

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the circumstances surrounding the
death of a man at HMP Swansea in March 2014**

Our Vision

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

This is the investigation report into the death of a man at HMP Swansea, who was found hanging in his cell in March 2014. He was 26 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Swansea was undertaken. The prison cooperated fully with the investigation.

On 19 February 2014, the man was sentenced to prison for assaulting his girlfriend and was taken to HMP Swansea. When he arrived at the prison, he told a nurse that he intended to kill himself and staff began suicide and self-harm prevention procedures. He was dependent on alcohol and began a detoxification programme. He was placed in a cell designed with fewer ligature points to help reduce the risk of hanging. He had a number of factors which increased his risk of suicide, but he appeared to improve over the next two weeks and told prison staff that he no longer had thoughts of killing himself. He said he was looking forward to the future and that his girlfriend was supporting him. On 28 February, prison staff ended special monitoring as they were satisfied that his risk of suicide or self-harm had reduced sufficiently.

One evening at the beginning of March, the man's cellmate found him hanging from a sheet tied to the top of the bunk bed. Officers cut the sheet and began cardiopulmonary resuscitation assisted by nurses until paramedics arrived. Shortly after, the paramedics pronounced him dead.

Prison staff acted correctly in beginning suicide and self-harm prevention procedures when the man first arrived at Swansea. However, I am concerned that these procedures were not well managed: there were four different case managers for four reviews; the reviews were not sufficiently multi-disciplinary; actions intended to support him were not meaningful; and all actions were completed before the first case review with no other actions identified. I am also concerned that, although he had a history of self-harm and depression and had threatened to kill himself, a referral to the mental health team was not prioritised. As a result, the appointment was four weeks later, by which time he had taken his life.

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

CONTENTS

Summary

The investigation process

HMP Swansea

Key events

Issues

Recommendations

SUMMARY

1. On 19 February 2014, the man was sentenced to 166 days in prison for assaulting his girlfriend and was taken to HMP Swansea. He had been in prison before. During the reception process, a nurse began Prison Service suicide and self-harm prevention procedures, known as ACCT, as he said he would kill himself, had a history of depression and had previously taken a drug overdose. He had symptoms of alcohol withdrawal and the nurse gave him medication to relieve them.
2. The next morning, a nurse referred the man to the primary care mental health team because of his history of depression. A GP examined him and prescribed medication as part of an alcohol detoxification programme, as well as medication for depression and to relieve back pain. At his ACCT assessment and first case review that afternoon, he was tearful and again said that he would kill himself. He was anxious about his relationship with his girlfriend and whether he would be able to see his daughter. He was moved to a safer cell (designed to reduce the risk of hanging) and was observed every 30 minutes.
3. From 21 February, the man's mood appeared to improve after he had a positive phone call with his girlfriend. Prison staff ended suicide and self-harm prevention procedures on 28 February, although he was still undergoing alcohol detoxification and had not yet been assessed by the mental health team. He had had four ACCT reviews, each of which was chaired by a different case manager and the last two were not multi-disciplinary.
4. In early March the man told the prison chaplain that he was having relationship problems with his girlfriend and was initially tearful. He asked the chaplain if she could arrange a telephone call with his girlfriend. The chaplain said she would have to check that he was allowed to contact her and, if so, she would come back the next morning to facilitate the call. The chaplain said that when she left him around 4.00pm, he was calm and composed.
5. Later that afternoon, the man's cellmate came back from a hospital appointment. He found him hanged in his cell and alerted staff. An alarm was raised at 5.27pm and the control room called an ambulance. Officers and nurses attempted resuscitation until paramedics arrived. At 6.18pm, the paramedics pronounced him dead.
6. The investigation has found that prison staff appropriately identified that the man was at risk of suicide and self-harm and began ACCT suicide and self-harm prevention procedures appropriately, but the process was not managed sufficiently well to provide fully effective support. There were different case managers for each review, the reviews were not multi-disciplinary, and caremap actions did not result in meaningful action. We are concerned that a mental health referral was not given greater priority. We make two recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices informing staff and prisoners at HMP Swansea of the investigation and asking anyone who had relevant information to contact him. No one responded.
8. On 14 March 2014, the investigator visited the prison and spoke to the man's friend who had occupied a cell on the same landing. He obtained copies of the man's prison records and medical record. He interviewed members of staff at the prison in April 2014.
9. Healthcare Inspectorate Wales (HIW) reviewed the man's clinical care at the prison.
10. The investigator informed the local Coroner of the investigation. We have sent the Coroner a copy of this report.
11. One of the Ombudsman's family liaison officers and the investigator met members of the man's family to explain the investigation process and to give them the opportunity to identify matters for the investigation to consider. His family were concerned that a chaplain had not allowed him to make a telephone call to his girlfriend the day he died even though he was depressed. They were concerned that he had been placed back in his cell without any additional checks and that officers should have been alerted that he was distressed and might need extra support that evening and night, especially as he had recently been managed under suicide and self-harm prevention procedures. They wanted to know whether the prison staff were aware that he had attempted suicide twice in the community and whether staff had taken this into account in assessing his vulnerability.
12. The family received a copy of the draft report. They did not make any comments.

