Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dean George a prisoner at HMP Swansea on 10 April 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 Dean George was found hanged in his cell at HMP Swansea on 10 April 2016. He was 40 years old. I offer my condolences to Mr George's family and friends.

Mr George was familiar with prison life at Swansea and he had no known history of self-harm. While there was little to indicate that Mr George was at high and imminent risk of suicide at the time of his death and there was some evidence of good practice (in ensuring Mr George shared a cell with his friend), there were serious deficiencies in the way staff monitored his risk of suicide and self-harm. For example, staff failed to assess or review his risk and did not set caremap actions to reduce his risk.

I am concerned that Swansea's drug detoxification programme was not equivalent to that which Mr George could have expected in the community or, indeed, in an English prison. We have previously highlighted our concerns to the National Offender Management Service about the arrangements for managing drug dependent prisoners in Welsh prisons and our concern was recently echoed by Her Majesty's Inspectorate of Prisons in their thematic review of drug use in prison. We have not heard what progress the National Offender Management Service has made towards implementing our earlier recommendation, but I repeat my concerns.

I am also concerned that, despite Swansea accepting my recommendations in three previous investigations about the delay in calling an ambulance when an emergency code is used, there was another delay in calling an ambulance for Mr George. It is unacceptable that I need to repeat my recommendation for the fourth time.

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 **December 2016**

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Summary

Events

1. On 8 April 2016, Mr Dean George was sentenced to eight weeks in prison at HMP Swansea. It was not his first time at Swansea and staff had never previously identified him as at risk of suicide or self-harm.

2. At an initial health screen, Mr George tested positive for illicit drugs, including opiates. Unlike English prisons, Welsh prisons do not offer an integrated drug treatment system for prisoners who arrive dependent on substances, and they do not routinely offer opiate medication for maintenance or detoxification. A nurse gave Mr George non-opiate symptom relief as he had not received a prescription for opiates in the community. On 9 April, staff began monitoring Mr George's risk of suicide and self-harm after he told them he had tried to hang himself a few weeks earlier and had thoughts of taking his life. Officers put Mr George in a cell with a friend and checked him once an hour. Mr George refused to take part in the assessment and review of his risk of suicide and self-harm.

3. Mr George reportedly obtained and then took subutex, an opiate substitute, from other prisoners on the wing.

4. On the morning of 10 April, Mr George did not exercise outside. In the afternoon, his cellmate encouraged him to leave their cell to socialise with other prisoners, but Mr George did not do so.

5. When Mr George's cellmate returned to their cell an hour later, he found Mr George hanged. The cellmate raised the alarm and officers responded quickly. Staff and paramedics tried unsuccessfully to resuscitate Mr George, who had died.

Findings

6. Mr George had no history of self-harm or attempted suicide at Swansea. When he told staff that he had thoughts of taking his life, they started ACCT suicide and self-harm prevention procedures. While staff demonstrated good practice by enabling him to share a cell with a friend, they did not manage the ACCT procedures effectively. While we recognise that Mr George refused to participate in his ACCT assessment, staff should have used whatever information they had available about him to identify issues affecting Mr George's risk and a manager should have held a multidisciplinary ACCT review within 24 hours of starting ACCT monitoring. Instead, no one reviewed Mr George's risk or discussed how to reduce it. While Mr George's risk of suicide and self-harm was monitored, staff observed him at predictable hourly intervals.

7. Mr George tested positive for a number of illicit drugs when he arrived at Swansea. Nurses gave him medication to help with any withdrawal symptoms. Healthcare Inspectorate Wales concluded that the care Mr George received for opiate detoxification was not equivalent to that he would have received in the community as he would most likely have had access to opiate medication for withdrawal or stabilisation.

8. While it was a brief delay and is unlikely to have changed the outcome for Mr George, the control room did not call an ambulance as soon as they received the emergency medical code.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
    - ACCT assessors use all other available information to complete assessments, when a prisoner does not engage in the assessment process.
    - ACCT observations are made at irregular intervals.
    - A multi-disciplinary case review is held within 24 hours of an ACCT plan being opened.
    - All staff in contact with prisoners have training in suicide and self-harm prevention procedures with appropriate refresher training.
- The Chief Executive of the National Offender Management Service and the Director General for Health and Social Services/the Chief Executive of NHS Wales should ensure prisoners in Welsh prisons have access to effective drug detoxification treatment from their first night in custody.
- The Governor should ensure that control room staff call an ambulance immediately they receive a medical emergency code.

