and then took him into a side room where she asked him how he was and he took the dose of diazepam in front of her. He was not subject to any further clinical monitoring that night and was due to have a secondary health screen the next day.

42. The man took a shower and had a meal before he left the reception area at about 6.30pm. Officers escorted him to C wing (the induction unit) where he spoke to one of the Insiders for about five minutes. (Insiders are experienced prisoners who are trained to offer advice and support to newly-arrived prisoners.) The Insider said that he did not seem especially upset and did not mention any suicidal thoughts. He appeared happy to talk to him and did not raise any concerns. The Insider told him that they could talk again in the morning if he wanted further advice.

43. The officer in charge of locating newly-arrived prisoners that evening had received the man's cell sharing risk assessment (CSRA) and the incomplete self-harm and suicide screening form. He did not telephone the previous officer to ask him about the missing information and did not complete the screening form himself using the information from the CSRA. He told the investigator that he had been unsure whether the domestic violence offence and victims' names recorded on the CSRA related to a current or historical incident.

44. The officer spoke to the man in the wing association area immediately after he had seen the Insider. He did not ask him anything about the offences he was charged with. He recorded on the man's electronic prison record that his mood was fine, that it was his first time in prison and that he had not reported any self-harm issues. He did not consider that he was at risk of suicide and allocated him to cell 4 on the second landing of the induction unit.

45. An officer took the man to the cell (which was a double cell) and locked him inside at about 6.45pm, approximately 15 minutes after he had arrived on the induction unit. Newly-arrived prisoners at Cardiff do not have an association period during which they can mix with other prisoners on their first night.

46. The officer in charge of locating said that he had been waiting for another non-smoker to arrive to share a cell with the man. However, none of the other new arrivals were non-smokers and he said that out of 60 prisoners on the wing that night, the man was the only one who did not smoke. He went to his cell at about 7.40pm, explained that he had not found anyone for him to share with and asked him if he would be OK for the night. He told him that he should normally share a cell because he was withdrawing from alcohol. He asked him if he was having any suicidal thoughts and he said he was not. Although he had suffered a fit while he was in police custody, the officer said that he told him that he did not normally have fits associated with detoxification and that he was content to spend the night alone.

47. The officer told the investigator that he had asked the night patrol officer to keep an eye on the man. However, the C wing night patrol officer said during interview that nobody asked him to monitor him. There is nothing written about the need to check him in the wing observation book and nobody checked him during the night.

48. When he was interviewed, the night patrol officer said he could not recall anything remarkable about his handover from the wing staff that evening. He said he began his night shift at about 8.45pm. Along with a colleague, who started a shift later on at 9.30pm, he was responsible for C, D and E wings, a total of about 220 prisoners. The night patrol staff move between these wings during the night and the gates between the wings remain open. A nurse is based on the healthcare centre at night.

Events leading up to the incident

49. The man did not use his cell bell during the night to call for staff attention. The night patrol officer began a roll check of C and D wings at about 6.30am, while the other officer checked the prisoners on E wing. However, he then discovered that a prisoner on the third landing of C wing, who was subject to ACCT monitoring, had made cuts to his arms and neck. He radioed a code red medical emergency to alert the night orderly officer (NOO) and the nurse. The NOO arrived, unlocked the man's cell and the nurse took him to the wing treatment room. The NOO then took him to the healthcare centre. The night patrol officer stayed on C wing and went to write up his notes about this incident before continuing the roll check. By now, the time was about 7.20am and he had yet to check the man's cell.

50. An officer was asked to perform the day staff roll check on C wing when the officer normally responsible did not arrive for work. She began on the third landing and reached the man's cell on the second landing at about 7.23am. She looked through the observation panel once, closed it, then reopened it and realised that he had hanged himself. His back was towards her and he had tied one end of a torn bed sheet around his neck and the other to the bunk bed frame. He was wearing only a pair of jogging bottoms. She shouted for help and pressed the general alarm button, which was about ten

feet away. During interview, she could not remember whether she was carrying a radio at the time.