HMP SWANSEA

13. HMP Swansea is a small local prison, near the city centre, holding approximately 400 adult male prisoners. The prison receives sentenced or remanded men from courts mainly in the South Wales area.
14. Swansea is part of a pilot project with several other prisons aimed at addressing substance misuse and reducing associated offending. As part of this project, from 21 February 2014, the first night centre was moved from A1 to B Wing, where it now accommodates all new receptions and prisoners undergoing detoxification. The drug recovery unit, on A1 landing, is intended for prisoners who have completed their drug recovery plan.

Her Majesty's Inspectorate of Prisons

15. The most recent inspection of HMP Swansea was in December 2012. Inspectors noted that 69% of staff required ACCT refresher training, despite a previous recommendation about the need for this. Recommendations from previous Prisons and Probation Ombudsman's investigations had been consolidated into a single action plan but inspectors noted that reviews of the plan appeared perfunctory. Inspectors described the drug support unit as a positive initiative, but prescribing arrangements for substance misusers, at most risk during the early part of their stay at Swansea, were not sufficiently flexible and monitoring was too limited.

Independent Monitoring Board (IMB)

16. Every prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its annual report for the year ending May 2013, the IMB noted that, after three tragic deaths at the prison, suicide and self-harm refresher training was being undertaken. The IMB was concerned that too many deaths occurred on the induction wing in the early days of custody and hoped that the introduction of a drug recovery wing would help.

Assessment, care in custody and teamwork (ACCT) procedures

17. Assessment, Care in Custody and Teamwork (ACCT) is a Prison Service-wide process for supporting and monitoring prisoners thought to be at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary review meetings involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Previous deaths at Swansea

18. Since 2010, there have been four self-inflicted deaths at Swansea including the man's. There were no significant similarities with the circumstances of those cases.