The Investigation Process

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

10. The investigator visited Swansea on 14 April 2016. He obtained copies of relevant extracts from Mr George's prison and medical records.

11. Healthcare Inspectorate Wales commissioned a clinical reviewer to review Mr George's clinical care at the prison.

12. The investigator interviewed fifteen members of staff and one prisoner at Swansea in May and June 2016. The clinical reviewer joined him for some staff interviews.

13. We informed HM Coroner for Swansea and Neath Port of the investigation. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr George's family to explain the investigation. Mr George's mother was concerned about the way Swansea managed Mr George's drug withdrawal and monitored his risk of suicide and self-harm.

15. Mr George's family received a copy of the initial report. They raised a number of issues which we have responded to in separate correspondence.

Background Information

HMP Swansea

16. HMP Swansea is a local prison serving the courts in the South Wales area. It holds up to 450 sentenced or remanded men. At the time of Mr George's death, Abertawe Bro Morgannwg University (ABMU) Health Board provided healthcare at Swansea and were jointly responsible for healthcare provision with the Governor. From 1 July 2016, ABMU Health Board became solely responsible for providing healthcare services at Swansea.

Drug detoxification treatment in Welsh prisons and at HMP Swansea

17. HM Inspectorate of Prisons said in their thematic review of the 'Changing patterns of substance misuse in adult prisons and service responses' (December 2015) that, unlike in English prisons, an integrated drug treatment system (IDTS), which aims to give prisoners dependent on drugs access to the same quality of treatment as those in the community, is not available in Welsh prisons. Inspectors found that prisoners in Welsh prisons who were dependent on illicit opiates did not receive first night opiate substitution treatment but were generally offered symptom relief only, which increased the risk of physical and mental distress in prison. They said that new prisoners arriving in Welsh prisons with existing prescriptions for opiate substitution continued their treatment in prison. Inspectors noted that many Welsh prisoners were held in English prisons and received IDTS treatment which would not be available if they moved to Welsh prisons.

18. The IDTS programme used in English prisons allows prisoners to receive opiate substitutes (methadone or buprenorphine) for drug maintenance and withdrawal from the day they arrive in prison, depending on their situation and needs. Welsh prisons by contrast offer a withdrawal programme using non-opiate symptom relief and psychosocial or other clinical support. It is only after they have detoxified (which typically takes five to seven days) that the healthcare team and GP will decide whether or not prisoners should be prescribed opiate substitute treatment.

19. Swansea does not have a detoxification unit but there are crisis beds for acute episodes of drug withdrawal or illness. Staff identify prisoners with substance misuse issues at an initial reception health screen. Swansea's policy on 'Clinical Services for Substance Misuse' lists criteria and prescribing options for opiate detoxification and opiate maintenance treatment for prisoners on remand and sentenced prisoners. For sentenced prisoners, Swansea will consider whether to support a process of detoxification for those prisoners who have been 'maintained on a regime', and the prison will consider factors such as the length of the prisoner's sentence; his physical and mental health; a positive urine screen on reception into prison; and a willingness to attend psychosocial support in addition to taking prescribed medication. Swansea's policy says they will give prisoners opiate detoxification if they test positive for opiates; demonstrate a clinical dependence on opiates; are motivated to comply with the detox care plan;

and are willing to attend psychosocial support as well taking prescribed medication. Swansea's policy says that sentenced prisoners can start the detoxification process when they arrive in prison, but that maintenance can continue if the prisoner's sentence is considered too short to safely detoxify and they will receive community care on release or if the prison healthcare team and the community agency consider that it is appropriate for the prisoner to continue with a maintenance programme.

HM Inspectorate of Prisons (HMIP)

20. The most recent inspection of HMP Swansea was in October 2014. Inspectors found that the prison was a reasonably safe place, with good reception arrangements, but reported that first night induction was sometimes rushed. A high proportion of prisoners felt safe on their first night and there were enhanced checks for new arrivals.

