Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Benjamin Thomas a prisoner at HMP Cardiff on 27 October 2015

**A report by the Prisons and Probation Ombudsman**
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## Our Vision

**To carry out independent investigations to make custody and community supervision safer and fairer.**

## Our Values

**We are:**

**Impartial:** *we do not take sides*
**Respectful:** *we are considerate and courteous*
**Inclusive:** *we value diversity*
**Dedicated:** *we are determined and focused*
**Fair:** *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Benjamin Thomas was found hanged in his cell at HMP Cardiff on 27 October 2015. He was 35 years old. I offer my condolences to Mr Thomas' family and friends.

Mr Thomas had arrived at the prison only the day before his death. Staff assessed him when he arrived, but there was little to indicate that he was at high or imminent risk of suicide. Mr Thomas was dependent on heroin. He showed no signs of severe withdrawal symptoms and I am satisfied that he received appropriate treatment for his drug problems. During the short time he spent at Cardiff, I do not consider that staff could have foreseen or prevented his death.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **June 2016**

## Contents

# Summary

## Events

1. On Monday 26 October, Mr Benjamin Thomas was sentenced to 20 weeks in prison for burglary and theft, and was sent to HMP Cardiff.

2. At initial assessments, Mr Thomas said that he was dependent on heroin and he tested positive for methadone, opiates and benzodiazepines. Healthcare staff assessed that he had only mild withdrawal symptoms (he said he had taken drugs that day) and decided he would not need medication to alleviate symptoms of drug withdrawal until the next day. Mr Thomas had been in prison before. He raised no concerns, told staff he had no thoughts of suicide or self-harm and no one considered he was at risk.

3. Mr Thomas spent the night of 26 October, in a shared cell, in the first night centre. His cellmate said that they got on well and Mr Thomas seemed in good spirits. The next morning, both men moved to the prison's drug recovery unit, where they continued to share a cell.

4. On the afternoon of Tuesday 27 October, Mr Thomas told staff that he was worried that he might have a fit, as he had not received any medication. At 3.33pm, a nurse gave him lofexidine to alleviate the symptoms of opiate withdrawal. At 6.55pm, Mr Thomas pressed his cell bell and told a prison officer he had withdrawal symptoms and wanted diazepam and antidepressants. The officer checked with a nurse, who told him that Mr Thomas had received his dose of lofexidine for the day and had not been prescribed any other medication. The nurse suggested he asked healthcare staff the next day about the possibility of being prescribed antidepressants.

5. Mr Thomas' cellmate was sleeping that evening but woke just before 7.30pm and found that Mr Thomas had hanged himself by a sheet attached to the window bars. He rang the cell bell and untied the ligature from around Mr Thomas' neck. An officer responded, radioed an emergency and waited for other staff, who arrived within seconds, before going into the cell. The staff began cardiopulmonary resuscitation. Paramedics arrived and took Mr Thomas to hospital, but he was pronounced dead shortly afterwards.

## Findings

6. Prison and healthcare staff adequately assessed Mr Thomas' level of risk when he arrived at Cardiff. There were few signs that he was at raised risk of suicide and we do not consider that staff at Cardiff could have predicted or prevented his death. In his short time at the prison, staff managed his withdrawal from drugs appropriately, in line with the prison's protocol.

7. There was an appropriate emergency response. The officer who first arrived at the cell considered going in immediately but believed it would be safer for him, and the prison, if he waited for help, which arrived very quickly. We consider this was reasonable.

# The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Cardiff informing them of the investigation and asking anyone with relevant information to contact her. No one responded

9. The investigator visited Cardiff on 4 November 2015. She obtained copies of relevant extracts from Mr Thomas' prison and medical records and interviewed his cellmate.

10. Health Inspectorate Wales (HIW) commissioned a review of Mr Thomas' clinical care at the prison.

11. The investigator and the clinical reviewer interviewed seven members of staff at Cardiff on 17 and 18 November 2015. The investigator spoke to two other officers by telephone.

12. We informed HM Coroner for Cardiff and Vale of Glamorgan District of the investigation. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Thomas' partner to explain the investigation. She did not have any specific matters for the investigation to consider, but said that Mr Thomas had previously had some health issues and his actions were out of character.