KEY EVENTS

19. The man had been released from HMP Cardiff in January 2011 after serving a sentence for common assault against his girlfriend. He had previous convictions for theft, actual bodily harm and harassment. He was an alcoholic and had taken an overdose of medication in January 2010.
20. On 19 February 2014, the man attended court charged with common assault and battery against his girlfriend. He was convicted and sentenced to 166 days in prison. He arrived at HMP Swansea at 5.50pm. His escort record noted that he had self-harmed about three years previously, had a history of alcohol and drug abuse, had previously been charged with false imprisonment and that he had markers on his police record for weapons and racist and homophobic behaviour. He suffered from pain in his back and leg as a result of a spinal disc problem for which he was taking medication.
21. A reception officer recorded the information from the escort record on a cell sharing risk assessment and decided that, because the man was known to have racist and homophobic views, he would be regarded as a high risk for sharing a cell. He said that he had no thoughts of suicide or self-harm and the officer noted that he had explained the support available to him at Swansea. He did not regard him as a risk of suicide or self-harm despite a number of risk factors, including the fact that he had been convicted of a violent offence against his girlfriend.
22. The Head of Security interviewed the man because he had been assessed as high risk for sharing a cell. He said that he was homophobic but “not really racist”. The Head noted that he did not have to be located in a single cell as long as staff were aware of the identified risks when allocating him to a shared cell. He did not record any other concerns.
23. A mental health nurse completed a reception health assessment and recorded it on SystmOne, the electronic prison healthcare record, at 6.38pm. The man gave details of his community GP and told her that he had a girlfriend and a twelve week old baby daughter. He said that he had suffered from depression for some years and was on prescribed antidepressant medication (mirtazapine 45mg) and took painkillers (gabapentin 600mg), for back and leg pain from when he had been injured in a fall. He reported that he smoked cannabis regularly and drank around 140 units of alcohol a week. He told her that he had attempted suicide by taking an overdose three years earlier and that he would kill himself in prison by any means available to him. She observed that he had a mild tremor, was sweating and appeared anxious and agitated, which she thought indicated that he was withdrawing from alcohol. She was also a nurse prescriber and gave him 10mg of diazepam to treat alcohol withdrawal symptoms for his first night and noted that he should be referred to the primary mental health team.
24. At 6.50pm, the nurse opened an ACCT document because of the man’s comments that he would kill himself. She recorded that he had taken an

overdose in the past and had said he would kill himself in prison by any means available to him. She noted that his mood was low.

25. A custodial manager completed an ACCT immediate action plan and recorded that the man would benefit from sharing a cell with a suitable cell mate. Staff were required to observe him at least once an hour and record three meaningful conversations with him each day until an ACCT assessor interviewed him. Officers gave him a PIN number so he could use the prison telephone system and informed him about available support including Listeners (prisoners trained by the Samaritans to support other prisoners who are distressed). The manager noted that any medical intervention should be recorded on the ACCT caremap.
26. After reception, the man went to the prison's first night centre on A Wing. At 7.50pm, an officer interviewed him and recorded that he had named his mother as his next of kin. He noted that an ACCT had been opened but he said that he now had no thoughts of suicide. The officer outlined the prison rules and support available. The officer noted that he had ongoing alcohol problems but no drug problems and gave him a smoker's pack containing tobacco and cigarette papers. He was then allocated a shared cell.
27. At 5.50am on 20 February, a nurse recorded on SystmOne that the man had spent his first night with no problems, and had received detoxification medication. At 9.14am, a mental health nurse conducted a secondary health screen and noted that his mood was low, he had a history of alcohol abuse and he suffered from depression for which he was prescribed mirtazapine. He said that he had no history of mental health problems, and had self-harmed around two years previously but had no current thoughts of self-harm. She noted that he would benefit from an alcohol detoxification programme and, in line with the nurse's request at the reception health screen, and because of his history of depression, referred him to the primary mental health service. She also referred him to the prison's alcohol clinic.
28. The man's induction continued in a group with other prisoners. One of the chaplains spoke to him and recorded in the ACCT document that his mood was low and he had thoughts of self-harm. The chaplain told him of the support available from the chaplaincy service and other services in the prison.
29. As part of the induction process a family engagement officer from the Prison Advice and Care Team (PACT) interviewed the man, who said that he was concerned about his relationship with his girlfriend. The officer explained how PACT could help him with his relationship while he was in prison. As there were a number of other prisoners present, the officer told him that he would come back and see him a few days later so they could have a longer, private conversation. The officer knew that he was being managed under ACCT procedures and thought that this would allow him time to settle.
30. A substance misuse worker from the Counselling, Assessment, Referral, Advice and Throughcare services (CARATs) team (which provides interventions and services for prisoners with drug and alcohol problems), then

assessed the man, who agreed to address his alcohol and drug problems. He gave him an alcohol and cannabis in-cell activity and information pack and referred him to Alcoholics Anonymous (AA) and to Transitional Support Services, which provides post-release services in Wales.