21. Inspectors reported that incidents of self-harm were low for a local prison, but that there had been a number of serious incidents of self-harm among new prisoners. Inspectors reported that the quality of ACCT documents, used to manage those prisoners considered at risk of suicide or self-harm, was poor. They reported that initial assessment interviews did not always take place within 24 hours, caremaps did not reflect prisoners' needs and staff entries in ACCT records did not demonstrate a good level of care. Prisoners monitored under ACCT suicide and self-harm prevention procedures were positive about the support they had received from staff. Inspectors reported that Swansea had not acted on the learning points from previous Prisons and Probation Ombudsman investigation reports.

22. Inspectors noted that Swansea faced challenges in dealing with illicit drugs. They reported that prisoners used illicit opiate drugs in addition to the non-opiate symptom relief they received from Swansea in their early days in custody to reduce the effects of drug withdrawal. Inspectors recommended that all new prisoners at Swansea, who tested positive for opiates, should receive clinical stabilisation in line with the specific guidance (*Clinical Management of Drug Dependence in the Adult Prison Setting* 2006, p14) from their first night to reduce the risk of self-harm, suicide and overdose, and to give clinicians time to discuss future treatment options.

Independent Monitoring Board

23. 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 May 2015, the IMB reported that a considerable number of prisoners arrive at Swansea with drug issues and that a new initiative had enabled new arrivals to receive symptom relief medication for detoxification issues on arrival. The IMB also reported that the way staff operated ACCT procedures continued to be a concern.

Previous deaths at HMP Swansea

24. Mr George was the sixth prisoner to take his life at Swansea since 2010. All six prisoners died within their first week in prison but there are no other significant

similarities between the circumstances of the deaths. Despite this, in the three deaths before Mr George's death, we made recommendations to Swansea about the quality of their ACCT records and the delay in calling an emergency code.

25. We made a recommendation to the National Offender Management Service in our final report into a death in September 2010 about bringing the arrangements in Welsh prisons to treat prisoners withdrawing from drugs in line with English prisons. It is unclear what progress has been made in addressing this recommendation.

Assessment, Care in Custody and Teamwork

26. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process 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 case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

27. Mr Dean George had been to prison many times since 1993 for minor offences, and had served sentences at HMP Swansea. No one had identified him as at risk of suicide or self-harm in prison or in the community.

28. From April 2012 to January 2014, Mr George had seen community drug services, and had been prescribed methadone to reduce his risk of drug misuse. From January 2014, Mr George had no contact with community drug services.

29. On 31 January 2016, South Wales Police arrested and charged Mr George with theft. On 8 April, Mr George arrived at HMP Swansea having been sentenced to eight weeks in prison for not complying with the terms of his post-release supervision and a previous suspended sentence.

30. Mr George's escort record noted a previous history of violence, depression and anxiety. An officer interviewed Mr George and completed a cell sharing risk assessment for him. A Supervising Officer (SO) told Mr George it had been a long time since he was last in Swansea. He said Mr George appeared calm and not under the influence of drugs.

31. As Mr George had said he was racist and homophobic, the duty governor authorised him to share a cell with a prisoner of the same ethnicity and sexuality. An officer completed a first night immediate risk assessment, and Mr George said he had no thoughts of suicide or self-harm.

32. At an initial health screen, a nurse assessed Mr George, who tested positive for a number of illicit drugs including benzodiazepines, cocaine, amphetamines and opiates. The nurse noted that Mr George had mild symptoms of opiate withdrawal, including sweating, large pupils and, tremors. She gave Mr George symptomatic relief for his drug detoxification. Swansea has a no smoking policy, and the nurse gave Mr George nicotine patches to alleviate his nicotine withdrawal symptoms. The nurse noted that Mr George displayed no signs of irritability or anxiety, was not receiving treatment for any mental health issues, had no thoughts of suicide or self-harm or concerns about his physical health.

33. An officer and an Insider (a prisoner who gives advice to prisoners) spoke to Mr George in the first night and induction wing. The officer explained the support available to prisoners and recorded that Mr George had been in Swansea before. The officer gave him an e-cigarette and noted that Mr George did not want a telephone PIN number or to make a telephone call. Mr George told the officer that he had no thoughts of suicide or self-harm, was tired and wanted to sleep. Another officer gave Mr George a single cell. An officer checked on Mr George several times, and Mr George asked him for a second e-cigarette, but did not say he had any withdrawal symptoms. The officer told Mr George he could not issue any more e-cigarettes.

34. At 5.33am on 9 April, a nurse recorded in Mr George's medical record that there were no concerns about him that night and he appeared settled. There was no evidence to indicate acute withdrawal symptoms in the clinical notes.