14. Mr Thomas' partner received a copy of the initial report. She raised a number of issues and questions that do not impact on the factual accuracy of the report and have been addressed through separate correspondence.

## Background Information

### HMP Cardiff

15. HMP Cardiff holds around 800 men, mostly from South East Wales. Many of the prisoners come from local courts on remand. Cardiff and Vale University Health Board is responsible for delivering primary, physical and mental health services at the prison.

### HM Inspectorate of Prisons

16. The most recent inspection of HMP Cardiff was in March 2013. Inspectors reported that reception, first night and induction arrangements were good and prisoners received comprehensive information. Levels of self-harm were low and prisoners at risk were well supported.

17. Inspectors reported that illegal drugs were easily available but there was little targeted searching and there were few drug finds. Substance misuse provision was reasonably good and the newly established drug recovery wing was developing well, with peer support, group work and specially selected and trained staff who were highly regarded by prisoners. Prisoners with substance misuse issues received satisfactory clinical and psychosocial treatment. Lofexidine-based detoxification was the most common treatment offered to new prisoners who had used street drugs in the community. Opiate substitution therapy was not routinely provided.

### Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to August 2015, the IMB reported that reception, first night and induction arrangements were thorough, and few prisoners felt unsafe when they arrived. However, they were concerned that some induction interviews were not conducted privately, so questions about sensitive issues such as suicide and self-harm could be overheard by others.

### Previous deaths at HMP Cardiff

19. There have been two other self-inflicted deaths at Cardiff since 2014. There were no significant similarities with the circumstances of Mr Thomas' death.

# Key Events

### 26 October 2015

20. On Monday 26 October, Mr Benjamin Thomas was sentenced to 20 weeks in prison, for burglary and theft. He arrived at HMP Cardiff later that afternoon.

21. Mr Thomas phoned a friend from an office in reception, and gave no indication of any intention to harm himself. During the reception process, three Listeners (prisoners trained by the Samaritans to support other prisoners) spoke to the new prisoners. An officer explained the prison's rules and policies, including for suicide prevention and violence reduction. He recorded Mr Thomas' address and next of kin details in his record. He said that Mr Thomas had not stood out. He was polite and respectful and had not mentioned any problems.

22. At an initial health screen, Mr Thomas told a healthcare assistant that he was dependent on heroin. A urine sample tested positive for opiates, methadone (a heroin substitute) and benzodiazepines. They discussed a blood clot in his leg and he said that he had been receiving fragmin (to treat blood clots), and was waiting for a scan at hospital.

23. The healthcare assistant used a first night suicide/self-harm screening tool to assess Mr Thomas' risk. Mr Thomas said he had been in prison before, and had been on a drug detoxification programme in the community. He established that Mr Thomas had never been treated for mental health problems, or self-harmed and said he did not intend to harm himself. He did not consider that Mr Thomas was at risk of suicide or self-harm.

24. The healthcare assistant assessed Mr Thomas' withdrawal symptoms using the Clinical Opiate Withdrawal Scale (COWS). This scale assesses the level of drug withdrawal by rating 11 common opiate withdrawal signs (pulse rate, sweating, restlessness, pupil size, bone aches, runny nose, stomach upset, tremor, yawning, anxiety and gooseflesh skin). Mr Thomas said his muscles and joints ached. The healthcare assistant noted that he had a normal resting pulse, did not appear to be sweating or chilled, and was able to sit still, although he had a slight tremor in his hands. This suggested mild withdrawal. Mr Thomas scored eight on the COWS. The healthcare protocol says that any prisoner scoring eight or higher should be referred to a senior nurse to determine whether he needs immediate medication, so the healthcare assistant asked a nurse for advice.

25. The nurse told the investigator that a score between 5 and 12 is considered mild withdrawal (13-24 is moderate, 25-36 is moderate/severe and over 36 is severe). When a prisoner scores between 10 and 17, he is likely to be prescribed lofexidine (to relieve the symptoms of opiate withdrawal). He recalled that Mr Thomas had said he felt fine. He decided that Mr Thomas did not need any medication that night. The healthcare assistant sent a task on SystmOne (the prison healthcare record system) for a doctor to prescribe Mr Thomas' lofexidine the next morning.