31. Both the family engagement officer and substance misuse worker said that the man was keen to engage in their support programmes, but was tearful and anxious. He told them that he was worried that social services would stop him seeing his daughter because of his offence.
32. At 9.39am, a prison GP examined the man. The GP noted his level of alcohol consumption and he told the GP that he was experiencing tremors, insomnia and nausea. The GP recorded that his mood was low and that he had thoughts of harming himself but told him that there was nothing in his cell which would enable him to do this. He noted that the man did not have any hallucinations or psychotic symptoms, but had a history of depression, suffered from back pain and was concerned about having access to his daughter. The man said he had self-harmed three years earlier by taking an overdose. His medication was confirmed with his community GP and the GP prescribed mirtazapine 45mg for depression and gabapentin 600mg, an analgesic, for his back and leg pain. As part of his alcohol detoxification programme, the doctor prescribed diazepam 10mg, which was to be gradually reduced and thiamine, vitamin B, metoclopramide and omeprazole.
33. An officer locked the man back in his cell at around 10.30am and noted that he had raised no concerns. After he asked about them, wing staff later explained to him how to use the phone system, make applications and about visits arrangements.
34. At 3.10pm, a trained ACCT assessor from the prison's offender management unit saw the man for an ACCT assessment. He told her he had not been expecting a custodial sentence and was scared about losing his daughter because of the offence. He was tearful and upset and said he wanted to kill himself as he felt he had lost everything. However, he said his outlook might improve if he received help with his alcohol and violence problems and received bereavement counselling for the death of his father when he was a child. She noted that he had previously taken an overdose of medication. He suffered from depression and had taken mirtazapine for a number of years. He had been an alcoholic since the age of 18. He said he was not comfortable on A wing (the first night centre at the time) as his cellmate was not detoxifying and he asked to move to the detoxification wing. She agreed to refer him to counselling and that he should be transferred to the detoxification wing.
35. At 3.30pm, a Supervising Officer (SO) held the man's first ACCT case review which a nurse and officer attended. The ACCT assessor was not present but had spoken to the SO about her assessment before the review. The SO told the investigator that the man's mood was low, his eye contact poor, he was upset during the review and made statements about wanting to be dead. He said that he had spoken to the CARATs team about his alcohol problems. The nurse confirmed that he had been prescribed detoxification medication and had

been referred to the primary mental health team (known as Lighthouse at the time). The SO decided that he should be moved to a safer cell on C wing and that level of observations should be increased to every 30 minutes. He recorded that the man's risk was raised.

36. An ACCT caremap should identify the most urgent and pressing issues for the person at risk identified at the ACCT assessment interview and set a small number of realistic and achievable goals to help reduce their risk. The caremap should state clearly who is responsible for each action and should be reviewed and changed over time. The man's caremap identified three issues: (1) Alcohol issues, for which it was noted that he had engaged with the CARATs team; (2) Medication required (which had already been prescribed) and (3) Mental health issues, for which he had an appointment booked with Lighthouse. The SO signed and dated the caremap on 20 February and noted that all the actions identified had been completed. No other actions were added to the caremap at subsequent reviews.
37. At 9.00am on 21 February, the man asked for an ACCT case review to be held as he said he no longer had any thoughts of suicide or self-harm. At 2.30pm, the unit manager chaired the second ACCT case review which two nurses and an officer attended. The manager noted that the man had spoken to his girlfriend and she had told him that she wanted to continue their relationship. He said that he now felt totally different about life and no longer had any thoughts of suicide or self-harm. A nurse noted that he had shown signs of significant improvement in his appearance and attitude from the day before. The review recorded that his caremap was unchanged and his risk level was now considered low. The level of required observations was reduced to three meaningful conversations each day and a check each time night staff were required to patrol the wing (which they are required to do ten times each night). The next ACCT case review was scheduled for 28 February.
38. As the man was still on an alcohol detoxification programme, nurses were also required to check him. At 5.40am on 22 February, a nurse recorded on SystemOne that he had spent his third night detoxifying and there had been no concerns noted. At 11.14am, a nurse recorded that he appeared more settled on C wing and appeared to be coping well. On 24 February, a nurse saw him and recorded that he was okay and had not complained about any withdrawal symptoms.
39. On 25 February, the man was due to move to B Wing because of accommodation changes at the prison. (B Wing was now the first night centre and detoxification unit.) A prison manager therefore held a third ACCT case review at around 2.45pm that day, before the man moved. An officer was the only other member of staff present. The manager recorded that the man had spoken to his girlfriend, who had said that she would stand by him, but he noted that a breakdown in his relationship might be a trigger for self-harm. He said he had no current thoughts of suicide or self-harm and he did not raise any concerns about moving wings. His risk of suicide and self-harm was assessed as low and the level of observations remained the same. No changes were made to his caremap. The next ACCT review was scheduled for 28 February.