35. At 9.00am, a prison GP assessed Mr George. The GP approved the standard medication prescribed under the Swansea's policy for drug withdrawal and made plans for intervention and support from the prison's substance misuse nurses. (Healthcare Inspectorate Wales said that the aim of the drug regime was to alleviate the symptoms of withdrawal and included nicotine patches but not substitute medication licensed for the treatment of opiate withdrawal.) A healthcare manager assessed Mr George after he saw the GP. She recorded that Mr George was receiving symptom relief for drug detoxification treatment, had had no previous contact with mental health services, and denied thoughts of self-harm.

36. While in the healthcare waiting room, Mr George was assaulted by two other prisoners, who believed that he had tobacco concealed on him. An officer intervened to break up the fight. A nurse treated Mr George for bruising to his cheek and noted that he refused to have an X-ray or any other treatment. Officers took Mr George back to the first night and induction wing. (Healthcare Inspectorate Wales' clinical review says that Mr George did not ask for any substitute opiate medication as he already knew what medication was on offer at Swansea.)

37. A SO searched Mr George when he returned to the first night and induction wing but found nothing on Mr George. He said Mr George was aggressive and abusive during the search and denied having tobacco or drugs on him. He said he did not think Mr George was under the influence of drugs but was in the withdrawal process. When he told Mr George he would be moved to A wing, he initially refused, but later agreed.

38. Later that morning, when the SO interviewed Mr George for a probation assessment, he said Mr George was cooperative but subdued. Mr George had told him that he had tried to hang himself a few weeks earlier and had thought about killing himself. He told the officer he had nothing to live for. At 11.15am, the SO began ACCT suicide and self-harm prevention procedures. He told the investigator he had known Mr George for a long time, and that his low mood and comments about self-harming were out of character for him. He noted in the ACCT immediate action plan that Mr George was to share a cell, was to be checked once an hour until the ACCT review had been completed, and was aware how to access the Samaritans phone and Listeners.

39. Officers checked Mr George once an hour regularly and put him in a cell with a friend he had known for many years in the community. At 12.15pm, an officer noted Mr George was talking to his cellmate, had not collected his lunch, took his medication but had declined to exercise outside.

40. Between 3.00pm and 3.30pm, an officer, a trained ACCT assessor, asked Mr George to take part in the ACCT assessment interview in the office. (He said he could not remember who had asked him to do the assessment.) He had not met Mr George before and said Mr George refused to take part, saying he could not be bothered. He remained in his bed, lying under his blanket. He explained to Mr George the importance of carrying out the assessment interview and told the supervising officer on duty but could not recall who this was.

41. At 3.45pm, a SO noted in the ACCT that it might be better for Mr George's ACCT review to take place the following morning when Mr George might feel better. The SO noted that a nurse had told him Mr George was being supported and was taking his detoxification medication.

42. The cellmate told the investigator that Mr George was feeling low, and did not know if it was because of the fight in healthcare or because he was back in prison. He said Mr George asked him to tell officers he wanted them to stop monitoring him under suicide and self-harm prevention procedures. He said he could not recall which officers they spoke to. He said Mr George was restless, would not move from his bed, was snappy and complained of stomach cramps. He told the investigator he thought Mr George was withdrawing from drugs, and possibly also from smoking, and was not getting any medication for his detoxification. He said Mr George asked a nurse for medication, but could not recall who or when this was.

43. The cellmate told the investigator that he tried to help Mr George by asking other prisoners on the wing for subutex, a prescription drug used as a substitute for heroin, and was able to obtain some. He said that Mr George ate some food that evening, and after taking the subutex, felt a little better.

44. At 3.45pm, an officer noted in the ACCT record that Mr George came out of his cell to collect his food and medication. Although there is no record to indicate that staff checked Mr George between 4.30pm and 6.00pm, they checked him once an hour throughout the night, on the hour until the morning.

45. The cellmate said Mr George was cheerful and well liked, but kept things to himself and did not talk about his emotions. He said that Mr George never talked about harming himself. He said if he had known what Mr George had planned, he would have stopped him taking his life.

46. On 10 April, at 5.38am, a nurse recorded no concerns about Mr George that night and he appeared settled. At 7.15am, an officer noted in Mr George's ACCT record that he was watching television, had asked for the time and said he was okay.