51. Two officers were in the C wing office on the second landing, very close by, when they heard the officer shouting and then the general alarm. They joined her at the cell almost immediately. One officer went into the cell and supported the man's weight while the other cut through the bed sheet. The officer who had found him remained outside the cell. The officers said that his body was rigid and cold. They laid him on his back on the floor, but his knees were bent and leaning to one side. One officer removed the rest of the bed sheet from around his neck and the other checked for vital signs but could not find any. The officers were sure from the presence of rigor mortis that he had already died and therefore did not attempt to resuscitate him.

52. A nurse had started a day shift and was checking the prisoners in the healthcare centre when she heard the general alarm. Her manager told her that a member of healthcare staff was needed on C wing and that the prison staff had asked for help. She was unaware of the nature of the problem because the officers had not used a medical emergency response code. She was unsure if she should take an emergency bag but her manager told her to assess the situation first and collect an emergency response bag from the treatment room in the centre of the prison adjacent to C wing if necessary.

53. The nurse had been the first nurse to arrive for the day shift, so went to C wing on her own. She said that when she arrived at about 7.25am, she saw several officers gathered outside the cell. They told her that they thought the man had died. The cell door was pulled to. She went into the cell and assessed the man. She had no doubt that he had died some time earlier. She then became upset and was in a state of shock, but told the officers that he had been dead for some time. She checked that the officers had asked for an ambulance to be called. One of the officers took her to a side room for a cup of tea to recover from the shock.

54. Two more nurses had arrived on duty and came to C wing about two minutes after their colleague had assessed the man. They spoke to the officers outside the cell, who said that he was dead. They went into the cell and, like their colleague, they found no signs of life and agreed it was apparent that he had died. However, one felt that she had to do something and so she decided to attempt cardiopulmonary resuscitation (CPR).

55. One nurse ran to the treatment room at the centre of the prison to fetch the emergency response bag, oxygen and a defibrillator. She and her colleague then attached the defibrillator to the man and began CPR. The defibrillator advised them not to administer a shock as there was no detectable heart rhythm. One performed chest compressions whilst the other gave oxygen. They could not insert a plastic airway because the man's jaw was too stiff. They continued to perform CPR for the next 10 to 15 minutes. Throughout this attempt, he never showed any signs of life.

56. When the first nurse heard that two of her colleagues were attempting CPR, she could not understand why. She believed that there was nothing positive to be gained. However, she went back to the cell, observed and passed equipment to them.

57. Control room staff called an ambulance at 7.26am. Paramedics reached the prison gate at 7.35am and the wing at 7.43am. They told the nurses to stop performing CPR and advised them that the man had died. They confirmed the presence of rigor mortis and pronounced his death. One of the prison GPs certified death at 8.33am.

58. Inside the cell was a letter which the man had written to his wife asking her to persuade his parents to drop the charges against him because he was facing ten years in prison. He was under the impression that he was being charged with attempted murder.

59. At 8.15am, the safer custody manager arranged for staff to review all prisoners subject to ACCT monitoring, in case they had been adversely affected by the man's death. He held a debrief meeting for the staff involved in the emergency response to check on their welfare.

60. The Acting Governor of Cardiff and the family liaison officer visited the man's wife at 11.45am to break the news of his death and at 1.00pm, they visited his parents to inform them. The prison contributed towards the cost of the funeral in accordance with Prison Service guidance. The funeral was held on Monday 14 October.

61. The post-mortem examination found that the man had died as a result of hanging. The toxicology report only found expected amounts of therapeutic medication in his blood. The post-mortem examination also revealed that he had been suffering with a brain tumour. We do not know how, or whether, this had affected his mood and behaviour in the preceding weeks and months.

ISSUES

Managing the risk of suicide and self-harm

62. ACCT monitoring was not implemented for the man during the reception process. We believe that it should have been. There were a number of risk factors which should have alerted staff to his raised risk of suicide and self-harm.

63. Prison Service Instruction 64/2011 and Cardiff's own local suicide prevention and self-harm management policy both remind staff that the risk of suicide and self-harm is raised if a prisoner has been charged with a violent offence against a family member. The man had been charged with assaulting his mother and making threats to kill her when armed with a knife. This alone should have alerted staff to his heightened risk. The other risk factors were that it was his first time in prison, his first night in custody, and he was withdrawing from alcohol. There was a self-harm warning from court staff and police had also raised concerns on the PER. All these factors were significant indicators of risk of suicide and self-harm. Set against these, he consistently said he had no thoughts of suicide or self-harm when asked directly. His behaviour and demeanour gave no indications otherwise.