40. On 26 February at 10.46am, a nurse examined the man. She recorded that he was coping well under the detoxification programme. He told her that his mood was much better and he no longer needed to be supported by ACCT procedures. He said that pain in his leg, from an accident a couple of years earlier, was getting worse and he could not walk for long distances. He believed that the dose of gabapentin was not enough to control his pain and said that he was not sleeping well. She said that sleep disturbance was a symptom of alcohol withdrawal and should improve over time.
41. At 10.15am on 27 February, the family engagement officer saw the man on B wing as a follow up from his induction talk. He told the investigator that the man was calm and in a much better frame of mind than when he had last spoken to him. They talked for about ten minutes. He told him that he felt that he had made progress in prison and said his main concern was still that he would not be able to see his daughter although he had spoken to his girlfriend who had agreed that she would take her to the prison's baby group sessions. He completed applications to take part in family support intervention programmes.
42. After the meeting, the family engagement officer emailed an officer who was responsible for arranging the baby group sessions. He noted that he had seen the man as part of the induction process and he had completed an application for him to join the baby group. He asked the officer to go and see the man and told her that he was being managed under ACCT procedures.
43. The same day, at 10.41am, a nurse assessed the man, who said that he felt much better and had no current thoughts of suicide or self-harm. She recorded that he no longer needed to be monitored as part of the detoxification programme. He still continued to receive medication to alleviate his symptoms.
44. At 4.00pm on 28 February, a unit manager held a fourth ACCT case review, which an officer attended. No members of the healthcare team or from any other department were present. The manager recorded that his mood was positive and he had started to make plans for his release from prison and his future. He told the manager that he had no current thoughts of suicide or self-harm and regretted not making more of an effort with his family, something he planned to put right when he was released. The manager reminded him of the prison support networks available to him and it was agreed that the ACCT would be closed. An ACCT post-closure interview was planned for 7 March.
45. On 4 March, the man saw a doctor because he was not sleeping well and was missing receiving diazepam (which had been reduced to 5mg as part of the detoxification programme). The doctor prescribed Phenergan 75mg, an antihistamine which can be used as a mild sedative, to help him sleep. He did not note any other concerns.
46. The man moved to A wing on 6 March where he shared a cell with a cellmate. The next day, at around 9.00pm, the cellmate asked an officer to call a nurse as he thought that the man had had a fit as he had seen his limbs twitching for

several seconds. A nurse thought that he might have had an alcohol-withdrawal related fit while he was asleep. The cellmate said the nurse spoke to the man through the cell observation panel. The man said he was not aware of the twitching and that he had just completed his alcohol detoxification programme. The nurse noted that he looked alert and was orientated.

