Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Weeks a prisoner at HMP Cardiff on 21 October 2017

A report by the Prisons and Probation Ombudsman

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.

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

Mr Ian Weeks was found hanged in his cell at HMP Cardiff on 21 October 2017. He was 34 years old. I offer my condolences to his family and friends.

Mr Weeks was familiar with prison life and, despite his history of self-harm during previous periods in prison, we are satisfied that there were no indications that he was at risk of suicide at Cardiff, including in the days leading up to his death.

However, there is no record of any meaningful contact between Mr Weeks and staff at Cardiff and the prison does not have a personal officer scheme. If staff had interacted more with Mr Weeks, they might have been able to identify and address any concerns that he might have had and might have identified that he was at risk of suicide or self-harm.

Psychoactive substances were detected in Mr Weeks' system when he died. It is possible that they might have played a role in his death.

I am concerned that there was a delay before the officers who found Mr Weeks went into his cell to assist him.

I am also concerned that nursing staff inappropriately tried to resuscitate Mr Weeks when there were clear signs that he was dead, especially as Cardiff agreed to implement our previous recommendation about ensuring that staff understand the circumstances when resuscitation is appropriate.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **August 2018**

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Summary

Events

1. On 7 August 2017, Mr Ian Weeks was remanded to HMP Cardiff after he broke his bail conditions. It was not his first time in prison. Mr Weeks had self-harmed during three previous periods in prison.

2. At his initial health screen, healthcare staff noted that Mr Weeks had not been diagnosed with any mental health issues and that he had denied any thoughts of suicide or self-harm. Over the following weeks, he appears to have settled at Cardiff. For the most part he interacted with staff appropriately, and raised no issues or concerns. However, there was some intelligence to suggest that he was involved in the prison drug culture.

3. At around 6.15am on 21 October, officers found Mr Weeks hanged in his cell. There was a delay before they went into his cell. Although Mr Weeks showed no signs of life, healthcare staff tried to resuscitate him until paramedics arrived and pronounced him dead.

4. A toxicology examination found traces of psychoactive substances in Mr Weeks' bloodstream when he died.

Findings

5. Mr Weeks was familiar with prison life and kept to himself. We found no evidence to indicate to staff that Mr Weeks was at risk of suicide and we do not consider that staff could reasonably have predicted his actions. However, there is no evidence that staff interacted with him in a meaningful way which might have done more to elicit information about his risk.

6. There was a delay of over two minutes before the officers who found him unlocked his cell and went in.

7. Although Mr Weeks showed no signs of life, healthcare staff tried to resuscitate him, contrary to national guidelines.

8. Traces of new psychoactive substances were detected in Mr Weeks' bloodstream after his death and we cannot exclude the possibility that they might have played a part in him taking his life.

Recommendations

- The Governor should ensure that officers have meaningful contact with prisoners during their first weeks in custody, including one-to-one conversations that allow them to get to know prisoners and identify their needs.
- The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency in order to help preserve the life of a prisoner.

- The Governor should ensure that there is an effective and joined-up strategy to reduce the supply of and demand for illicit substances, and that staff remain alert for signs of their use.
- The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts form Mr Weeks' prison and medical records.

11. Health Inspectorate Wales (HIW) carried out a review of Mr Weeks' clinical care at the prison.

12. The investigator interviewed eleven members of staff and one prisoner, some jointly with a representative from HIW.

13. We informed HM Coroner for Bridgend and Glamorgan Valleys District and have sent him a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Week' family to explain the investigation. They did not have any specific questions. Mr Weeks' family received a copy of the initial report. They did not make any comments.

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 NHS 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 December 2016. Inspectors reported that despite staff shortages, staff prisoner relationships had been maintained and described the prison as stable during challenging times. Inspectors reported that although incidents of self-harm had increased since their last inspection, prisoners in crisis were well-supported and the quality of self-harm monitoring procedures was good.

Independent Monitoring Board

17. 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 ending August 2016, the IMB said that staff at Cardiff maintained positive relationships with prisoners but that staff shortages restricted the prison's regime.

Previous deaths at HMP Cardiff

18. There have been four other self-inflicted deaths at HMP Cardiff since 2013. In our investigation report into a death in September 2013, we recommended that staff should be aware of the circumstances in which resuscitation is inappropriate. Cardiff accepted this recommendation.

Assessment, Care in Custody and Teamwork

19. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Psychoactive substances

20. Psychoactive substances, previously known as 'legal highs' (although they are now illegal), are an increasing problem across prisons. They are difficult to detect and can affect people in a number of ways. Individuals under the influence of psychoactive substances can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. There is also potential for them to precipitate and exacerbate the deterioration of mental health with links to suicide and self-harm.

