

**Circumstances surrounding the death of a man, a prisoner at HMP
Swansea, in hospital, Swansea, in May 2005**

Report by the Prisons and Probation Ombudsman for England and Wales

November 2006

This is the report of an investigation into the death of a man in hospital, Swansea, in May 2005. The man had been found hanging in his cell at HMP Swansea on the morning of 4 May. He was transferred to hospital the same day, and bail was granted by a Crown Court on 10 May. At the time of his death, the man was awaiting trial at that court.

I took over responsibility for investigating deaths in prison custody in April 2004, and this was the second apparently self inflicted death that I have investigated at Swansea. The purpose of the investigation was to establish the circumstances and events surrounding the man's death, including the quality of care provided by the Prison Service. The investigation was led by two of my colleagues from my office. I am most grateful to them and to a qualified nurse from my office for supplying a detailed clinical review.

I thank the Governor of Swansea and his staff for the co-operation my investigators received at all stages of the investigation. I pay particular tribute to the outstanding liaison work of the Head of Audit and Healthcare at Swansea. She responded promptly and with unfailing charm to the many questions posed by my colleagues. I am also obliged to South Wales Police for the assistance he gave to my investigators.

One of my colleagues and a Family Liaison Officer from my office, met with the man's mother and sister who asked for a number of questions to be addressed. I have endeavoured to deal with all these issues in my report. I acknowledge the help I have received from the man's solicitor in Powys in responding to some of the family's concerns. I offer my profound condolences to the family on their loss.

The man was a man with very limited experience of prison custody. In the week before his death, he had been told by his solicitor that the charge against him was likely to be elevated from inflicting grievous bodily harm to murder. My report and the accompanying clinical review make a number of critical observations about healthcare and suicide prevention policy at Swansea. On the other hand, the way in which staff tried to revive the man when he was found hanging is worthy of the highest praise. And arrangements for contacting and supporting his family once he had been transferred to hospital were exemplary. I am very happy to report that eight of the nine recommendations I have made have been accepted. Eight of the nine recommendations made by my qualified nurse in her clinical review have also been fully accepted.

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Prisons and Probation Ombudsman

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Summary

1. The man was born in 1966 and was 38 years old at the time of his death in May 2005. He was arrested after his partner of many years was found dead in the flat they shared in Llandrindod Wells.
2. The charge against the man when he was first received at HMP Shrewsbury on 23 February was grievous bodily harm. He was not an experienced prisoner, having served just one previous short sentence in 1996.
3. The man's solicitor said that both the man and his partner consumed high levels of alcohol. He worked as a casual labourer on farms when he could, but his social circle in Llandrindod Wells was one where everyone consumed alcohol to excess. The man had suffered from epilepsy since childhood and experienced frequent fits, but from his teenage years he took his medication erratically.
4. The nurse who saw him on arrival at HMP Shrewsbury opened an F2052SH immediately due to information she had received from his time in police custody, his bizarre answers to her questions and his statement that he did not know whether he would harm himself or others. (The F2052SH is a form opened when a prisoner has self-harmed or is thought to be at risk of doing so.) On 3 March, the man appeared at Crown Court and was then transferred to HMP Swansea.
5. The F2052SH remained open at Swansea for just over a month before being closed at a case review on 7 April. The risk of self harm that the man posed to himself was reviewed at regular intervals during that period, although the staff who attended the reviews were seldom the same.
6. The man moved from the induction wing at Swansea to the main residential wing on 11 March. On 24 March, he again appeared at Crown Court. He had hoped that bail would be granted, but it was refused and he was later seen crying in his cell on his return to prison.
7. The following day, a mental health nurse was asked to see him in his cell. He had raised anxiety levels and felt that another prisoner was going to kill him. The nurse recommended location on the Vulnerable Prisoner Unit but there were no places available so he was admitted to the Healthcare Centre for a few days.
8. On 29 March, the man was transferred to a single cell on C wing (the Vulnerable Prisoner Unit). On 31 March, he was seen by a psychiatrist who found no psychiatric symptoms although she noted that he appeared anxious and presented as "an odd individual".
9. The man remained on C wing until 22 April. During the three and a half weeks he spent on C wing he very seldom emerged from his cell, turned down opportunities for association and exercise and did not always collect his medication. On 22 April, wing staff asked a mental health nurse to

again see the man as they were concerned by his bizarre behaviour. He was shouting and screaming, and staff thought he might be in distress because of the noise from an extractor fan after a fire alarm. The nurse admitted the man to the Healthcare Centre for mental health observations and he remained there over the weekend. On the morning of 25 April, he assaulted a senior healthcare officer and was transferred to the Segregation Unit under restraint. The punishment imposed on the man for assault was five days cellular confinement and he remained in the Segregation Unit until 30 April.

10. On 28 April, the man was visited by his solicitor who told him about a letter dated 27 April from the Crown Prosecution Service (CPS). The letter stated the prosecution's confident expectation that, when final evidence from the pathologist was available, the charge against him would be elevated to one of murder. The man was said by his solicitor to be extremely despondent when he heard this news. A copy of the CPS letter was found by my investigators in his cell after his death.
11. The Deputy Governor had instructed on 8 April that staff were to be extra vigilant in the week before and after the man's court appearance. His punishment in the Segregation Unit finished on 30 April, and on that date he was moved to cell E1-1, which is on the same landing as the punishment cells but belongs to the Vulnerable Prisoner Unit. There is no documented evidence of extra staff vigilance during the time he spent in that cell.
12. On the morning of 4 May, the man was found hanging in his cell just after prisoners had returned to the wing from exercise. Nursing and prison staff jointly made strenuous and highly professional attempts to revive him before paramedics arrived on the scene. The paramedics informed staff in the cell that the man had a spontaneous pulse, and he was transferred to a hospital in Swansea. The man was granted bail on 10 May but sadly died in the hospital late on the evening of 15 May.
13. Follow-up action taken by the Governor and his staff after the man was found hanging was of very high quality. Staff behaved with sensitivity and compassion, with practical support being demonstrated to his mother and family in a number of significant ways.
14. My report makes a number of recommendations designed to improve suicide prevention and clinical procedures at Swansea.

The Investigation

15. Since 1 April 2004, I have had responsibility for investigating all deaths in prison custody in England and Wales. Although the man died in hospital, I am required to investigate the circumstances in view of his attempt to hang himself in his cell at HMP Swansea eleven days before.
16. This investigation was undertaken by two investigators from my office. They issued notices to staff and prisoners, telling them of the investigation and its terms of reference, and offering them the opportunity to participate.
17. My investigators visited the prison on a number of occasions and inspected the cell where the man was discovered hanging. They interviewed both staff and prisoners who had had significant contact with him. They reviewed all relevant documentation, and met the detective leading the police investigation into the man's death. They also had a very useful meeting with the current chairman of the Independent Monitoring Board at Swansea, and with a previous chairman of the Board.
18. One of my Family Liaison Officers (FLOs) made contact with the man's mother. A meeting was arranged at which the man's mother and sister raised a number of issues that are addressed in this report which I hope provides them with answers.
19. My investigators made contact with the solicitor acting for the man, and he kindly supplied some biographical information about his client. The investigators studied my report on the apparently self-inflicted death of another prisoner at Swansea on 1 November 2004. They also conducted a detailed review of Self Harm At Risk forms at Swansea.
20. I commissioned a clinical review of the care the man received at Swansea and HMP Shrewsbury. I am very grateful to my qualified nurse for producing a speedy, thorough and wide-ranging review.