47. On the morning of Saturday 8 March 2014, the man telephoned his girlfriend and his mother. Transcripts of the telephone calls show that he did not make any references to having any thoughts of suicide or self-harm. His girlfriend said she hated what he had put her through but she was willing to give him another chance. She told him that she intended to book a visit to see him the next Wednesday.
48. At 11.00am, a SO, the wing manager, interviewed the man for his post-closure ACCT case review. The SO told the investigator that he did not know him. They discussed his problem with alcohol and he said that he had now come to terms with this and realised it had nearly cost him his relationship with his girlfriend and his child. He was ready to manage his alcohol abuse and was grateful that his girlfriend was supporting him. The SO noted that the man's risk of self-harm was low and the ACCT document would remain closed.
49. The man telephoned his girlfriend on 9 March. His girlfriend said she loved him and she hated him. He said that he was confused by this and felt she was playing games with him. He said he would change and stop drinking and that he would have nothing without her. His girlfriend said she would visit him in the week and would give him one more chance. He told her that he had an appointment with the prison psychiatrist a week on Monday. The phone call ended mid-conversation when his telephone credit expired.
50. The man's cellmate told the investigator that the man was a tidy man who did not leave their cell much, except to collect meals and to have a shower. He said that the man was always writing letters to his girlfriend, although he seems to be having relationship problems which caused his mood to be low. He said that the man cried a lot, often first thing in the morning and then at night. He said the man appeared depressed but he never expressed any thoughts of suicide or self-harm. He said that he had advised him to speak to a Listener to help him but he had refused to do so as he said he did not want to talk about his feelings to others.
51. One morning, a few days later, the cellmate said that the man had asked a prison officer to check whether any visits had been booked for him but none had been. He said that the man was upset as he had expected his girlfriend to have booked a visit.
52. Around 11.45am, the man and his cellmate collected lunch and returned to their cell when the cellmate realised he had forgotten his soup bowl. He stood up and placed his hand behind the cell door (which was half-shut) to open it and go back to the servery to get his bowl. At the same time, the man kicked the door to close it and his cellmate's hand got trapped in the door. They told an officer about the injury after lunch.

53. A chaplain arrived on A wing around 2.45pm to see the man because he had made an application the day before to see a member of the chaplaincy team. She went to tell the staff in the wing office that she was going to see him. The cellmate was in the office at the time with his hand bandaged and told her what had happened. He was about to go to hospital to have his injury examined. She then went to see the man.
54. The chaplain said she stood at the door of the man's cell and introduced herself. He told her that he wanted to make a phone call to his girlfriend but he had no telephone credit. She asked him for more information and he started to cry and told her that his girlfriend had told him that he would not see her or his child again. She told him that she would have to confirm whether he was allowed to contact his girlfriend in case this had been restricted because she was the victim of his offence. He said that he was allowed contact her, but she said that she would need to confirm this with the prison's offender management unit and, if he was allowed, she would arrange for him to call the next morning. She told the investigator that he stopped crying and they talked a little about his girlfriend and he told her that he was okay. She said he was calm and composed and showed no signs of aggression. He did not say that he was not coping.
55. The chaplain told staff in the wing office that she was leaving the wing. The SO told the investigator that the chaplain spoke to her about the man. She said he was a little distressed and upset and wanted to contact his girlfriend. She did not know him and agreed with the chaplain that she needed to check with the offender management unit before he was given a telephone call to his girlfriend.
56. The chaplain went back to her office and, around 4.15pm, a member of staff from the offender management unit confirmed that the man was allowed to contact his girlfriend. As it was almost the time when prisoners are locked in their cells for the last meal of the day, the chaplain decided to go and see him the next morning, as she had originally told him. Her shift finished at 4.00pm and she left the prison soon after receiving the call from the offender management unit.
57. The cellmate came back to the wing from hospital at around 5.25pm after being diagnosed with bruising and swelling to his hand. It was association time when prisoners are able to socialise with each other and take showers and make telephone calls, but when he got back to his cell the door was locked. He opened the observation panel but the lights were off and it was dark inside. He asked a SO, who was on the landing above, to unlock his cell for him.
58. A nurse was on the landing talking to the cellmate when the SO unlocked the cell. He went in and then called for help. The SO ran to the cell and found the man was hanging from a ligature made from a whole bed sheet, tied to the top of the bed frame. He had placed himself between the bunk bed and a cabinet at the right-hand side of the cell. The excess of the bed sheet material covered the back of the bed, which made it difficult to see him. His feet were on the bottom bed. The SO shouted for help and supported the body until another

SO, an officer and a nurse arrived seconds later. The officer cut the ligature and the nurse, who did not have a radio, left the cell and shouted to an officer on the wing that he needed the medical emergency bag and defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) and further nursing assistance. When the nurse returned to the cell, the man was being lowered to the floor.