21. In July 2015, we published a Learning Lessons Bulletin about the use of psychoactive substances and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of psychoactive substances; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

22. HM Prisons and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of psychoactive substances are included in the testing process.

Key Events

23. Mr Ian Weeks had many previous convictions since 2001 for theft, the possession of drugs and offensive weapons, and offences against property and the person. He had been to prison many times. During his previous sentences from 2001 to August 2016, Mr Weeks never expressed any suicidal thoughts, or indicated that he had mental health issues and he was not treated by prison mental health services.

24. On 6 August 2016, when he was at HMP Winchester, Mr Weeks told staff that he had taken an overdose of paracetamol. He later made cuts to his arm as he was upset that he had not been taken to hospital. He was taken to hospital to treat his cuts; paracetamol levels in Mr Weeks' blood indicated a raised (but not harmful) level. Staff monitored Mr Weeks under suicide and self-harm procedures, known as ACCT. Despite their efforts, Mr Weeks refused to engage with the prison's mental health team, and he told them that he was not feeling suicidal.

25. On 5 February 2017, Mr Weeks made cuts to his arm and a ligature was found in his cell which he had put around his neck. Staff monitored him under ACCT procedures. A note of intent was also found in his cell. It said that he had ruined his family's lives. ACCT monitoring stopped on 15 February but started again on 21 February after Mr Weeks cut his wrist and told staff that he was scared for his safety after incurring a drug debt. The ACCT was closed on 7 March. On 24 April, Mr Weeks was released from prison.

26. On 24 July, Mr Weeks was arrested for possession of a weapon and the attempted assault of and criminal damage against his father. On 2 August, he was bailed.

27. On 7 August, Mr Weeks broke his bail conditions. The police were called and Mr Weeks was arrested. On 8 August, he was remanded to HMP Cardiff.

28. At an initial health screen, a healthcare assistant assessed Mr Weeks. He noted that Mr Weeks had no thoughts of suicide or self-harm, that he had not previously harmed himself in prison (which was incorrect) and that he had not received treatment from prison mental health teams. He noted no concerns about Mr Weeks' physical health. (No warnings or concerns about Mr Weeks' state of mind or mental health were noted on the paperwork that accompanied him from court.)

29. An officer interviewed Mr Weeks and completed a first night in custody booklet, as was standard practice. The booklet included a suicide and self-harm screening tool which the officer completed. Mr Weeks told the officer that he had last been released from prison in April, and had been charged with the assault of his father. He said that his family were not aware that he was in prison. Mr Weeks said that he had no thoughts of suicide or self-harm. Because he had taken a hostage during a previous sentence, Mr Weeks was considered a high risk to other prisoners and was given a single cell. The officer made arrangements for Mr Weeks to speak to his girlfriend, who was his next of kin, by telephone. Mr Weeks signed a disclaimer which said that he did not want a prison induction as he was fully aware of prison regimes.

30. On 9 August, at a second healthcare assessment, Mr Weeks told a nurse that he understood prison procedures and the health services available to him. He said that he had no mental health issues and denied any thoughts of suicide or self-harm. She noted "minor concerns" about Mr Weeks' previous incidents of an overdose and of self-harm.

31. On 11 August, Mr Weeks' offender supervisor told him that he was subject to a restraining order and that he was not to have any contact with his father. Mr Weeks raised no concerns or issues with him.

32. Over the following weeks Mr Weeks, for the most part, caused few concerns and was compliant with the prison's regime. However, on 25 August, intelligence noted that letters written by him explained to visitors how to smuggle drugs and phones into the prison. On 13 September, further intelligence suggested that Mr Weeks had damaged his cell window in order to receive drugs.

33. On 13 October, Mr Weeks was asked to provide a urine sample for a standard drug test. He refused to do so and was charged with disobeying a lawful order. The matter was referred to the prison's independent adjudicator for a disciplinary hearing, which was to have taken place on 26 October.

34. After Mr Weeks' death, an officer from the wing on which Mr Weeks lived told the investigator that Mr Weeks did not interact much with staff, but did with other prisoners, with whom he had made friends. The officer said that he saw no evidence that Mr Weeks was being bullied, and he added that Mr Weeks was confident in handling himself and caused no problems for staff. The officer said that the only issue Mr Weeks had raised with him was when he asked for some emergency phone credits, which the officer gave him.

35. Prisoner A, in the cell next to Mr Weeks' cell, told the investigator that he would sometimes share teabags and other things with Mr Weeks. He said that although Mr Weeks appeared to keep to himself, he would often sit in his cell with him and chat. He said that it was clear that Mr Weeks was worried and had been affected by his offence and case. He said that Mr Weeks told him that the whole thing had been "blown up out of all proportion". He said that about a week before his death, Mr Weeks had told him that he would do "something silly", but he said he did not take this seriously as prisoners often made such comments.