64. Neither the reception officers nor the reception healthcare assistant thought that ACCT monitoring was a necessary precaution. Our interviews found that the reception and induction staff were unable to identify all of the man's risk factors, and could not explain how they had balanced the risks they had identified against their perceptions of his mood and behaviour.

65. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. However, we are concerned that staff relied so heavily on the man's presentation, when he had a number of known risk factors when he arrived at Cardiff. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We consider that more weight should have been given to the known risk factors in comparison to his presentation.

66. It is worrying that the staff did not even discuss whether to open an ACCT document for the man. It is perhaps even more concerning that they told the investigator that they would not necessarily have considered ACCT monitoring even if they had correctly identified all of his risk factors.

67. The staff seemed confused during our interviews about what constitutes a violent offence against a family member. The man's alleged offences of assault and threats to kill against his mother did not register with them as a risk factor for suicide in the same way that an assault against a partner would have done. The staff did not grasp the severity of the offence and the mental trauma it might have caused him once he had had an opportunity to reflect on his actions.

68. Our interviews also showed that the staff failed to identify that warnings about the man's risk of suicide and self-harm had been received. The police marked on the Person Escort Record that a suicide and self-harm warning form was attached, but this additional sheet of information prepared by the police officer (it seems never to have been an actual warning form), initially stapled to the PER, does not appear to have been seen at the prison and it was not among the papers in his records after he died. Nevertheless, the fact of its existence was clearly identified and prison staff should have checked with the police if it was missing.

69. The Notification to the Governor form completed at court (primarily intended to advise prison staff about the man's charges and any witnesses he was not supposed to contact) contained a self-harm warning added by court staff. This warning was clearly written and visible to anybody who glanced at the form. Reception staff did not act on this warning either because they did not read the form properly or because the only warning form they look for as a matter of course is the more common suicide and self-harm warning form sent by the police or escort staff. The reception officer incorrectly recorded that no warning had been received.

70. This is not the first case in recent times at Cardiff where a prisoner has taken his own life during the early stages of custody after being charged with offences against a family member. After the PPO made recommendations in investigation reports into deaths in 2012, the prison developed a new suicide and self-harm screening form for reception staff to use. The induction officer who interviewed the man did not complete this form properly, and failed to record the charges of violence against a family member. The officer's assessment of the risk of suicide was therefore incomplete.

71. We believe that the screening form requires some minor amendments. The first two questions concern clinical issues (detoxification and mental health). However, we understand that the reception healthcare staff refused to complete these questions because the form does not make it clear who is supposed to provide the information and sign for it. Also, the screening tool offers no guidance to the reception officer about how to use the information gathered in order to make a decision about whether ACCT monitoring should be initiated.

72. During our interviews, we were not convinced that staff understood either why they were asking a question or how to weigh any evidence they gathered against the man's presentation. There was no specific training given to officers and healthcare staff when the new screening form was introduced. We think that training is needed, and that it should include a very clear summary of the main suicide risk factors and an explanation of why each is significant. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

73. We are also concerned about the suitability of the clinical suicide screening tool used by the reception healthcare staff. There are 11 questions, with a threshold of 6 which would indicate a need for a mental health referral. The healthcare assistant scored the man zero using this screening tool. At first this seems difficult to understand, taking into account his known risk factors. However, the screening tool does not take into account issues such as the charges a prisoner is facing or whether he is withdrawing from drugs or alcohol.

74. The clinical screening tool asks about previous diagnoses, treatment and medication, previous suicide attempts in and out of prison, current suicidal thoughts, a family history of suicide, sources of support, homelessness and time spent in care. Healthcare staff also ask the prisoner if he is feeling hopeless. A point is scored for a prisoner who has been in prison before rather than for those like the man who are in prison for the first time and known to be a higher risk.

75. As the man scored zero, in spite of his other risk factors, we are concerned that the clinical screening tool could give healthcare staff false reassurance about a prisoner who is actually at a high risk of suicide. We make the following recommendation:

The Head of Healthcare should ensure that the clinical suicide screening tool reflects current research and evidence-based practice including custodial risk factors and is suitable for use in a prison setting.