26. An officer completed a cell sharing risk assessment and noted that Mr Thomas had no thoughts of self-harm. The healthcare assistant agreed that Mr Thomas was suitable to share a cell. An officer took Mr Thomas to the prison's first night

centre. An Insider and a Listener (peer supporters) explained routine prison processes, such as how to order items from the prison shop, select meals from the menu and arrange visits.

27. Mr Thomas shared a cell with a cellmate. The cellmate said that they got on well and laughed and joked together. Mr Thomas told him he was coming off heroin and that as he had taken some that day, his detoxification would not start until the next day. He had talked about missing someone, but the cellmate could not remember who that was. After that, he did not seem to want to talk and the cellmate went to sleep.

### 27 October 2015

28. On the Tuesday morning, the cellmate said that Mr Thomas was 'all over the place' and wanted some medication.

29. A prison GP prescribed Mr Thomas lofexidine to be administered under supervision over the next 11 days. A healthcare assistant contacted Mr Thomas' GP, who said that Mr Thomas was not currently prescribed any medication.

30. That morning, a nurse discussed his drug use with Mr Thomas. Mr Thomas said he injected heroin and took crack cocaine. He said he felt well, although he thought he might fit and needed medication. He said he had no mental health problems or thoughts of suicide or self-harm. She did not consider that Mr Thomas looked as if he was likely to have a fit.

31. Mr Thomas asked to see someone from the Counselling, Assessment, Referral, Advice and Throughcare Service (CARATS), which provides interventions and services for prisoners with drug and alcohol problems. A drugs worker spoke to him and Mr Thomas asked to be prescribed valium. The drugs worker said that he could not prescribe medication and advised him to speak to healthcare staff. He checked with a nurse that Mr Thomas would be receiving lofexidine. He said Mr Thomas did not seem to be suffering from withdrawal symptoms. He described him as lively and said he engaged well. Mr Thomas mentioned that he had recently split up with his partner and hoped to reconcile with her after he was released.

32. Mr Thomas and his cellmate were both moved to the drug recovery unit, a detoxification landing on F Wing. They continued to share a cell and the cellmate had the top bunk.

33. Mr Thomas saw a prison chaplain during his induction. He told the chaplain that he had no thoughts of suicide or self-harm and did not need to be monitored under ACCT suicide and self-harm prevention procedures.

34. A nurse said she saw Mr Thomas several times that day. He told her again that he felt he was going to have a fit and said the same to other staff. She said that if he had shown signs of withdrawal, she would have prioritised his medication. She asked him whether he had any thoughts of suicide or self-harm, and he said he had none.

35. A nurse noted in Mr Thomas' healthcare record that she gave Mr Thomas his lofexidine at 3.33pm. Another nurse said that she saw her colleague giving Mr Thomas his medication.

36. The cellmate said that Mr Thomas seemed calmer and less jittery after receiving his medication. He told the cellmate that he had also bought and taken subutex (a heroin substitute) from another prisoner on the unit and had paid for this with some tobacco. (Toxicology tests after Mr Thomas' death did not detect this or any other illicit drugs.)

37. Mr Thomas made three telephone calls on 27 October. Two were unanswered. His last call, at 4.19pm, was to the friend he had telephoned the day before, when he had first arrived. They spoke about finding someone to look after a dog and clearing out Mr Thomas' personal items from his house. Mr Thomas said he had been unable to contact his partner and his friend said no one had seen her for a few days.

38. All prisoners were locked in their cells in the late afternoon. The cellmate said he and Mr Thomas chatted generally about being in prison. At 6.50pm, the cellmate said he felt drowsy because of the medication he was taking for alcohol withdrawal and needed to sleep. He said he told Mr Thomas to wake him if he needed anything. He said that the cell light and television were on and Mr Thomas was pacing around the cell.

39. Five minutes later, at 6.55pm, Mr Thomas rang the cell bell and told an officer that he had withdrawal symptoms and wanted diazepam and antidepressants. The officer telephoned a nurse in the healthcare centre. She said Mr Thomas had not been prescribed antidepressants, diazepam was given for alcohol withdrawal and he had received his lofexidine medication for detoxification. She suggested that he ask a nurse in the morning about a possible prescription of antidepressants. The officer passed this on to Mr Thomas, who mumbled something and walked away from the door. He told the investigator that although Mr Thomas seemed a little anxious and frustrated, he did not appear to be too bad. He noted that the cellmate was in bed, but he could not tell if he was asleep or watching television.