36. Prisoner A said that because Mr Weeks was short of money, he believed that he was "making arrangements" with other prisoners so that he could buy things from the prison shop. He said that he did not believe that Mr Weeks was being bullied but had been pushed into trading drugs in the prison due to his money issues. He said that Mr Weeks was not "cut out" for what he was doing and that Mr Weeks had complained to him previously that prisoners had not paid him for drugs that he had given them.

37. In the days leading to his death, Mr Weeks spoke almost daily to his girlfriend, sometimes using another prisoner's telephone account to make the telephone calls. Mr Weeks spoke generally about family issues, his court case and frequently expressed his concerns about the wellbeing of his girlfriend and how he did not want events to upset her.

38. On 20 October, Mr Weeks spoke to his girlfriend at least eleven times. During these final calls, Mr Weeks gave her no indication of the actions that he was later to take but he discussed making a payment to another prisoner and his worries about his charges and court case.

39. Prisoner A said that during the day, Mr Weeks had told him about a conversation that he had had with his girlfriend, in which she told him that she would not leave anything out about his alleged offence, if asked in court. He said that he chatted to Mr Weeks that evening, as he always did, just before being locked up and stated that Mr Weeks appeared more stressed and more worried than he had the night before and did not appear to want to leave his cell. He said that this was the last time he spoke to Mr Weeks.

40. Prisoner A said that because of Mr Weeks' behaviour, Prisoner B, another prisoner on the wing, had asked a member of staff if he could share a cell with Mr Weeks. He said that staff told Prisoner B that he could not do this because Mr Weeks was a high-risk prisoner. Prisoner B later gave the same account to a prison GP after Mr Weeks' death. The investigator was unable to speak to Prisoner B to establish who he had spoken because he had been released from prison. There is no record in Mr Weeks' prison notes that such a conversation took place.

41. At around 6.00pm on 20 October, an officer came on duty. He said that staff did not raise concerns about Mr Weeks during the handover. He said that at around 6.50pm, he carried out his early evening roll check and that Mr Weeks raised no concerns. He handed over to Officer A at around 8.30pm. No concerns were raised about Mr Weeks. Officer A said he checked Mr Weeks' cell when carrying out his roll check. Again, there were no concerns about Mr Weeks. An Operational Support Grade (OSG), who was working with Officer A that evening, said that the wing was quiet during the night and Mr Weeks raised no concerns.

42. At around 6.15am on 21 October, the OSG checked on Mr Weeks during the morning roll check. He looked through the observation panel and, because the cell light was on, he could see Mr Weeks hanging from the cell's privacy curtain rail. He told Officer A, who was close by. Officer A immediately called a medical emergency code blue. (An emergency code blue alerts all staff to a life-threatening situation such as when a prisoner is unconscious or not breathing.) The control room operator called an ambulance.

43. A minute and a half after calling the code blue, Officer A radioed for permission from the night manager to unlock and go into the cell. She radioed back and gave the officer permission to enter the cell if he thought it necessary. (Although she was aware of the code blue, she was not aware at this time that Mr Weeks had hanged himself.)

44. Two and a half minutes after Mr Weeks was found, Officer A unlocked the cell door and went in with the OSG. The OSG took Mr Weeks' weight while the officer cut the ligature, which was made from bed sheets, from around his neck. The officers said that Mr Weeks was stiff, not breathing and that his airway appeared blocked by his swollen tongue. The officers did not start cardiopulmonary resuscitation (CPR), and concluded that Mr Weeks was dead. The officers left the cell and waited for medical assistance.

45. At around 6.21am, a nurse arrived with Officer A, who had left the area earlier to find a face mask, carrying emergency equipment. The nurse checked for signs of life but there were none. She noted that Mr Weeks' tongue was purple and swollen. She instructed the OSG to start CPR. The nurse noted that a blood-stained piece of material was wrapped around Mr Weeks' wrist. She left the cell for a minute to collect the defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) which was on the wing. When she returned, she attached the defibrillator but it found no shockable heart rhythm. A healthcare assistant, who had been relieved from the healthcare unit by an operational support grade, arrived at the cell at around 6.28am. She helped the nurse in her effort to resuscitate Mr Weeks.

46. At about 6.30pm, paramedics arrived and continued resuscitation efforts unsuccessfully. At 6.44am, paramedics pronounced that Mr Weeks had died.

47. Mr Weeks left a note of intent in his cell, addressed to his girlfriend, in which he referred to a number of family issues, expressed feelings of being let down, said he had nothing left and that he was not prepared to stay in prison any longer.