Alcohol withdrawal

76. The man was intoxicated during the incident which led to the charges against him. He had alcohol misuse problems which had caused him to fit and require hospital treatment for withdrawal symptoms when he was in police custody. There is no indication what medication he received while he was in police custody.

77. In reception at Cardiff, a healthcare assistant scored the man 12 on the CIWA-Ar alcohol withdrawal scale, prompting a nurse to give him 10mg of diazepam for mild to moderate withdrawal symptoms on his first night in Cardiff. He was due to see a nurse for a secondary health screening the next morning and could then have been referred to a GP if appropriate. Healthcare Inspectorate Wales (HIW) found that the clinical treatment offered to him in reception was reasonable.

78. Nonetheless, we have some concerns about the procedures at Cardiff for men like the man who are withdrawing from alcohol. Following our

investigation of the death of a man at Cardiff in June 2012, we recommended that the prison should revise its local policy for managing prisoners withdrawing from alcohol to meet the requirements specified in Prison Service Order (PS0) 3550 'Clinical Services for Substance Misusers'. The prison accepted this recommendation.

79. However, Cardiff's alcohol detoxification guidelines do not reflect the current practice of reception healthcare staff and remain outdated. While the actual treatment which the man received in reception (use of the CIWA-Ar assessment and dispensing of 10mg diazepam for a score of 12) was up-to-date and in line with agreed prescribing practice, the most recent guidelines are outdated and indicate a totally different assessment scale and dose of diazepam. We do not consider that our previous recommendation has been appropriately implemented which is a concern as the existing guidelines risk confusion about the appropriate treatment for alcohol withdrawal. We make the following recommendation:

The Head of Healthcare should ensure that Cardiff has an up-to-date local policy which clearly instructs staff how to assess, medicate, locate and monitor prisoners withdrawing from alcohol.

80. Prison Service Order 3550 requires that, where possible, treatment should be given in a healthcare setting by trained and experienced staff. We are concerned that there is no requirement for prisoners with alcohol withdrawal symptoms like the man to be monitored on their first night at Cardiff. As we indicated in a previous report, it is a requirement for prisons in England that 'all drug and alcohol dependent prisoners arriving in reception must always be offered immediate admission to a stabilisation unit' which has 24 hour healthcare cover. The provisions in English prisons, which operate the Integrated Drug Treatment System, do not apply in Wales, but nevertheless we consider that for similar safety reasons all prisoners who are prescribed treatment for alcohol withdrawal symptoms should be checked regularly at least until they have a secondary health screen. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners who are prescribed medication to treat alcohol withdrawal symptoms on their first night are checked for safety every two hours until they receive a secondary health screen to determine the level of necessary ongoing support.

First night location and checks

81. We are also concerned that the man did not share a cell on his first night. The healthcare assistant had recognised the increased risk for someone withdrawing from alcohol by noting that he should share a cell and the officer on the first night unit who allocated cells acknowledged that he would normally be required to share a cell because he was withdrawing from alcohol. The Head of Healthcare has also acknowledged to the investigator that the existing outdated alcohol detoxification guidelines for healthcare staff do not, but should, reflect the accepted first night practice, which is for prisoners withdrawing from alcohol to share a cell if possible on their first night.

82. The man was a standard cell-sharing risk. He was located in a double cell but was locked up alone because another non-smoker could not easily be found to share with him. The first night unit officer said that he was the only one of 60 prisoners on the wing who did not smoke. This seems extraordinary but we have not been able to establish whether this was indeed the case. The officer said that he had hoped to find somebody to share with him on his first night because of his alcohol withdrawal symptoms. He reflected during interview that he could have moved an experienced prisoner from another wing to share the cell with him.

83. In a previous case of a death in November 2012, we identified that the prison had not followed its own policy in relation to shared cells and recommended that all newly arrived prisoners should be allocated shared cells for their induction period, unless there were clearly recorded reasons to justify a single cell. The prison accepted this recommendation but it is apparent from the man's case that this was not adequately implemented. We understand that managers have now instructed that the orderly officer will approve any decision to locate prisoners alone on their first night in Cardiff. However, it is a serious concern that they have so far failed to ensure this happens despite previous assurances.