The Man

21. The man was born in September 1966, and he was 38 years old when he died in hospital, Swansea on 15 May 2005. He gave some information about himself to a nurse when she conducted a psychiatric assessment soon after his arrival at Swansea. He told the nurse that he was the father of two children, but one had died and he had never met the other boy.
22. The victim of his alleged offence was his partner, with whom he had been together for 20 years. The man did not use drugs, but drank one and a half litres of vodka per day. He told the nurse that he was briefly admitted to hospital in 1983, but the psychiatrist could not do anything for him. He also said he had cut his wrists in 1997 when he was in a low mood and had been admitted to hospital for two weeks.
23. His list of previous convictions appears to indicate he was imprisoned on just one occasion before 2005. In July 1996, the man was sentenced to three months imprisonment for assault occasioning actual bodily harm. Five separate offences in between those dates had been dealt with by way of community penalties or fines.
24. The man's solicitor supplied some biographical information about his client to my investigators. He wrote that his client began abusing alcohol and other substances during his teenage years. The man lived with his partner at a number of locations in Wales. The solicitor referred to high levels of alcohol consumption by both partners, and said that it was a volatile relationship. The man worked as a casual labourer on farms when he could, but his social circle was one where everyone consumed alcohol to excess.
25. Dyfed Powys Police supplied some information about the circumstances of the offence. They wrote that the man and his partner lived at a flat. They were well known to local police as a result of numerous domestic incidents having been reported over a number of years. The police alleged that some of these incidents involved violence on his partner by the man. They were both known as heavy drinkers, and the police said they could be described as alcoholics. According to the police, neither of them worked.
26. An ambulance was called to the couple's flat during the afternoon of 19 February 2005. The ambulance crew found the man's partner lying on the floor of the main living room. She had significant bruising and was dead. The man was arrested and taken first to a police station before being transferred to Brecon police station. When he was first remanded in custody to HMP Shrewsbury on 23 February, the charge was that he had inflicted grievous bodily harm on his partner. However, on 27 April, shortly before he hanged himself, the Crown Prosecution Service wrote to his solicitor informing him that the pathologist's evidence had yet to be finalised as to the exact cause of death. The letter continued that "the Prosecution confidently expect that when this evidence is to hand that it will elevate the charge to one of murder".

27. The man was certainly aware of that likely development because my investigators found a copy of the letter in his cell after his death. Additionally, his solicitor wrote to one of my investigators about the visit he made to his client at Swansea on 28 April to discuss the evidence received. Prison staff told him that the man was "very wound up and agitated". When the visit began, the solicitor described him as appearing extremely demoralised in manner. During the visit, the man's solicitor summarised the evidence against him. At the end of the meeting, when getting ready to leave, the man "made a comment to the effect that he had lost everything he had ever had and ever wanted".

Time in prison custody before 4 May

28. The man's first court appearance was on 23 February 2005, at a Magistrates' Court. The alleged offence was committing grievous bodily harm with intent, and he was sent for trial at Crown Court. He was remanded in custody to HMP Shrewsbury, and the court ordered that he be produced at the Crown Court on 4 March.
29. The man's medical care during the ten days he spent at Shrewsbury is described in the clinical review prepared by the clinical reviewer. The First Reception Health Screen was conducted by a nurse. The man told her that he had been in Cardiff prison once before, over seven years previously. He also said he had seen a doctor in the last few months to receive medication for epilepsy. The nurse wrote on the screening form that the man looked very unkempt and very thin. The nurse recorded his significant use of alcohol and that he had seen a psychiatrist approximately 14 years previously. The man at first told the nurse that he would not harm himself, but then stated he did not know what he would do once located on the wing. He stated he had no recollection of the events of the last few days, and therefore he could not understand how he had ended up in his current situation.
30. The man told the prison doctor that he had not taken his epilepsy medication for four years, and that his last fit had been four months previously.
31. The nurse appropriately decided to open a Self Harm At Risk form (F2052SH). On the first page of the form she wrote that she was concerned because:
 - the man gave bizarre answers to questions,
 - he made little eye contact during interview,
 - he kept changing his answers to questions,
 - he appeared very nervous
 - of the information received from police custody.
32. The nurse recorded the man as saying that he did not remember the events of the last few days, and he did not know if he would harm himself or others.
33. The Self Harm form must be reviewed within 72 hours of being opened, and the first review duly took place at Shrewsbury on 26 February. The summary of that review noted that he was denying any thoughts of self harm or suicide, and his mood seemed bright and bubbly. He did not appear confused, but the review co-ordinator wrote that some of his behaviour was a little odd at times. The previous day he had been seen crying during a visit, though he appeared to have calmed down by the end of the visit when he returned to the wing. After the visit he was interviewed by a nurse, in response to a mental health referral by the nurse.

34. A second F2052SH review took place at Shrewsbury on 1 March. The senior officer who chaired the review wrote that the man had no idea what he had been charged with or why he was in prison. He stated that he had no thoughts of suicide “yet”. He did not seem to make any sense at all, so the review panel recommended that the Self Harm form should remain open until his court appearance as “he seems very unpredictable and vulnerable at present”.
35. On 3 March, after appearing at Crown Court, the man was transferred to HMP Swansea. The Self Harm form contains an entry that he was happy enough to be at Swansea, and was charged with killing his fiancée. A Cell Sharing Risk Assessment (CSRA) must be completed on the first night at each new prison. Although the officer who completed Section 2 of the CSRA wrote that the man did not have an open 2052SH, the member of the Healthcare Team who completed Section 3 was aware of the ongoing F2052SH. The decision recorded at Section 4 of the CSRA was that the man should remain in a single cell overnight, with a further review taking place the following day. A nurse made an entry at 8 pm in F2052SH which states: “Contacted Doctor (the prison’s Medical Officer). Verbal order for single cell.” The doctor saw the man the following morning and wrote that he remained resentful about his medication, but was not actively suicidal.
36. An Officer carried out a number of induction procedures with the man on 3 March, and in his interview summary afterwards wrote that he was a very bizarre individual. The Officer stated that the man did not make much sense at all during interview, and the officer found him difficult to evaluate.
37. Prison Service Order (PSO) 2700 sets out policy on suicide and self harm prevention. Chapter 4.1 of the document is devoted to accommodation for at-risk prisoners, stating:

“At-risk prisoners should be routinely allocated to shared accommodation, unless the prisoner represents a risk to others, their behaviour is too disturbing to other prisoners or shared accommodation is not available.”
38. The officer who completed Section 2 of the Risk Assessment form assessed the man’s risk of harm to others as medium. The member of healthcare staff who completed Section 3 of the form assessed the risk that he posed to other prisoners as being low. It is not clear whether any thought was given on the man’s arrival at Swansea to locating him in shared accommodation because he was on an open Self Harm At Risk form.
39. The first review of his Self Harm At Risk form at Swansea took place on 4 March. A Principal Officer chaired the review panel. The review summary described the man as a very chatty individual with a fairly positive attitude. It added that he was unclear about his current charges and the nature of the injuries to his victim. He was described as being “somewhat paranoid about shared accommodation”.

40. The man was located on F wing, the induction wing at Swansea, from his arrival on 3 March until 11 March. On that date, he moved from F to A wing which is the main wing of the prison. He remained on A wing until 24 March.
41. An entry in the Clinical Record on 5 March states that the man was continuing to refuse his medication for epilepsy. He said he would refuse until he saw a specialist. One of the key findings in the Clinical Review is that the man's compliance with his anti-epilepsy medication was erratic throughout his time at Swansea.
42. The second review of his Self Harm form at Swansea took place on 7 March. Again the review was chaired by the Principal Officer, and the man himself was again present. The review summary noted that he continued to be annoyed about the lack of knowledge regarding his current period of custody. The man wished staff to take him under escort to his bank in order to facilitate drawing money from his account. He was advised to speak with his solicitor who visited the next day. The review concluded that there was no intention of self harm but "we will continue to monitor due to bizarre behaviour".
43. The next review of the man's Self Harm form took place on 21 March, with a Senior officer chairing the review. The man himself was present but there was no healthcare representative. The review summary stated:

"A very bizarre character who I suspect has mental health issues. HCC contacted and informed ... There are concerns about possible bail application but if fails court date 28 March is an obvious trigger point. To remain on live F2052SH for ten days which will allow for developments with bail or court."
44. An entry in F2052SH on 15 March indicates that an officer unlocked the man from his cell so that he could make a telephone call to his mother. The officer noted that she was going to contact his solicitor to see what was to happen "court wise".
45. The man's next court appearance was on 24, not 28, March. On that date, he appeared at Merthyr Tydfil Crown Court but his application for bail was refused. An escort officer at court made an entry in the F2052SH at 12:50, observing that the man was upset by the denial of bail. He returned to Swansea in the middle of the afternoon and at 5:40pm a prison officer answered his cell bell. He found him crying and not making a lot of sense. Ten minutes later, the officer made another entry in the F2052SH in which he wrote that "he had found a light for the man and he was much more settled now. He was having a smoke and watching the television."
46. At 5:30pm on 25 March, the man was described as feeling low. The next entry at 6:15pm recorded that he was in his cell crying with his head in his hands. An officer rang the Healthcare Centre and told staff there that their attendance was required. A nurse, who has mental health expertise, went

to see the man in his cell. He wrote in the Self Harm form that the prisoner had raised anxiety levels and thought there were people on A wing who intended to harm him. He wanted to be out of the prison, particularly A wing. He said that those people would kill him if he stayed. The nurse recommended the man's transfer to the Vulnerable Prisoner Unit, but no places were available on C wing - where prisoners who have asked to be segregated from other prisoners are held. A Principal Officer, the most senior officer on duty that evening, instructed that the man should be located in the Healthcare Centre until the next day.