47. An officer said staff discussed Mr George at their morning briefing. At 9.00am, the officer unlocked Mr George so he could collect his medication. He noted that Mr George appeared settled and said he was okay, but told the investigator he had minimal contact with him. At 11.00am, the officer noted that Mr George was asleep on his bed. At 12.00pm, the officer noted that Mr George was on his bed, lying under his blanket and had refused to collect his food or speak to his cellmate or him.

48. The cellmate said that Mr George stayed in his bed that morning, was snappy and asked how he could get out of Swansea and go to Cardiff. He said Mr George said he wanted a cigarette, but that he had not suspected Mr George would try to take his life.

49. SO 1 said that when he arrived for work at about 1.30pm, SO 2, who was managing A Wing, told him that Mr George had not had his ACCT review as he had refused to talk to staff. He said she told him that he might be asked to carry

out the review. He said he told her, and later another SO, that he could not do the ACCT review because he had opened the ACCT the previous day and had been told that Mr George had refused to engage with the ACCT assessor anyway. He said he spoke to an officer, the ACCT assessor on duty that day, who said he would try to engage with Mr George later. The officer said another officer asked Mr George if he wanted to take part in the assessment. Mr George refused to speak to the officer.

50. At 1.00pm, an officer noted in the ACCT record that Mr George was lying on his bed awake and that at 1.45pm, he again declined to exercise outside. SO 1 asked the officer to ask Mr George if he would take part in an ACCT review. At 1.50pm, the officer asked Mr George if he would take part in the first ACCT review. Mr George told the officer he would not, saying all he wanted was to go to HMP Cardiff. Mr George refused to participate in any other conversation. The officer said he told the SO, but could not recall the detail of their conversation.

51. The cellmate told the investigator that he encouraged Mr George to get out of bed, exercise and have a shower, and offered to go with him to see if they could get some more subutex from other prisoners on the wing. At 2.50pm, two officers began unlocking cells on the wing for association. Officer A unlocked Mr George's cell to allow him and his cellmate to socialise with the other prisoners and returned a couple of minutes later to lock their cell door. The officer saw that Mr George had not left the cell and asked him if he was coming out for the association period. He said Mr George was lying in bed with the sheet up to his shoulders. Mr George told the officer he was okay but would not come out. He said that he had no reason to be concerned when he spoke to Mr George, and he locked the cell door. He said it was not unusual for prisoners to stay in their cells during the association period. This was most likely the last time that anyone saw Mr George alive. The cellmate said he left the cell to shower and the officer said the cellmate had left the cell when he went back to lock it.

52. At 3.00pm, Officer B recorded in the ACCT record that Mr George was unlocked for the association period. He said that when he made the entry in the ACCT record, he was unaware that Mr George had not come out of his cell for association.

53. At 3.55pm, the cellmate returned to his cell. Through the observation panel he saw Mr George hanged in the cell. He shouted to Officer B, who was unlocking cells nearby, to help him quickly.

54. Officer B alerted other officers by blowing his whistle as he was not carrying a radio. Realising that something was wrong, an officer pressed the general alarm at 3.56pm. An officer, who was working in the control room, radioed the location of the general alarm to all staff. A custodial manager called an emergency code blue at 3.57pm. (A code blue indicates that a prisoner is unconscious or not breathing.)

55. When he arrived at the cell, Officer B looked through the observation panel and saw Mr George hanging. The officer unlocked the cell door and went in, followed by the cellmate. He discovered that Mr George had hanged himself from the window bars with a ligature made of bedding. He and the cellmate took the weight of Mr George's body. Two more officers also responded to the alarm and

went into the cell soon after Officer B. Officer A helped support Mr George while the other officer cut the ligature and removed if from around Mr George's neck. The officers lay Mr George on the cell floor. Unable to find a pulse or other signs of life, the officers immediately tried to resuscitate Mr George.

56. At 3.56pm, a nurse, who was nearby on the wing, heard the general alarm. He went to Mr George's cell and realised that the emergency was a code blue, life-threatening situation. At 3.58pm, he radioed his colleague to bring the emergency response bag, defibrillator and oxygen. His colleague arrived quickly and checked for signs of life, but there were none. He asked a custodial manager to call an ambulance immediately. At 3.59pm, the custodial manager radioed the control room asking again for an ambulance. The incident report log notes that the ambulance was called at 4.00pm. The nurse attached the defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) but it found no shockable heart rhythm. The nurses and an officer kept trying to resuscitate Mr George.