40. The cellmate said he woke up around 7.28pm. He had not heard any noises or been disturbed while he had been asleep. The television was still on, but the light was off. He got out of bed and went to switch on the kettle to make a cup of tea. He saw Mr Thomas and thought he was sitting on the heating pipe along the floor, as prisoners did this to keep warm. When he switched on the cell light, he saw that Mr Thomas was hanging from the window bars, by a ligature made from a bed sheet.

41. The cellmate rang the cell bell for help (this was recorded at 7.28pm) and then tried to untie the sheet, but it was too tight. He used a lighter to try to burn it off, but this was also unsuccessful. He eventually managed to loosen it. He said Mr Thomas looked grey and felt clammy. He could not find a pulse in either his wrist or his neck and thought that Mr Thomas had died.

42. An officer had been in an office on the landing above and arrived at the cell approximately two minutes after hearing the cell bell. He looked through the

observation panel in the cell door and saw Mr Thomas hanging from the window bars, with the cellmate apparently supporting his weight. He radioed an emergency code blue and told the cellmate to lay Mr Thomas on the floor in the recovery position. Another officer who was on duty in the control room, telephoned for an ambulance immediately he heard the code blue. He noted he had completed the call by 7.34pm.

43. The officer waited for help before opening the cell. He said that as he was the only officer on the unit and there were two prisoners in the cell, he was concerned about his own safety and that of the prison. He continued to give instructions to the cellmate through the door.

44. Within a few seconds, another officer arrived and both officers went into the cell. They checked Mr Thomas, who was not breathing and had no pulse. One officer then began chest compressions and the other moved the cellmate to another cell. More staff arrived shortly afterwards. An officer checked Mr Thomas' neck and wrist. He said he felt warm, but had no pulse.

45. Healthcare staff and the night manager arrived shortly afterwards. A nurse brought a bag of emergency equipment and a healthcare assistant brought a defibrillator.

46. An officer, who was a trained first-aider, took over chest compressions and the healthcare assistant attached the defibrillator. The nurse tried to insert an airway, but the chest compressions had caused Mr Thomas to vomit, so she placed it in his nose. The defibrillator found no shockable heart rhythm and they continued cardiopulmonary resuscitation.

47. At 7.37pm, the ambulance arrived at the prison and paramedics reached the cell within two minutes. The paramedics took over emergency treatment and, at 8.22pm, took Mr Thomas to hospital. Two officers went with him. At 8.45pm, one of the officers telephoned to let the prison know that Mr Thomas had died.

### Contact with Mr Thomas' family

48. A nurse and an officer acted as the prison's family liaison officers. Mr Thomas had named his partner as his next of kin with an address in Weston-super-Mare. However, the address was incomplete and there was no telephone number. Prison staff were unable to locate the address and asked the police for help, who then supplied the full address. The Governor and the family liaison officers left the prison at 1.00am and arrived at the address in Weston-super-Mare at 2.25am. Mr Thomas' partner was not there, but they spoke to her mother, who said that she had not been there for two weeks. At 4.30am, Mr Thomas' partner telephoned the prison. Staff told her what had happened and offered condolences and support.

49. Mr Thomas' funeral was held on 19 November. The prison paid funeral costs, in line with national guidance.

## Support for prisoners and staff

50. After Mr Thomas' death, the night manager debriefed the staff involved in the emergency response to allow them the opportunity to discuss any issues arising, and to offer her support and that of the staff care team.

51. Mr Thomas' cellmate initially assisted police with their enquiries and was subsequently spoken to by the safer custody manager, who checked his well-being. He also thanked the cellmate for his help during the emergency incident.

52. The prison posted notices informing other prisoners of Mr Thomas' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Thomas' death.

## Post-mortem report

53. The post-mortem report was not available at the time of issuing this report. A toxicology report said that no drugs or alcohol were detected in Mr Thomas' body, although a single, therapeutic dose of lofexidine (Mr Thomas' only medication) would not have shown up on the test.