47. The man's application to be segregated from other prisoners was recorded on a most unsatisfactory document. The document stated that he wanted segregation under Prison Rule 43, although the relevant Prison Rule has been Rule 45 for several years. A prison number at the foot of the form had been crossed out and the man's prison number written in its place. He was recorded as saying he did not feel safe. He was worried that there were people on A wing who would kill him because they knew his girlfriend and thought that he had murdered her.
48. The Governor's response to the man's application was recorded on another unsatisfactory form. That form was dated March 1993 and suggested that a Board of Visitors member was required to authorise the man's continued segregation. The forms used were seriously out of date and should have been destroyed when new procedures were created by Prison Service Order 1700.

I recommend that the correct forms and terminology are introduced with immediate effect.

49. The Medical Officer wrote in the man's clinical record on 27 March that he was content to go to Rule 45 location, and on 29 March he did so.
50. A further review of his Self Harm At Risk form was also conducted on 29 March. The review was held in the Healthcare Centre with a Senior Nurse in the chair. Three other members of healthcare staff attended, though none of them had attended any of the man's previous F2052SH reviews. The review summary was that he had not expressed any thoughts of self harm, but was very quiet and did not interact for very long. The staff thought it might be beneficial to reassess him once he had been relocated.
51. On the afternoon of 29 March, the man moved from the Healthcare Centre to the Vulnerable Prisoners Unit. He remained in that cell until 22 April. On arrival, he said to an officer that he was happy to be relocated in a single cell on C wing because he feared for his safety if he returned to A wing.
52. The next self harm review took place on 1 April, soon after the man's arrival on C wing. The review was chaired by a Senior officer who is responsible for day to day management on C and E wings. He wrote that the man gave the impression that he was very unsure of himself and did not answer questions properly. He wanted to maintain his single cell

status. Elements identified in the support plan were that his single accommodation should remain and he should be made fully aware of all facilities available.

53. As indicated in the clinical review, the man had been seen by a consultant psychiatrist from a clinic the previous day. The self harm review on 1 April took place at 9:30am, and the remainder of that day was very eventful. There are four separate entries in the man's clinical record and a large number of significant entries in the F2052SH. At 10:05am, an officer saw the man on the floor of his cell. He appeared to be having a fit so the officer called for a nurse. A nurse estimated that the fit lasted approximately four minutes. At 10:50am, the officer wrote that the man was shouting and screaming. He smashed his kettle and threw furniture about. At 11:15am, he told a nurse that he wanted to go home and appeared agitated. A mental health nurse, saw the man in his cell at 11:45am. He still wanted to go home and the nurse said he would contact the man's mother to see when she planned to visit. The mental health nurse did indeed contact his mother, although he had some difficulty as the first telephone number he was given was incorrect. The officer observed at 1:00pm that the man had moved all his bedding under his bed, and had settled down there. At 4:00pm, the officer wrote: "A bit bizarre. Thinks he's under quarantine, but convinced him everything was alright, he then talked a lot better."
54. The officer is a very experienced officer who has worked on C wing for the last seven years. He made a further entry on the self harm form on 3 April after he talked to the man about why he was not collecting his food and medication that day. The simple reply that the man gave him was that there was no point, but he would not elaborate any further.
55. On 6 April, the Self Harm form notes that the man was brought out of his cell for an interview with HM Chief Inspector of Prisons. The Chief Inspector of Prisons made an announced inspection at Swansea between 4 and 7 April. My investigators discovered that the Chief Inspector herself had contact with the man in the unit. He told her that he had been "down", but he was confident that he would be released on bail following his next court appearance. This surprised her as a member of staff had said that the man faced a murder charge. They had a conversation where he appeared to be considerably adrift from reality. The man referred to a policeman who had kicked his dog, and alleged that the policeman kept moving house to wherever the man moved. The Chief Inspector's opinion was that the man was obviously mentally disturbed.
56. On 7 April, a case review was held at which it was decided to close the man's self harm at risk form. The review was chaired by a Senior officer and attended by the man himself, an Officer from C wing, a Mental Health Nurse, and a Probation Officer. The review summary states that it was decided to take the man off the F2052SH after consultation with all of the above. He was advised that "we would still be available as a help source whenever required". He was happy to remain in a single cell. The last paragraph of the review summary is as follows:

“Staff to be aware of him at all times, especially when his court appearance of 29/4/05 has been and gone. Possibly a reassessment of his needs would be made on or after that date.”

57. The support plan for the man was that staff should remain observant of him at all times, that he should remain in a single cell, and that he should remain on his present medication. One of the questions asked by the man’s mother when my Family Liaison Officer and Investigator visited her was why he was taken off the F2052SH. I discuss this question and other matters related to F2052SH procedures at Swansea in a later section of this report.
58. The clinical review describes the picture of the man that emerges from the F2052SH. He almost always declined to go out for exercise, and was described as liking his own company. He often became unreasonably irritable with staff over such things as having no letters. He found the prison routine and periods of lock up difficult to bear. The clinical reviewer reports that aggression, hyperactivity and increased alertness are known side effects of the medication prescribed for the man’s epilepsy.
59. The man spent nearly a month on the Vulnerable Prisoner Unit and both staff and prisoners had clear memories of his time there. An officer has worked on C wing for the last six years. He recalled that the man did not mix with the other prisoners on C wing. There was association every weekend when cell doors were unlocked so that prisoners could relax with each other. The man never came out of his cell. On a daily basis, prisoners were given the opportunity to take exercise together but he always declined. The officer was asked if the man ever came out of his cell, and replied that he only came out to get his meals and his medication. He might have ventured out while his cell was being cleaned, but apart from that he remained in the cell.
60. A prisoner gave a vivid description of the noise the man would make when the staff had gone off duty at the end of the evening shift. He said:

“It would all go quiet, the officers would go home, after 8:00pm say or 9:00pm, silent, only you don’t hear an officer or nothing. So when you hear bang bang, and one of the boys or myself would turn the TV down, see what was going on and you could hear him (the man) shouting and all this ‘get away and leave me alone’ and boom boom on the door and stuff but there was no one or anyone around, he would just kick off. And he would go quiet and that would be it for the night maybe.”
61. The clinical review refers to non-collection of medication on 17 April, and another epileptic fit on 19 April. On 22 April, a nurse who is a registered mental health nurse, was asked by the Officer to come and see the man in his cell on C wing. He had been screaming and shouting. Staff thought that he might be in distress because of the noise from an extractor fan after a fire alarm. When the nurse managed to make conversation with him, the man told her that staff were messing with his head and trying to

drive him mental. He was concerned about his family and felt they were being killed. The nurse decided that he should be admitted immediately to the Healthcare Centre for a period of mental health assessment. The stated aim of the care plan drawn up for the man on 22 April was to minimise his symptoms of distress, but his stay in healthcare proved short-lived. Early on the morning of Monday 25 April, the man hit a Senior officer on the left side of his head with an open palm. He was forcibly transferred from healthcare to the Segregation Unit on E wing.