57. At 4.20pm, paramedics arrived at Mr George's cell, and continued trying unsuccessfully to resuscitate him but recorded at 4.34pm that Mr George had died.

Contact with Mr George's family

58. Mr George had named his partner, who lived in Port Talbot, as his next of kin. At 7.00pm, staff broke the news of Mr George's death. Shortly afterwards, they broke the news of Mr George's death to his mother, who lived nearby. The prison offered to contribute to the cost of Mr George's funeral in line with national policy.

Support for prisoners and staff

59. Managers debriefed the staff involved in the emergency response and offered support. Staff notified prisoners of Mr George's death, and offered them support. Officers reviewed prisoners assessed as at risk of suicide and self-harm in case the news of Mr George's death had affected them. The cellmate said prison staff had supported him well after the incident.

Post-mortem report

60. The post-mortem report gave the cause of death as hanging. Toxicology tests showed that Mr George had opiates, benzodiazepines and cannabinoids in his bloodstream at the time he died. Therapeutic levels of promethazine/promazine, quinine and diazepam were detected, and toxicology tests showed that Mr George had taken a number of drugs including cannabis and amphetamine at some point before his death.

Findings

Assessment of risk of suicide and self-harm

61. PSI 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff in contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff in reception at Swansea should have recognised Mr George as at risk of suicide earlier and started ACCT monitoring when he arrived at the prison.

62. The PSI lists a number of risk factors and potential triggers for suicide and self-harm. These include early days in custody, previous self-harm, substance misuse and mental illness. Staff in reception should assess new prisoners' risk of suicide and self-harm and be alert to any increased risk, and address any concerns, including opening an ACCT if necessary.

63. Mr George arrived with some risk factors: his escort record noted he had depression, anxiety and was withdrawing from drugs. However, he had no history of self-harm and had been in Swansea several times before. When Mr George arrived at prison, he told two officers and a nurse, who interviewed him in reception and on the first night and induction wing, that he had no thoughts of suicide or self-harm. The nurse noted that Mr George displayed no signs of anxiety and all three members of staff considered that he was not at risk. We are satisfied that staff considered his risk and it was reasonable for them to conclude that Mr George did not need to be monitored under ACCT procedures when he arrived.

Management of suicide and self-harm procedures

64. Mr George had been at Swansea before and he had never been considered at risk of suicide or self-harm in prison until 9 April 2016 when an officer began ACCT monitoring after Mr George said he had thoughts about taking his life. We have identified a number of deficiencies in the way staff operated ACCT procedures in the short time before Mr George's death.

65. PSI 64/2011 says that if a prisoner refuses to participate in an ACCT assessment, the assessor must carry out the assessment based on all available information about their risks. An officer told the investigator that he was not aware that an ACCT assessment could take place without Mr George being present and the officer who opened the ACCT, believed this prevented him from chairing an ACCT review. The PSI says that a case manager should hold a multi-disciplinary first ACCT case review within 24 hours of an ACCT plan being opened, ideally immediately after the assessment interview.

66. While we were unable to interview the supervising officer responsible for A wing on 10 April and cannot therefore establish the reasons why officers did not follow ACCT procedures, what we do know is that a manager did not ensure that the ACCT assessment and review took place within 24 hours of Mr George being identified as at risk of suicide and self-harm. This was a significant failure which meant Mr George's risk was never assessed or reviewed before he died. The

failure to assess or review Mr George meant that there was no effective interaction or discussion to identify his needs that day, but only hourly checks and the occasional brief interaction with officers going about their duties.

67. Staff set no caremap actions to reduce Mr George's risk and no one reviewed the frequency of his observations, which remained at one an hour. Contrary to the instructions in the PSI, the checks were conducted and recorded at regular hourly intervals which would have allowed Mr George to predict when the next check would be, and in the absence of his cellmate, to take his life.