59. An officer pressed the general alarm to alert staff to the incident. This was recorded in the prison's control room log at 5.27pm. The SO said she then radioed a code blue emergency. (This indicates a life threatening situation when a prisoner is unconscious or had breathing difficulties.) At 5.28pm, the control room called an ambulance.
60. The officer, a trained first aid responder, and the nurse checked the man for signs of life. He was not breathing, appeared grey and had a cut on his left wrist. The officer started cardiopulmonary resuscitation by doing chest compressions and the nurse maintained his airway, using a mouth guard. Two more nurses arrived with emergency equipment and continued to attempt resuscitation. Paramedics arrived at the cell at 5.42pm and took over emergency treatment. The resuscitation attempts were unsuccessful and, at 6.18pm, paramedics confirmed that he had died.

Events after the man's death

61. The man had left four letters in his cell, dated 11 March, addressed to his mother and family, aunt, girlfriend and his daughter. In the letter to his girlfriend, he wrote that he knew that she had not booked a prison visit to see him. Another letter was found addressed to his girlfriend, dated 28 February. In the letters to his girlfriend and family, he clearly stated his suicidal intention and said he was sorry for what he had done.

Support for prisoners

62. Notices informed prisoners of the man's death and the support that was available for them if they needed it. All prisoners subject to ACCT procedures were reviewed in case they had been affected by the death. The cellmate was moved to a different cell and supported by a Listener and prison staff.

Support for staff

63. Shortly after the man's death was confirmed, the Head of Residential Services debriefed the staff who had been involved in the incident to support them, although some of the staff we interviewed were not satisfied that the debrief was adequate. The staff care team visited the wing and offered further support.

Family Liaison

64. A prison chaplain acted as the prison's family liaison officer after the man's death. He and the acting Governor went to the man's mother's home to break the news. They arrived shortly after 8.30pm and offered support and sympathy.

While they were there, she contacted his girlfriend to let her know that he had died.

65. The chaplain remained in frequent contact with the family and offered financial assistance towards funeral costs in line with Prison Service guidance. The funeral was held on 31 March 2014.

Post-mortem report

66. The post-mortem examination concluded that the cause of the man's death was hanging.

ISSUES

Mental health care

67. The man received appropriate reception health screens and a GP reviewed him the day after he arrived at the prison. The GP appropriately prescribed medication for an alcohol detoxification, for depression and for pain relief. He was also referred to the Lighthouse primary mental health team and to the substance misuse team. However, Health Inspectorate Wales (HIW) was concerned that he was not given an appointment with the primary mental health team until 17 March. HIW noted that, under the Welsh Mental Health Measure 2010, mental health services should be provided as soon as possible to ensure that the patient's mental health does not deteriorate further.
68. We do not consider that the man's appointment was given sufficient priority for someone who had a history of depression, had previously taken an overdose, was withdrawing from alcohol and had said that he would kill himself in prison by any means necessary. It also does not appear that the nature of the appointment was fully explained to him, as he had told his girlfriend that he had an appointment with a psychiatrist when he had been booked to see a mental health nurse. HIW considered that the lack of priority for a mental health appointment meant that this aspect of his care was not equivalent to that he would have expected to receive in the community. We make the following recommendation:

The Governor and Head of Healthcare should ensure that the prisoners identified as being at risk of suicide and self-harm are prioritised for appointments with the mental health team.