62. After the assault by the man on the Senior officer, approved Control and Restraint Techniques were used by staff to manage the man and move him to the Segregation Unit. Ratchet handcuffs were used. The reason given by the Duty Governor for authorising the use of force was that the man had been totally non-compliant after the assault on the Senior officer.
63. The man was charged under the Prison Rules, and appeared before the Deputy Governor on 26 April. He pleaded not guilty to the charge and told the adjudicating governor that he had done it because he was wound up. The charge was found proved and the punishment imposed by the Deputy Governor was five days of cellular confinement in the Segregation Unit. The period of cellular confinement expired on Saturday 30 April. On that date, the man was moved from cell E1-4 to cell E1-1. In interview, an officer explained that E1-1 is not a Segregation Unit cell but an overspill from the Vulnerable Prisoner Unit which is frequently full to and beyond capacity. It was in cell E1-1 that the man was found hanging just four days later.

Discovery of the man hanging in his cell

64. On the morning of Wednesday 4 May, three regular members of staff were on duty on C and E wings. They were a Senior officer and two Officers. The two officers had both been regular officers on C wing for a number of years. One of the officers recalled that the man left his cell once before 9:00am to pick up his canteen (prison shop) order on the wing. Wednesday was canteen day for C wing prisoners. At 9:00am, the officer went around the cells on C wing asking prisoners if they wished to go out on exercise. At that time, the officer went inside the man's cell and found him sitting on his bed. He was dressed in his prison clothes. As usual, he declined exercise. From 9:00am until approximately 9:30am, the officer and the second officer supervised 17 prisoners on the exercise yard. The exercise period takes place at the same time each day.
65. On Wednesdays, prisoners from C wing are able to attend education classes, and some prisoners proceed directly from exercise to education without being locked back in their cells. The door leading to the education area is very near cell E1-1, and some prisoners were waiting there while wing staff unlocked the other men who would go to education. Two additional members of staff happened to be on C wing at the time when the man was first discovered. They were a Senior officer, who is Training Manager at Swansea, and an officer, who was carrying out drug tests on a number of C wing prisoners.
66. There is conflicting evidence in staff statements about the time at which the man was first found hanging, but I believe the log kept by an officer is a reliable source of information and he began his log at 9:35am. The prison has also supplied closed circuit television footage of what was happening outside the man's cell. The footage shows a prisoner approaching the man's cell door at 9:34am then an officer arrives and goes into the cell at 9:35am. First information about the emergency came when a prisoner looked inside the man's cell and shouted to staff that he was hanging.
67. An officer was the member of staff nearest the cell. He immediately ran to the cell and looked through the spy glass. He saw that the man was hanging from the window bars of his cell with a ligature, made from a sheet, tied around his neck. He opened the cell door and rushed in to take the man's weight. In interview, the officer said that the man was facing him as he ran into the cell. The cell window was straight in front of the officer. The ligature was attached to the right side of the window as the officer looked into the cell. The man's feet were on the floor and the man said he was in a slumped position, as if all his weight was on the ligature. A prisoner helped the officer to support the man's weight.
68. While the officer and the prisoner were holding the man's weight, another officer and a senior officer entered the cell. They were trying to loosen the ligature around the man's neck. They had to do so by hand as they had no equipment that would cut through the ligature. The first officer on the scene left the cell in order to obtain a pair of scissors from the office a few

yards away but, by the time he returned, the ligature had already been loosened. The senior officer and the prisoner said in interview that they removed the knot around the man's neck. The prisoner's recollection was that, when he entered the cell, the man's feet were not quite on the ground but on top of the pipe at the rear of the cell. The man was on tip toe, leaning away from the window.

69. Once the knot had been loosened, the prisoner said that a couple of officers held the man's body while he held his neck and head. The man was placed slowly on the floor so that the staff could resuscitate him. At that stage, the prisoner was ordered from the cell.
70. The senior officer's statement indicates that he checked for life signs, but there was no pulse or breathing and the man's eyes were fixed and dilated. With the assistance of another officer, the senior officer immediately began cardio pulmonary resuscitation (CPR). The senior officer gave mouth to mouth resuscitation and the officer began chest compressions. At this time, the drug testing officer was in the far corner of the cell near the window and he began keeping a log which continued until the point at which the man was placed in an ambulance. The drug testing officer's log states that CPR began at 9:36am.
71. The drug testing officer, who kept the log, is an experienced officer who has worked for the last 14 years at Swansea. As he kept the log in the corner of the cell, he was in an ideal position to observe every single action that was taken to try to revive the man. He said that the staff involved had acted very conscientiously and respectfully. He recalled that "when the ligature was removed, he (the man) wasn't just dumped down, he was very carefully placed on the floor and once he had to be moved away from the back wall, he was moved very gently, there was no dragging him, he was treated as a person rather than just a thing to be worked on".
72. The first nurse entered the cell. The drug testing officer's log times her arrival at 9:39am. In interview, the nurse stated that her area of nursing expertise was Accident and Emergency and general surgery. She explained that she was a first responder, and also defibrillator and oxygen therapy trained. She explained that a defibrillator is used to stimulate a person's heart, and prepare them to go to hospital. The machine passes a current through to the heart to trigger it and get it into a rhythm. In her previous professional life, the nurse had used CPR in about five situations.
73. The nurse explained in some detail how she knew the senior officer was doing mouth to mouth correctly: "He'd covered the mouth with a mouth piece, he had the head back in the right position, he was blowing the air in and you could see the chest rising. So I knew he was doing a good job of getting the air in."
74. As she ran to C wing, the nurse did not know the kind of emergency to which she was responding. She said in interview that she did not have any useful equipment about her person, and that equipment arrived with a

First Responder Officer. She was not aware of any equipment arriving in the cell prior to the first responder officer joining her. He brought a first responder kit which is a full first aid kit with a defibrillator and oxygen as well. The first responder officer was carrying a first responder pager that morning. Whilst it was not his pager duty, a shout from an officer working near him had alerted him to the emergency. The log kept by the drug testing officer states that the first responder officer arrived at 9:40am. There is a further log entry at 9:42am stating that the first responder officer and the nurse alternated on chest compressions. The senior officer maintained respiration to the man from his arrival in the cell until he was eventually relieved by paramedics.

75. The first entry in the Incident Log kept in the prison's Control Room states that there was a general alarm at 9:35am and then an ambulance was called at 9:40am. The Control Room Log states that the ambulance arrived at 9:47am, but the drug testing officer's log times the arrival of three paramedics at 9:44am. I consider this officer's version to be reliable because he was in cell E1-1, just a few inches away from colleagues attempting to revive the man. My investigators visited the Control Room and the officer on duty demonstrated to them that different pieces of equipment in that room show different times.
76. Even after the arrival of the paramedics, the first responder officer continued with chest compressions. Then at 9:52am, the paramedics detected a faint pulse and said that the man would be taken to hospital. The drug testing officer recorded at 9:56am information from the paramedics that the man was breathing independently and had a spontaneous pulse. At 10:05am, the man was placed on an ambulance stretcher immediately outside the cell door, and at 10:07am the ambulance took him to a hospital in Swansea. He remained at the hospital until his death at 11:35pm on 15 May 2005. The pathologist's comments following post-mortem examination are that:
"Death in this case is attributed to a severe bilateral bronchopneumonia in a patient who remained comatose due to hypoxic brain damage following an episode of severe asphyxia attributed to hanging."