# Findings

### Assessing Mr Thomas' risk

54. Prison Service Instruction (PSI) 64/2011, covering safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include early days in custody and substance misuse. New prisoners must be assessed in reception so staff can assess their risk of suicide or self-harm and act appropriately to address any concerns, including beginning suicide and self-harm monitoring procedures if necessary.

55. In a PPO thematic report, published in April 2014, about risk factors in self-inflicted deaths, we identified that too often assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. We have also recently issued a Learning Lessons Bulletin (February 2016) reinforcing the need for prison staff to be aware of the particular vulnerabilities of prisoners in the early days in custody.

56. We are satisfied that the healthcare assistant and the officer who assessed Mr Thomas on the day he arrived at Cardiff, properly considered his risk factors and concluded he was not at risk. Other Cardiff staff we spoke to about Mr Thomas had no concerns about him, or his risk of suicide or self-harm. Although Mr Thomas mentioned to a drugs worker that he had relationship problems, which would have been a further risk factor, he seemed confident that these would be resolved and the drugs worker had no concerns about him.

57. This was not Mr Thomas' first time in prison and he was serving a short sentence. There was no external information from the court or escort staff about any previous risk associated with Mr Thomas, and nothing to indicate that he had previously self-harmed or attempted suicide. His actions were sudden and unexpected and he left no note to explain his actions. We are satisfied that staff at Cardiff assessed Mr Thomas appropriately and could not have predicted or prevented his death.

### Mr Thomas' clinical care and detoxification

58. The prison has a policy for managing new prisoners withdrawing from opiates, published on 29 January 2015. This says that assessment of withdrawal should begin at a prisoner's first reception screening. Healthcare staff should record a full history of drug use, including amounts used, in the prisoner's healthcare record. They should score the prisoner's signs and symptoms of withdrawal, using COWS and use drug-testing kits to confirm opiate use before prescribing medication. If a prisoner has severe withdrawal, healthcare staff can prescribe a first dose of lofexidine in reception. Otherwise, prisoners wait until the GP prescribes medication the next morning.

59. Mr Thomas said he had taken drugs that day. He scored eight on COWS, which indicated mild withdrawal, and he tested positive for methadone, opiates and benzodiazepines. A nurse decided that Mr Thomas should not have medication that night, but wait for the doctor to prescribe it the next morning. A healthcare assistant noted that he had consulted a nurse, but neither of them recorded the reasons for the decision.

60. Healthcare Inspectorate Wales (HIW) was satisfied that staff followed the opiate protocol and managed Mr Thomas' withdrawal from drugs properly and in line with the prison's policy. They assessed his physical and mental health correctly appropriately and his care and treatment was in line with his identified needs. The clinical reviewer concluded that Mr Thomas' care at Cardiff was equivalent to that he could have expected to receive in the community.

### Emergency response

61. When the officer responded to the cell bell on the evening of 27 October, he saw that Mr Thomas was hanging and his cellmate was checking for signs of life. He radioed a code blue call immediately and gave the cellmate instructions on what to do. The officer said he assessed the situation, but he did not consider it was safe for him to open the cell as he was the only officer on F wing, there were two prisoners in the cell, and he did not know either of them. He therefore waited for help before going in.

62. Prison Service Instruction (PSI) 24/2011 gives national guidance on entering cells at night when there are few staff on duty. The PSI says that under normal circumstances, the night manager must give authority to unlock a cell at night and a minimum number of staff (according to local risk guidelines) should be present when it is opened. Preservation of life must take precedence over this, but staff should not take any action that they feel would put themselves, or others, in danger. Where there appears to be a threat to life, staff should perform a dynamic risk assessment, inform the control room and open and enter cells on their own, if they feel safe to do so. Cardiff's local policy reflects the guidance given in the PSI and states that, normally, a minimum of two staff should be present, including the night manager.

63. Staff in this position must make a rapid assessment of the situation. We understand that the officer was concerned about his safety and the security of the prison and made a reasonable decision to wait for help. Commendably, the cellmate had removed the ligature from around Mr Thomas' neck and another officer arrived very quickly and began cardiopulmonary resuscitation. Healthcare staff attended promptly with appropriate emergency equipment and the control room called an ambulance as soon as they received the officer's code blue message. Prison and healthcare staff took appropriate measures to try to resuscitate Mr Thomas and there was effective team working. HIW was satisfied that the response to the emergency was managed well.

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