84. New prisoners arriving at Cardiff are located on the first night centre. Irrespective of checking the safety of prisoners withdrawing from alcohol or drugs, we are concerned that there are no additional checks for new prisoners spending their first night at the prison. Prison Service Instruction 74/2011 requires governors to ensure that arrangements are in place for staff to monitor prisoners' safety and well-being throughout the first night. At their last inspection HM Inspectorate of Prisons criticised the lack of adequate safety checks for new arrivals in the first night centre. One of the main purposes of having a dedicated wing for newly-arrived prisoners is to help ensure they are safe and receive the support they require. We make the following recommendation:

The Governor should ensure that, unless risk assessments indicate otherwise, prisoners on the first night centre should be allocated shared cells and checked periodically throughout their first night.

Emergency response

85. Although prison staff were already nearby and responded quickly, the officer who found the man hanging in his cell pressed the general alarm, rather than using the medical emergency response code blue over the radio, as the local Governor's Order 49/12, issued on 24 October 2012, requires. The lack of a coded message to indicate the nature of the incident meant that the nurse arrived without an emergency response bag and that an ambulance was not called immediately, as it should have been under the policy. Since the Governor's Order was issued, Prison Service Instruction 03/2013 has been introduced, which outlines the latest requirements for prisons in relation to medical emergency response codes. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Cardiff has a Medical Emergency Response Code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances**

86. Two nurses performed cardiopulmonary resuscitation (CPR) without consulting the first nurse to visit the cell, who had already left the scene after deciding that she would not attempt CPR because she had observed clear signs of death. The other nurses said they felt obliged to try CPR, even though they knew the situation was hopeless. As HIW highlight in their review, the nurses concerned were commendably motivated by their duty of care, however futile the effort.

87. We agree with HIW that staff need guidance and reassurance about when it is acceptable not to perform CPR, to minimise the distress for all involved. This does not mean that nurses have to continue CPR because they are not trained to certify death. We fully understand the commendable wish to continue performing CPR until death has been formally confirmed, but do not consider that healthcare staff or any prison staff should be expected to carry out CPR in circumstances when it is clear that from the presence of the signs such as rigor mortis that the person is dead. The European Resuscitation Council Guidelines for Resuscitation 2010 state that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …" We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

RECOMMENDATIONS

1. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

    - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
    - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.
    - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

2. The Head of Healthcare should ensure that the clinical suicide screening tool reflects current research and evidence-based practice including custodial risk factors and is suitable for use in a prison setting.

3. The Head of Healthcare should ensure that Cardiff has an up-to-date local policy which clearly instructs staff how to assess, medicate, locate and monitor prisoners withdrawing from alcohol.

4. The Governor and Head of Healthcare should ensure that prisoners who are prescribed medication to treat alcohol withdrawal symptoms on their first night are checked for safety every two hours until they receive a secondary health screen to determine the level of necessary ongoing support.

5. The Governor should ensure that, unless risk assessments indicate otherwise, prisoners on the first night centre should be allocated shared cells and checked periodically throughout their first night.

6. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Cardiff has a Medical Emergency Response Code protocol which:

    - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
    - Ensures staff called to the scene bring the relevant equipment; and
    - Ensures there are no delays in calling, directing or discharging ambulances

7. The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

No	Recommendation	Accepted / Not Accepted	Action	Target date and Function Responsible	Progress (to be updated after 6 months)
1	The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff: □ Have a clear understanding of responsibilities and the need to share all relevant information about risk. □ Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs. □ Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.	Accepted	Staff have been reminded that they must adhere to Prison Service Instruction 64/2011 and QTLB No12 (attached). Staff have been also been reminded of their responsibilities to share all relevant information about risk. A notice to staff has been issued to reiterate this. ☐ A 'Suicide and Self-Harm Risk Screening Tool' was devised and implemented within HMP Cardiff on 1 Feb 2013. This assessment provides for a consolidated review of the known suicide and self-harm risk factors, with the contributions of specifically trained health and custodial service staff being documented in one place. Following the tragic death of the	03-03-14 Governor & Safer Custody	

			man in September 2013, we further reviewed the assessment to emphasise the need to properly consider the known risk factors and other available evidence – in order to provide the best professional care outcome for each individual. ☐ We will continue to open ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.		
2	The Head of Healthcare should ensure that the clinical suicide screening tool reflects current research and evidence-based practice including custodial risk factors and is suitable for use in a prison setting	Accepted	The use of this 'Clinical Suicide Prevention Screening Tool' will be withdrawn. All relevant Health Care Staff will now contribute to the custodial risk assessment screening tool. Staff will receive the appropriate training before being required to complete such an assessment.	03-03-14 Clinical Director & Governor	