Contact with the man's family and other events following his death

77. The follow-up action taken by the prison once the man had been transferred to hospital was impressively quick and humane. When he arrived at Shrewsbury prison on 23 February, he said that his next of kin was his uncle and gave a telephone number but not an address. The chaplain at Swansea, was appointed to liaise with the man's family. The chaplain spoke to the man's uncle's wife at 10:30am on 4 May, but she directed him to call a closer relative. The chaplain also found a telephone number for the man's mother from computerised records in the prison of telephone calls he had made. The chaplain said that in total the man had made very few telephone calls, two to his solicitor and three to his mother.
78. The chaplain could not reach the man's mother by landline, but did manage to make contact on her mobile telephone. The Security Principal Officer, suggested that somebody should collect the man's mother and take her to the hospital. The chaplain and one of his Roman Catholic lay chaplains went to find her. Her home is 20-25 miles from Swansea, and they had some difficulty locating the man's mother in the town but eventually found her at about 4:00pm. They then took her in their car to the hospital, where her son was in the Intensive Therapy Unit North. She was able to see her son there. The chaplain stayed with her for about an hour.
79. The man's mother had been collected at very short notice, and the prison did its utmost to give her practical support during her time at the hospital. On the morning of 5 May, she was informed that the prison would arrange transport for her to buy necessities in Swansea. A taxi arranged by the prison took her to buy what she needed, and then brought her back to the hospital. This practical and financial support continued for many days. A briefing note at the beginning of the following week, when bail was granted to the man, indicates that his mother was to be told that the arrangement for taxi provision would continue until Friday 13 May. A local taxi firm was instructed to continue taking her to Swansea for food or incidental items until then.
80. A succession of senior managers from the prison, including the Governor and Deputy Governor, visited the hospital on a daily basis. This was excellent practice for a number of reasons. Senior staff were able to speak directly with the man's mother and deal with her questions promptly. They were able to support escort staff on duty at the hospital and, importantly, they were able to make security and other decisions about the man on the basis of their personal experience and observations.
81. The prison made clear efforts to treat the man's and his family as decently and humanely as possible during his time at the hospital. A Hospital Risk Assessment was completed on 4 May when he first went to hospital. A principal officer recorded the possibility that the man's current charge of GBH would be upgraded following the death of his partner. At that stage, the Governor ordered that restraints should be used by the escorting staff at the officers' discretion. A further risk assessment was carried out on 6

May, by which time more information was available about the man's medical condition. The Governor decided on that date that restraints were not to be used. He wrote on the form that officers were to be situated outside the door to the unit where the man was being cared for. They were to obtain regular updates on his medical condition and keep the prison informed. They were also to offer support to the man's family. A senior officer made a note in the bed watch log at 7:45pm that evening. He wrote that he and an officer had taken over the escort and that the man's mother was at the bedside. They talked to her and gave her support. The senior officer informed her that they would move away from her space to give the family some dignity, but her son would be observed from time to time. She thanked the staff.

82. The man was granted bail from the Crown Court on 10 May on condition that he lived and slept each night at the hospital. The Governor had written to the Crown Court on 9 May supporting the bail application made by the man's solicitor. He indicated that he wished to withdraw the officers staffing the bed watch at the hospital, as it appeared both unnecessary and intrusive for the family.
83. A further example of good practice is that on 4 May the Governor commissioned his own investigation to establish the facts surrounding the self harm event that had occurred earlier in the day. A governor grade was instructed to report by 18 May, and to deal with a number of issues in her report including whether there were any indications of bullying or intimidation towards the man. This governor and a principal officer conducted a number of interviews with staff and prisoners, but suspended their inquiry on the morning of 16 May after hearing that the man had died the previous evening. All documents relating to the governor's inquiry are annexed to this report.
84. The prison made a significant contribution to funeral expenses incurred by the family. One prisoner complained to my investigators that he had asked for mental health help soon after seeing the man hanging, but he did not see a psychiatrist as quickly as he thought he should have done.

Swansea Prison

85. Swansea is a category B male local prison with an operational capacity of 425. It is predominantly Victorian in design, but there has been extensive refurbishment over the last three years including the chapel, Healthcare Centre, gate and external cladding of D wing.
86. The Prison Service gives all prisons a star rating from one to four, based on various assessments and internal audits. Swansea has a three star rating at the moment, but recently launched a Performance Improvement Planning Process with the aim of being promoted to four star.
87. The last apparently self inflicted death took place on 1 November 2004. There are several apparent parallels between the death of the man and that of the other prisoner on 1 November 2004.
88. Her Majesty's Chief Inspector of Prisons carried out an announced inspection at Swansea at the beginning of April 2005. The Chief Inspector has kindly made a copy of her draft report available to my investigator. She notes that relationships between staff and prisoners were relaxed, but states that there had been no effective anti-bullying strategy for some time. A new strategy had been introduced shortly before her visit, but officers had not been trained in it. Some were confused about how it operated, and others were unaware of the strategy. Very few prisoners had yet been dealt with under the new strategy, and it was not clear how identified bullies were dealt with.
89. Regarding suicide prevention, the Chief Inspector reports that there had been efforts to learn from two apparently self-inflicted deaths in recent months. However, one of the recommendations following a death in November 2003, that staff should be issued with ligature shears, had still not been implemented at the time of her inspection. Reviews for prisoners at risk were not arranged in advance, which limited a multi-disciplinary approach. Support plans were too general, and mainly indicated that "all staff" were responsible.
90. The Chief Inspector observed that the Segregation Unit was an annex of C wing, with five standard cells and one special cell. There were no prisoners in the unit during the inspection. Record keeping was inadequate, and there was no managerial oversight or monitoring of trends of use. No one could provide her with authorisation records for segregation.
91. In relation to the Vulnerable Prisoner Unit, the Chief Inspector wrote that the reasons why some prisoners were held there were not clear or were inadequate. There was little evidence of attempts to encourage prisoners to return to the mainstream of the prison. The regime on the VPU was very poor and, except for daily association and a day's education each week, was more like a segregation unit. Although vulnerable prisoners felt safe on the VPU, the Chief Inspector had concerns about its purpose, and the negative effective on prisoners who were held there for long periods

and for repeated sentences. The Chief Inspector recommends that, so long as there is a Vulnerable Prisoner Unit, it should have a clear purpose and an effective personal officer scheme. She also states that it should have a full purposeful day for prisoners, with opportunities for activity, time out of cell and access to facilities equal to the rest of the prison.

92. The Chief Inspector's report includes a paragraph on First Responders. She writes that 16 staff had been trained by the local Ambulance Service as part of a first response team. This was part of a national initiative which had provided some modern first aid equipment. Its primary purpose was to respond to people who suffered sudden collapses. The Chief Inspector said that there was no arrangement to ensure that this important resource was available at all times. She recommends that sufficient members of the First Response Team should be available to cover the prison throughout a 24-hour period. However, the clinical reviewer raises some questions about the operation of the First Responder system in her clinical review. She observes that there appears to be "confusion between the role of health care staff and the role of first responders". She notes that Swansea has 24 hour health care cover, leading her to question why a first responder system has been introduced. The clinical reviewer recommends a review of the added value being achieved by the first responder system.

Issues considered during the investigation

1. Bullying

93. After her son's death, the man's mother asked my FLO whether there were any reports or signs of him being bullied. When the Governor instructed the governor grade on 4 May to conduct an investigation, one of the matters he asked her to address was whether there were any indications of bullying or intimidation towards the man.
94. The possibility that the man had been bullied by other prisoners on C wing was raised on the morning of 4 May, very soon after he was discovered hanging. It was one of the matters discussed at the de-brief chaired by the Governor at 11:00am. The intelligence about possible bullying was supplied by three prisoners who were cleaners on C wing. A "number one" prisoner cleaner on C Wing, was one of those who volunteered the information. They named other prisoners on C wing as the bullies. The cleaners were angry that prisoners such as these had been praised by staff for raising the alarm and, in one case, had helped to support the man's body when he was first discovered. The cleaners alleged that, far from being heroes, these prisoners had been bullying and tormenting the man.
95. There is conflicting evidence about whether bullying was a significant issue on C wing, and whether the man, in particular, was being bullied. When my investigators interviewed him in early June, the prisoner had been a cleaner on C wing for over five months. He was unlocked all day, and was therefore in a very good position to see and know what was going on. This prisoner said that three prisoners had been going to the man's door a few times and calling him names and teasing him. He alleged this had been going on for three or four weeks before the man was found hanging. This prisoner alleged that one prisoner, who had been released, had been squirting urine under the man's door from a milk bottle and that it went on for a couple of weeks. This prisoner said that name calling and teasing had gone on both before and after the six days that the man spent in the Segregation Unit.
96. This prisoner could see that the man was not an experienced prisoner, and that he had mental health problems. He recalled that the man would scream out and shout at prisoners who went to his door. He would "tell them to buggar off but they would just laugh and joke, laugh at his expense". This prisoner also claimed that the prisoners who went to the man's door and found him hanging on 4 May had gone there to aggravate him. My investigators asked this prisoner whether the staff on C wing knew about the harassment of the man. He said that he thought not. He said that prisoners on C wing are "banged up" nearly all day. He thought that when prisoners were unlocked, the staff had a hard job trying to get them all together and to see what was going on. The opposite view was expressed by other prisoners interviewed during the investigation. They said that because C wing was a small wing, the staff must have known about any bullying that was occurring.