Management of the man's risk of suicide and self-harm

69. When he arrived at Swansea, the man had a number of factors which increased his risk of suicide and self-harm including a violent offence against a family member, a previous suicide attempt, a history of depression and the fact that he was withdrawing from alcohol. It is not apparent that reception officers identified any of these risk factors, but a nurse appropriately opened an ACCT document when he told her that he intended to kill himself in prison. The ACCT remained open for eight days. We have some concerns about the quality of the ACCT management and the support he received as a result.
70. Prison Service Instruction 64/2011 requires that ACCT case reviews are held by a multidisciplinary team where possible. Members of the healthcare team attended only the first two reviews of the four ACCT reviews held. No one from the mental health team attended any of the reviews and no one from any other discipline attended the last two reviews, which were conducted by a manager and a wing officer.
71. At the first case review, a caremap was produced as ACCT procedures require, but all of the actions on the caremap were shown as being completed at the time of the review. Two of these actions (a meeting with the CARATs team and

a medication review) had taken place before the ACCT review. The third action was for the man to be referred to the mental health team. The referral had been made but he had yet to attend an appointment which had been set for 17 March.

72. We do not consider that these actions provided appropriate ongoing support for the man. His relationship with his girlfriend and contact with his daughter was evidently a source of anxiety for him, but there was no caremap action to address this issue. Although he was receiving some help from the family engagement officer, this was a clear risk factor which should have resulted in a caremap action. The family engagement officer did not attend any ACCT reviews. No new actions were added to the caremap after the first case review and we consider the caremap should have had more specific actions clearly aimed in themselves at reducing his risk. We consider that it would have been prudent not to close the ACCT until the outcome of the mental health referral was known and discussed fully at an ACCT case review which included all those involved in his care.
73. Four different managers chaired the four ACCT case reviews, and another different manager held the post-closure review with the man. We do not consider this allowed appropriate continuity of care which appears to have been exacerbated by him being held on three different wings during his time at the prison. We are pleased to note that the Governor issued a notice (32/2014) in April 2014 covering ACCT case management which includes instructions to staff including that the appointed ACCT case manager will continue to manage the case wherever the prisoner is located.
74. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **Fully considering and recording all the known risk factors of newly-arrived prisoners when determining their risk of self-harm or suicide.**
- **That caremaps have specific meaningful actions aimed at reducing prisoners' risks to themselves, that progress against caremaps is considered at each review and that caremaps are updated if additional needs are identified.**
- **Holding consistently managed multidisciplinary case reviews which include all relevant people involved in a prisoner's care**
- **Inviting contributions from healthcare staff if they cannot attend a case review.**

The man's request for a telephone call on 11 March

75. Before he died, the man asked to see a member of the chaplaincy team. The chaplain saw him in the afternoon of 11 March and he asked if she could arrange for him to make a telephone call to his girlfriend as he had no telephone credit. She did not know him and said that she would arrange the

call once she had checked that he was allowed to call her. As his girlfriend was the victim of his offence we consider that this was an appropriate response. There was little at the time to indicate to her that this was a matter of urgency and she did not know that he had recently been managed under ACCT procedures as at risk of suicide and self-harm.

76. The man's family told us that they were concerned that he was not offered any further support at that stage as he had been tearful when he spoke to the chaplain. The chaplain said that he was calm and composed and no longer tearful when she told him that she would check with the offender management unit. He said that he was content to wait until the next morning. She reported her conversation to a SO who was managing the wing that day.
77. The SO did not usually work on the wing and did not know the man at all. She did not know that he had previously been on an ACCT. He was on A wing very briefly when the ACCT was opened, and returned to A wing after the ACCT was closed. It is unfortunate that, because the ACCT had been closed, there was no immediate record on A wing to show that relationship difficulties were a possible trigger for suicide and self-harm for him. As a result, the chaplain and SO were unaware that he might be at raised risk of suicide and self-harm. We consider that, when the chaplain left him, there was no immediate reason to have offered him further support as she was actively dealing with his issue and he had seemed content with this and prepared to wait until the next day.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that the prisoners identified as being at risk of suicide and self-harm are prioritised for appointments with the mental health team.
2. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - Fully considering and recording all the known risk factors of newly-arrived prisoners when determining their risk of self-harm or suicide.
 - That caremaps have specific meaningful actions aimed at reducing prisoners' risks to themselves, that progress against caremaps is considered at each review and that caremaps are updated if additional needs are identified.
 - Holding consistently managed multidisciplinary case reviews which include all relevant people involved in a prisoner's care
 - Inviting contributions from healthcare staff if they cannot attend a case review.