3	The Head of Healthcare should ensure that Cardiff has an up-to-date local policy which clearly instructs staff how to assess, medicate, locate and monitor prisoners withdrawing from alcohol.	Accepted	Our current practise and management of patients who are withdrawing from Alcohol is up to date and evidence based (NICE 2010 guidelines). The severity of withdrawal is assessed using a standardised scale- The CIWA-ar (Sullivan et al 1989) in reception. This is completed on our 'IT System One', so there is an audit trail to evidence this is our current practise at HMP Cardiff. If a patient scores between 8-15 on this rating scale a PGD is used to prescribe Diazepam, if a patient scores above 15 the doctor is contacted to advise regarding further management. Our Healthcare staff have received appropriate guidance and training for management of patients withdrawing from alcohol provided by the Royal College of General Practitioner's. Our local policy has been updated to include the appropriate location and monitoring of patients	03-03-14 Clinical Director & Governor	

			withdrawing from Alcohol. If patients are suffering from severe Alcohol withdrawal they are located on Healthcare.		
4	The Governor and Head of Healthcare should ensure that prisoners who are prescribed medication to treat alcohol withdrawal symptoms on their first night are checked for safety every two hours until they receive a secondary health screen to determine the level of necessary ongoing support	Accepted	The initial screening of all newly received prisoners will be undertaken by a health care worker trained to identify those with immediate health needs due to substance misuse. Staff will be informed via Safer Custody meetings and a notice to staff; that all prisoners on prescribed medication to treat alcohol withdrawal symptoms will be checked every two hours during their first night in custody or until the secondary health screen is complete.	03-03-14 Clinical Director & Governor	
5	The Governor should ensure that, unless risk assessments indicate otherwise, prisoners on the first night centre should be allocated shared cells and checked periodically throughout their first night.	Accepted	Further investment has been allocated to ensure that sufficient cells with double bunk accommodation are available on the first night centre. All prisoners save for those deemed unsafe to be placed in shared accommodated (cell sharing risk assessment – prisoners	14-03-14 Governor	

			presenting a risk to others); will be placed into shared accommodation for at least their first night. Prisoners are identified as 'first night in custody' via magnetic signage fixed to their cell door. Prisoners will be check periodically throughout the night during their first night and night orders will be revised to affect this.		
6	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Cardiff has a Medical Emergency Response Code protocol which: □ Provides guidance to staff on efficiently communicating the nature of a medical emergency; □ Ensures staff called to the scene bring the relevant equipment; and □ Ensures there are no delays in calling, directing or discharging	Accepted	Governors Order 02.13 applies and this has been reissued This order informs staff the importance of calling for am ambulance at the earliest opportunity, where there are grave concerns for a prisoner's health. The establishment will continue to comply with PSI 03/13 (effective date 28th Feb 2013) and a recent MOJ Internal Audit of our compliance to these requirements (15 Jan 2014) awarded a 'green rating'. This signifies that "there was a sound system of risk management and control likely to achieve system objectives. Controls are operating as intended	21-03-14 Governor	

	ambulances		and are proportionate to the risk". Since July 2013, a weekly detail for nurses to check resuscitation equipment was introduced, including the batteries of all Defibrillators, (this is signed for). We now have two more Defibrillators, so there is easy access to a Defibrillator on all wings and Healthcare		
7	The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate	Accepted	NOMS will be developing further guidance in conjunction with NHS England for emergency response to include the non-resuscitation of prisoners where there are clear signs of rigor mortis. This will be issued to all prisons. In the meantime we are reviewing our local policy on resuscitation if rigor mortis has developed, taking into account guidance from the BMA, RCN and Resuscitation council published in 2007.	Equality, Rights and Decency Group, NOMS for completion by 31/12/14	