97. Two of the prisoners who were alleged to have bullied the man were interviewed by my investigators. The first was aggrieved that he had been accused of bullying, both on the day the man was found hanging and subsequently. He said that he should have been placed on anti-bullying measures if there was any evidence against him, and also made the point that prisoners on C wing had a lot to lose if they stepped out of line. He was well aware that bullying could lead to expulsion from the wing, and said vulnerable prisoners would not wish to be “kicked off” a VP wing.
98. An officer who is a highly experienced officer on C wing, and his confident assertion in interview was that bullying is not a major problem on C wing. He was not aware of the man being the victim of any bullying by other prisoners prior to 4 May. He spoke of the management problems created by having a mixture of sex offenders and non-sex offenders on the same wing. Although sex offenders should be rapidly transferred to HMP Parc, numbers often built up at Swansea because no places were available at Parc. This sometimes led to sex offenders suffering “a little bit of verbal bullying, being called ‘nonces’, that sort of thing”.
99. In her report on the announced inspection of Swansea in April, the Chief Inspector of Prisons includes a section on bullying which states that the anti-bullying strategy at the prison had had a low profile, and it was difficult to establish its effectiveness. The evidence from surveys and prisoners suggested that bullying was not a significant problem. She also observed that the minutes of the anti-bullying committee suggested that many incidents were dealt with without referral to the formal strategy.
100. My investigators met the prison’s anti-bullying co-ordinator who had returned to duty from a period of maternity leave. In addition to anti-bullying, she had many other responsibilities. Incidents of alleged bullying that were referred to her were promptly and thoroughly investigated, but she expressed some frustration that not all incidents were being referred. There had been just one low level incident on C wing in 2005, and that did not involve the man.
101. The evidence about whether he was bullied by other prisoners on C wing is inconclusive. Two officers saw no evidence whatsoever that it was happening. No information about bullying on C wing was brought to the attention of the anti-bullying co-ordinator before 4 May. The evidence from the cleaner must be treated with some caution, although I am not aware of any motive he might have for supplying untruthful information. If verbal harassment of the man did take place, it was something that the staff on C wing did not know about. He was a solitary man, and both staff and prisoners on C wing considered that he had severe mental health problems. It is possible that some of the prisoners verbally exploited his vulnerability and the fact that he was not ‘streetwise’ in the prison environment.

2. F2052SH

102. My investigators studied carefully all the F2052SH case reviews that were held on the man at Swansea. A striking feature, set out in tabular form in an annex, is that the staff attending one review were seldom the same as those who attended the next or previous reviews. His first two reviews at Swansea, on 4 and 7 March, were chaired by the same Principal Officer but he did not attend any subsequent reviews. The final review on 7 April was chaired by a senior officer who had not attended any previous reviews and who was not the regular Senior officer on C and E wings. The probation officer and nurse who attended the final review had both participated in one previous review, although on different dates.
103. The absence of staff continuity at case reviews appeared to be a pattern. HMCIP's report on Swansea observes that reviews were not arranged in advance by wing staff, and it was difficult to get representatives from other disciplines to attend at short notice. Most reviews were attended by wing staff and healthcare staff only. The Chief Inspector also noted that "most plans we looked at were non-specific with 'all staff' being responsible and there were few personalised entries to meet the needs of individual prisoners".
104. The number of F2052SHs open at the time of the Chief Inspector's inspection was two, and there were just three open in the prison when my investigators conducted an audit on 16 June. In the company of one of Swansea's Suicide Prevention Co-ordinators, my investigators closely analysed two of the three Self Harm At Risk forms open on that date. Case reviews had been held twice on both prisoners. My investigators noted that the group of staff attending the first review was entirely different from the group attending the second. Such absence of continuity makes it more likely, in my opinion, that important issues identified at a previous review may not be pursued adequately or at all at the next review. Mr T was one of the cases examined by my investigators. At his first review, there was a good deal of discussion about medication issues, and the Daily Support Record section of F2052SH shows significant medical contact between the first and second review. On one date, for example, the prisoner was hearing voices during the night and was told he would be seen by a doctor the next day. This duly happened. However, the prisoner himself appears not to have attended the second review, and there was no recorded discussion of the medical issues that had prompted concern the previous week.
105. In interview, the senior officer indicated that the decision to close the Self Harm At Risk form on The man on 7 April was unanimous. The senior officer was a suicide prevention trainer at Swansea for many years, and is therefore familiar with the issues. In interview, he was "absolutely positive" that the decision to close the form on 7 April was appropriate. I do not criticise the senior officer and his colleagues for their decision which I fully accept was made in good faith on the basis of such information as they had.

106. The senior officer and his colleagues correctly identified the next court appearance on 29 April as an important event for the man. The senior officer recalled that at the review meeting the man thought “he would go to court and possibly walk from court or at least get a very minimal sentence ... He wasn’t really looking into the future with a view of possibly becoming a lifer.” The review summary noted that re-assessment of his needs should possibly be made on or after 29 April, but the mechanism for achieving this was not spelled out. The support plan stated that staff were to remain observant of the man at all times.
107. In February 2005, the Governor of Swansea had published an Order announcing that, with immediate effect, all F2052SHs were to be forwarded to the Deputy Governor after closure. The Deputy Governor saw the closed form on 8 April and added a sentence about the forthcoming court appearance as follows:
- “I have advised the senior officer I/C Seg today to ensure that the diary and observation books are marked up with the summary, and to be extra vigilant the week before and after court appearance by the man.”
108. On 22 April, one week before his court appearance, the man was screaming and shouting in his cell on C wing. The officer was so concerned about the man’s welfare that he rang a nurse who admitted him to the Healthcare Centre for mental health observations. On the same day, the officer made an entry in the Register of Prisoners on Segregation (the daily diary) which said that the man was to be monitored with reference to his general behaviour on the wing. This entry does not appear to have been made in response to the Deputy Governor’s instruction of 8 April. In interview, the officer said that he had been speaking to the nurse before the fire alarm incident on B wing which seemed to upset the man so greatly. The nurse had asked the officer to check on the man’s general behaviour, and it was for that reason that he made his entry in the wing diary.
109. The man spent the weekend in the Healthcare Centre, but was taken to the Segregation Unit on the morning of 25 April after the assault on the senior officer. The only entry in the Wing Observation Book in the week leading up to his court appearance was made on 25 April. That entry, made by a senior officer, was prompted by the assault in the Healthcare Centre, and not by the Deputy Governor’s instruction about extra vigilance due to a heightened risk of self harm. The senior officer’s entry noted that a risk assessment had been carried out and two members of staff were to be present at all times when the man was unlocked. The next risk assessment would be on 29 April, and he recorded concerns about the man’s explosive and volatile nature. He wrote that the man had been located on E wing for an adjudication after the staff assault, and that increased observations would be required at night.
110. The first risk assessment is not timed and dated. However, it is a reasonable assumption that it was written on 25 April as the action plan section refers to awaiting the adjudication that took place on 26 April. The

stated reason for the assessment was the assault committed by the man, and the fact that he was currently segregated.

111. There is no evidence of compliance with the Deputy Governor's instruction that there should be extra vigilance before and after the man's court appearance. There are no relevant entries in the diary, and the next entry in the Wing Observation Book came on 4 May after he had been found hanging.