68. While we acknowledge that, had an assessment and review taken place, it is unlikely to have prevented Mr George's death because staff would most likely not have increased the number of times they monitored him, ACCT procedures were poorly managed. We, therefore, 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 that:

- **ACCT assessors use all other available information to complete assessments when a prisoner does not engage in the assessment process.**
- **ACCT observations are made at irregular intervals**
- **A multi-disciplinary case review is held within 24 hours of an ACCT plan being opened**
- **All staff in contact with prisoners have training in suicide and self-harm prevention procedures with appropriate refresher training.**

Substance withdrawal and detoxification

69. While we do not link Mr George's substance withdrawal treatment to his death, Healthcare Inspectorate Wales' clinical review concluded that his withdrawal treatment was not equivalent to that he would have received in the community, where he would have had access to an opiate substitute treatment. We note, in addition, the actions he reportedly took to secure and take illicit drugs, in the absence of opiate substitutes.

70. When Mr George arrived at Swansea, he tested positive for a number of illicit drugs including opiates. In line with Swansea's policy, he was offered symptom relief for his addiction, which he accepted. Because of his familiarity with substance misuse services, Mr George would have been familiar with opiate-based treatments for drug maintenance and withdrawal. On his second day at Swansea, Mr George might have obtained from other prisoners subutex, an opiate substitute. Although Mr George took all of his medication on 9 April, he only took the diazepam element the next day, which suggests that his withdrawal symptoms might have subsided after he obtained subutex. The toxicology results were not conclusive about the drugs Mr George took in the days before his death.

71. In their clinical review, Healthcare Inspectorate Wales noted anecdotal evidence from staff and Mr George's cellmate that non-prescribed medication and illegal drugs were freely available at Swansea and that prisoners might self- medicate in the absence of opiate substitutes. This reflected HMIP's findings in their 2015 thematic report into substance misuse. They noted that diverted medication was popular among prisoners who felt they could not obtain a prescription for medication which mimicked the effects of illegal drugs. Mr George's reported actions are consistent with this analysis.

72. HMIP concluded that the lack of an integrated drug treatment system in Wales led to poorer outcomes for some prisoners and created inconsistency in substance misuse treatment between prisons in England and Wales. HMIP said that the drug treatment system in prison needed to be the same across the prison estate and equivalent to that in the community. This inequality has been highlighted in previous reviews and reports from the IMB, recent HMIP inspection and in the Thematic Report by HMIP, 'Changing patterns of substance misuse in adult prisons and service responses'. In that report, HMIP made a recommendation to the Welsh Assembly, Ministers and the National Offender Management Service that prisoners in England and Wales should have consistent access to equivalent substance misuse treatment.

73. In their clinical review, Healthcare Inspectorate Wales concluded that the treatments Swansea offered Mr George for opiate detoxification were not equivalent to the treatments he would have been able to access in the community. Healthcare Inspectorate Wales said that prisoners' treatment options for substance misuse were limited by the current practice within Wales, and Mr George did not receive medication to reduce his withdrawal symptoms effectively.

74. Healthcare Inspectorate Wales noted that there was no evidence that Swansea completed a full assessment of the substance misuse by prisoners or their mental health needs in their early days of custody or recorded a care plan appropriately. Although there was a policy for treating prisoners who misused substances, this did not give clear guidance on the options available to prescribers or provide pathways for specific groups of prisoners such as those withdrawing from alcohol, opiates or new psychoactive substances. Health Inspectorate Wales made a number of recommendations, which the Governor and Head of Healthcare need to address. We make the following recommendation:

The Chief Executive of the National Offender Management Service and the Director General for Health and Social Services/the Chief Executive of NHS Wales should ensure prisoners in Welsh prisons have access to effective drug detoxification treatment from their first night in custody.

Emergency response

75. PSI 03/2013 on Medical Emergency Response Codes requires staff to use a code blue or equivalent code in a medical emergency and for the control room to call an ambulance immediately an emergency code is used. The PSI is clear that prisons should not wait for healthcare staff or a duty manager to decide

whether an ambulance is needed and that an ambulance can be cancelled later if not needed.

76. Despite the custodial manager first calling a medical emergency code blue at 3.57pm, the control room did not call an ambulance until 4.00pm after the nurse had examined Mr George. The control room operator said that when staff called an emergency code red or blue, Swansea did not automatically call an ambulance. A healthcare manager and other staff confirmed that Swansea only called an ambulance after a member of nursing staff had attended the emergency and assessed the situation. While in this case, there was a delay of two minutes which would probably not have changed the outcome for Mr George, in other emergencies, any delay could be critical. We make the following recommendation:

The Governor should ensure that control room staff call an ambulance immediately they receive a medical emergency code.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141