112. I was encouraged to learn about the issue of Governor's Order 15.2005 on 7 June while my investigation into the circumstances of the man's death was proceeding. The last paragraph of the Governor's Order reads as follows:

"Reviews are to be multi-disciplinary where possible, that includes representation from Healthcare, current Residential unit, Suicide Prevention Co-ordinators, and the prisoner. If the prisoner has no objection and if it is practicable, families may be invited or consulted during visits. Most reviews are predictable and it is the Unit Manager's responsibility to advise potential attendees well in advance to improve attendance and quality of information. Attempts must be made to involve the same people on Case Reviews where possible, as their purpose is to share information and provide continuity on how the prisoner is coping and to make 'team' based decisions on the case management action plan."

113. On 14 April, the Deputy Governor, issued a Notice to Staff. The notice announced that an officer was stepping down from the role of Suicide Prevention Co-ordinator which he had held for several years. He has been replaced by two senior officers and an officer who are undertaking the task jointly on a roster basis. My investigators met the new Suicide Prevention Co-ordinators, and were impressed by their commitment and motivation.

114. However, I was very surprised to learn that the new co-ordinators have no profiled time for the task. They were dependent on the goodwill of their existing managers so that they could be released from normal duties. They were coming into the prison ahead of shift and doing suicide prevention work when they should have been taking meal breaks. I do not think it is fair that staff should undertake such vital work in time that is snatched from other duties or from their own free time. I make a recommendation about this matter later in my report.

115. Many prisons in England and Wales have already adopted ACCT (Assessment, Care in Custody and Teamwork) in succession to the F2052SH procedures. ACC T is to be introduced at Swansea shortly. ACCT will bring some welcome reforms such as having a Case Manager and named staff who will be responsible for actioning particular sections of the care and management plan drawn up for each prisoner thought to be at risk of self harm. I believe, however, that the issues identified in this section of my report are much too critical to await the implementation of ACCT.

3. Issue of fish knives

116. On 28 April, the Governor issued Order 12.2005. The Order was entitled Suicide Prevention – issue of safety knife “fish” to discipline and healthcare staff. The implementation date was 2 May, two days before the man was found hanging. The Governor announced that he intended to introduce the use of safety fish knives at Swansea, following recommendations from several investigations after deaths in custody and from the Safer Custody Group in the National Offender Management Service. The last apparently self-inflicted death at Swansea occurred in November 2004, and in my investigation report I recommended that the Governor consider whether it would be appropriate for all wing staff to carry ligature cutters. My draft report was not issued to the Governor until April 2005.
117. The Governor explained to my investigators that his order was designed to encourage staff to carry safety fish knives. The order did not make it compulsory for staff to carry knives.
118. The staff who responded to the emergency on the morning of 4 May and rushed into the man’s cell were not carrying fish knives. An officer said that staff had difficulty trying to loosen the ligature around the man’s neck. A senior officer described the ligature as “quite tight”, and he therefore instructed another officer to fetch scissors from the wing office nearby. Before this officer returned, the senior officer managed to loosen the noose from around the man’s neck. A C wing prisoner said that he too had helped to loosen the ligature.
119. I do not think that the outcome would have been different if staff had been carrying safety fish knives. Although the ligature was tightly knotted, it had been removed in the very short space of time required for the officer to run from the cell to the wing office and back again. I was pleased to learn that in the days after 4 May, large numbers of safety knives have been issued to staff at Swansea.

4. Clinical review

120. I am grateful to my qualified nurse for supplying a detailed clinical review. She review states that the primary care the man received in Shrewsbury and then in Swansea was commensurate with primary care in the community. At Swansea, he was immediately put on a psychiatrist’s waiting list by the nurse who undertook a mental health assessment. The man received a comprehensive consultation from the psychiatrist after a four week delay, but no mental illness was diagnosed. The clinical reviewer records that had suffered from epilepsy since childhood, experiencing quite frequent fits. From his teenage years, his compliance with his medication was erratic.
121. The clinical reviewer notes the post-mortem finding that the man died of pneumonia, and observes that a chest infection, such as pneumonia, is

not uncommon as a complication of coma and artificial ventilation. She found no act or omission which could have materially altered the outcome of his situation. She has, however, made a number of recommendations which could improve the health service for prisoners at Swansea in future. I endorse all of those recommendations.

Conclusions

122. The man was remanded in custody in February 2005, following the death of his long term partner. The charge against him was that he had inflicted grievous bodily harm on her, although shortly before his death he received the news from his solicitor that the Crown Prosecution Service confidently expected to elevate the charge to one of murder.
123. The man was not an experienced prisoner. His list of previous convictions shows that he had previously served just one short prison sentence in 1996. Staff and prisoners both felt that his mental health was not good, although the psychiatrist who examined him at Swansea said he was not mentally ill.
124. The man was isolated at Swansea. He did not receive visits and had very few telephone calls. During the last few weeks of his life, he emerged rarely from his cell on C wing, declining opportunities to mix with other prisoners on association or on the exercise yard. Outside prison his compliance with his medication regime for epilepsy was erratic, and he did not always take his medication whilst at Swansea.
125. There seems little doubt that proceedings at court were of great significance to him. On 24 March, for instance, he went to court hoping for bail. He was refused bail, and wing staff saw him crying in his cell on 7 April, the day that his Self Harm At Risk form was closed. The man told the staff reviewing his case that he thought he would go to court, and possibly walk from court or at least get a minimal sentence. The man's solicitor has indicated that he seemed very despondent indeed when given the news on 28 April that he was likely to be facing a murder charge. He appeared to realise that he would be unable to return to his former life in Llandrindod Wells.
126. The man was considered to be at risk of self harm continuously from his arrival at Shrewsbury on 23 February until his Self Harm At Risk Form was closed at Swansea on 7 April. My investigation has uncovered a number of weaknesses in the way that the F2052SH system was operating at Swansea at that time. The review panel on 7 April correctly predicted that the man's appearance at Crown Court on 29 April would be a significant event. The first item in the support plan drawn up during the review was that staff were to remain observant of him at all times, but no detail was supplied about how that part of the plan was to be achieved.
127. The Deputy Governor's written instruction on 8 April, about the need for extra vigilance in the week before and after the court appearance, did not lead to entries in the diary and C wing Observation books at the relevant times. The diary entry made by an officer on 22 April was inserted at the request of a nurse who was concerned about the man's mental health. The staff who attended successive case reviews on the man and other prisoners on open F2052SHs were not generally the same. There was an absence of clear evidence that important issues raised at previous reviews were either progressed or resolved at subsequent reviews.

128. I commend the Governor for issuing his Order of 7 June which sets out clearly a number of improvements he wishes to see in the operation of the review system.

I recommend that a Senior Manager or Suicide Prevention Co-ordinator at Swansea should be tasked with providing a written monthly report to the Governor on compliance with the instructions in his order of 7 June, until such time as ACCT is introduced at Swansea.

129. The way in which staff are deployed at Swansea is a matter for local management, but I wish to make observations on two staffing matters that impact on suicide and self harm prevention. I was surprised to discover that the three newly appointed Suicide Prevention Co-ordinators at Swansea have no profiled time in which to do their work. I do not think that they will be able to perform their vital role to a high standard if they are carrying out suicide prevention duties in the margins of other tasks.

I recommend that the Governor gives urgent consideration to the possibility of providing profiled time each week for suicide prevention duties to be undertaken by the Suicide Prevention Co-ordinators in rotation.

130. Each day, the staffing of the Vulnerable Prisoner Unit (C wing) and the Segregation Unit (E wing) at Swansea is undertaken by a senior officer and two prison officers. My investigators were aware of certain periods of the day, notably adjudications each morning, when staff were required to give almost undivided attention to one unit at the apparent expense of the other. My investigators observed that there is usually at least one prisoner on an open F2052SH on C wing. I am concerned about the safety of such prisoners when the regular staff are absent from the wing because they are required to perform other duties. I do not see how staff can observe and interact with potentially suicidal prisoners while they are absent from the wing.

I recommend that the Governor reviews the staffing profile of C and E wings, so the safety and well being of prisoners, particularly those on open Self Harm At Risk forms, on both wings is not compromised.

131. The ligature around the man's neck on 4 May was tightly knotted, and staff responding to the emergency were not carrying anti-ligature knives. Fortunately, despite the absence of such knives, the ligature was quickly removed in this case. During the previous week, the Governor had already published an order encouraging all discipline and healthcare staff to carry safety fish knives. I am aware that many staff at Swansea now carry such knives.

I recommend that all uniformed staff at Swansea who are in regular contact with prisoners should carry anti-ligature safety knives.

132. I am satisfied that staff on C wing did not, and would not, condone prisoner-prisoner bullying. It is possible that the man was the victim of some verbal harassment by other prisoners of which staff were not aware. I note comments in the Chief Inspector's report suggesting that many bullying incidents were dealt with without referral to the prison's formal anti-bullying strategy. The Chief Inspector also refers to the need for staff to be trained in the new strategy. I support the recommendations made by her in the Bullying section of her inspection report.

I recommend that anti-bullying training for staff should be arranged as a matter of priority.

133. The efforts made to revive the man after he was discovered were most impressive. My clinical reviewer, reports that the nurses and officers who attempted to restore The man's breathing and circulation acted competently. She adds that they deserve credit for maintaining basic life support until paramedics could take over, enabling the man to be removed to hospital alive.

134. An eye witness account of the resuscitation attempts has been provided by a respected member of the Swansea community outside the prison, and a former chairman of the prison's Independent Monitoring Board. The former chairman happened to be visiting on the morning of 4 May, and made his way to the scene of the emergency. He saw the man unconscious on the floor of his cell and records that his contact with the incident lasted approximately eight minutes. The former chairman writes:

"During this incident I was very impressed with the attitude and efficiency of all concerned in trying to preserve life. As an ex-RNLI member, I appreciated the effort and expertise demonstrated in this difficult situation, and the professional and caring attitude of all concerned."

135. It is clear that strenuous, skilled and committed efforts were made to revive the man when he was found hanging. Two officers and a senior officer immediately commenced cardio pulmonary resuscitation. The arrangements for summoning the nurse and the first responder officer to the scene were less than perfect but, once present, both those members of staff used their training and expertise, in conjunction with the senior officer, as they strove to resuscitate the man. The work done by these four named members of staff was skilled, compassionate and arduous. It is deserving of recognition.

I recommend that the Prison Service Area Manager for Wales formally commends the four members of staff who attempted to restore the man's breathing and circulation.

136. The actions taken by the prison in response to this tragic event were exemplary. The Governor and his colleagues took a series of humane and effective decisions from the time that the man was transferred to hospital. The prison chaplain and a colleague went to find the man's

mother and bring her to his bedside at the hospital. Practical support was supplied to her while she was at the hospital. For example, the prison arranged and paid for taxis to take her backwards and forwards so that she could obtain necessary supplies. Regular visits were made to the hospital by senior staff, including the Governing Governor and his deputy. This meant they were able to maintain face to face contact with the man's mother, and that appropriate decisions were made rapidly in response to new medical information.

137. On 6 May, the man was moved from a large open intensive care unit to a side ward. A fresh risk assessment was conducted and escorting staff were instructed to sit outside the room so that their presence was as unobtrusive as possible. Escorting staff explicitly recognised the need to treat the man's visitors in a dignified and decent way.
138. The Governor immediately set up an investigation into the circumstances of the man's self injury on 4 May. On 9 May, he wrote to Merthyr Tydfil Crown Court supporting the solicitor's application for bail to be granted. The man's mother has asked why staff were not immediately removed from the hospital when bail was granted the following day. The Deputy Governor has indicated that staff remained at the hospital for a few hours after bail was granted simply to offer support to her. An e-mail from Swansea to my investigators states that "staff remained to answer any questions she might have about 'what happens now etc', and prepare for their withdrawal rather than leave her feeling abandoned and isolated". I consider that the Governor's decision to leave staff in post at the hospital for a short time after the granting of bail was appropriate in the circumstances. It was consistent with his obvious desire throughout the preceding week to offer the man's mother practical support, without being unduly intrusive.
139. My investigators were told by a prisoner they interviewed that there was "too much bang up" on C wing. His view that there was too much time in cell is set out in more measured tones in the Chief Inspector's report. She writes about C wing:
- "The prisoners' regime was very limited. The published regime offered only half an hour for exercise each day, two one and a quarter hour evening association periods in the week and one hour each day at weekends. On days when there was no association or education prisoners had just one and a quarter hours out of cell."
140. Staff lamented the fact that vulnerable prisoners were no longer able to work in the tailors' shop. It seems that the man preferred his own company, but the absence of purposeful activity serves no-one's interest.

I recommend, as I understand will HMCIP, that the Vulnerable Prisoner Unit should have a full purposeful day for prisoners with increased opportunities for activity and time out of cell.

141. The man was an inexperienced prisoner who found it very difficult to cope with the pressures of imprisonment at Swansea while he awaited his trial. He was facing a serious charge which was likely to become still more serious. Once he was removed from F2052SH procedures there was no clear system for supporting and observing him at regular intervals. I readily acknowledge the fact that staff gave or obtained help for him on a number of occasions. A good example is the telephone call made by an officer to the Healthcare Centre when the man became acutely distressed on the morning of 22 April. I recognise that the provision of meaningful support for prisoners like him, who find it difficult to cope, carries some resource implications.
142. The personal officer scheme is a good way of supplying support and care for a needy individual such as the man. The Chief Inspector writes in general terms that personal officers at Swansea did not routinely introduce themselves to prisoners and record this in wing history sheets. She recommends that “personal officers should identify themselves to prisoners and make regular, meaningful entries in wing records, which managers should check”. I support that recommendation.
143. With specific reference to C Wing, the Chief Inspector recommends the introduction of an effective personal officer scheme.

I recommend, as I understand will HMCIP, the introduction of a strengthened and effective personal officer scheme on C wing.

144. At the end of her comprehensive clinical review, the clinical reviewer makes nine recommendations to the Governor and Healthcare Manager. I fully endorse each of these recommendations.
145. The man’s mother asked why Swansea did not respond to a faxed message from her son’s solicitor which enquired about his mental health and other personal matters. The fax and a letter were sent on 3 May, the day before her son was found hanging. My investigators wrote to the man’s solicitor about this issue. The solicitor provided a log of faxes sent from his office on 3 May. One fax was sent to a Swansea code at 11:15am that morning but the number on the log (301465) is not the number of any fax machine at HMP Swansea. There is no evidence that the solicitor’s fax arrived at the prison on 3 May. The letter certainly arrived on 4 May and the governor spoke to the man’s mother about it when she arrived at the hospital that afternoon to see her son.

Recommendations

- 1. I recommend that the Prison Service Area Manager for Wales formally commends the four members of staff who attempted to restore the man's breathing and circulation.**
- 2. I recommend that the correct forms and terminology for segregating prisoners under Prison Rule 45 are introduced with immediate effect.**
- 3. I recommend that a Senior Manager or Suicide Prevention Co-ordinator at Swansea should be tasked with providing a written monthly report to the Governor on compliance with the instructions in his order of 7 June 2005 until such time as ACCT is introduced at Swansea.**
- 4. I recommend that the Governor gives urgent consideration to the possibility of providing profiled time each week for suicide prevention duties to be undertaken by the Suicide Prevention Co-ordinators on rotation.**
- 5. I recommend that the Governor reviews the staffing profile on C and E Wings so the safety and well being of prisoners, particularly those on open Self Harm At Risk forms, on both wings is not compromised.**
- 6. I recommend that all uniformed staff at Swansea who are in regular contact with prisoners should carry anti-ligature safety knives.**
- 7. I recommend that anti-bullying training for staff should be arranged as a matter of priority.**
- 8. I recommend, as I understand will HMCIP, that the Vulnerable Prisoner Unit should have a full purposeful day for prisoners with increased opportunities for activity and time out of cell.**
- 9. I recommend, as I understand will HMCIP, the introduction of a strengthened and effective personal officer scheme on C wing.**

I also endorse the recommendations made by my qualified nurse at the conclusion of her clinical review.