48. Intelligence submitted after Mr Weeks' death noted that Prisoner B had told staff that he believed Mr Weeks had been bullied by other prisoners and that he had been told upsetting news about his partner. Other intelligence noted that prisoners, who were unidentified, had been heard to say that Mr Weeks had taken his life because he was in debt to other prisoners on the wing for drugs, had been let down by another prisoner and had a number of family issues.

Contact with Mr Week's family

49. Mr Weeks named his girlfriend as his next of kin. An officer and the Acting Head of Healthcare were appointed as family liaison officers. They broke the news of Mr Weeks' death later that morning. The prison offered to contribute to the cost of his funeral in line with national policy.

Support for prisoners and staff

50. The duty governor debriefed the staff involved in the emergency response and offered support. Staff notified prisoners of Mr Weeks' death, and offered them support. Officers reviewed prisoners assessed as at risk of suicide and self-harm in case the news of Mr Weeks' death had affected them.

Post-mortem report

51. A post-mortem examination concluded that Mr Weeks died from hanging. A toxicology examination found traces of psychoactive substances in Mr Weeks' bloodstream when he died.

Findings

Assessment of risk of suicide and self-harm

52. PSI 64/2011, which governs ACCT 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. The PSI lists several 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 should continually assess prisoners' risk of suicide and self-harm, be alert to increased risk and address any concerns.

53. We have considered whether staff at Cardiff should have recognised Mr Weeks as at risk of suicide and started ACCT monitoring when he first arrived at Cardiff and over the following weeks he was there. Mr Weeks arrived with some risk factors: his offences were against close family members and he had been remanded in prison for breaching his bail conditions. He was, though, very familiar with prison life and routine. When Mr Weeks arrived at Cardiff, he told the first night officer and healthcare staff that he had no thoughts of suicide or self-harm and the nurse noted his history of self-harm.

54. We are satisfied that staff considered Mr Weeks' risk appropriately when he arrived at Cardiff and that it was reasonable for them to conclude that he did not need to be monitored under ACCT procedures. We found no evidence that staff were aware of any increase in his risk in the weeks and days leading to his death or that they had reason to consider that he was at risk. We are satisfied that it was reasonable for staff to conclude on that basis that Mr Weeks did not pose a risk of suicide or self-harm, which warranted ACCT monitoring.

Personal Officer Scheme

55. We are concerned that there were no significant entries in Mr Weeks' records to indicate that any member of staff had any meaningful interactions or conversations with him. There is no personal officer scheme in operation at Cardiff and no guidance about the expected level of contact that officers should make with prisoners, which results in a reduced level of opportunity for prisoners to have significant one-to-one contact with staff. This is particularly important during a prisoner's first days in custody. We consider that the lack of such contact presents clear risks of a missed opportunities for staff to identify whether Mr Weeks had any issues or concerns which might have led to him being more vulnerable to thoughts of suicide and self-harm.

56. We note that Cardiff will shortly introduce the 'keyworker' scheme, an expectation of which is that wing staff have allocated time with prisoners every week. In the meantime, we make the following recommendation:

The Governor should ensure that officers have meaningful contact with prisoners during their first weeks in custody, including one-to-one conversations that allow them to get to know prisoners and identify their needs.

Entering cells in an emergency

57. Prison Service Instruction (PSI) 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The PSI says that the preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, that cells may be unlocked without the authority of the night manager. It says that an individual member of staff can enter the cell on their own subject to a dynamic risk assessment. Cardiff's local policy reflects the provisions of the PSI.

58. Officer A told the investigator that he had been trained not to go into a cell immediately but to ask for the night manager's permission first. The OSG said that he did not enter the cell as he did not carry keys and his understanding was that permission was needed to enter a cell. This was not in line with local instructions.

59. We recognise that it can be difficult for staff in such circumstances to make instant decisions but when there is a potentially life-threatening situation, it is essential to act quickly and exercise operational judgement. Given that the officers said it was clear that Mr Weeks was hanging, that there were two of them, that Mr Weeks was in a single cell, and that the night manager and other staff and been alerted and were making their way to the cell, the officers should have gone into the cell immediately without first seeking permission to do so. Although the delay in entering Mr Weeks' cell is unlikely to have made any difference to the outcome for him, it could be critical in future cases. We therefore make the following recommendation.

    The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency in order to help preserve the life of a prisoner.

Psychoactive substances

60. We are concerned about the prevalence of psychoactive substances in prisons and their effect on the behaviours and health of those taking them, including an association with suicide and self-harm. In July 2015, we published a Learning Lessons Bulletin about the deaths associated with the use of psychoactive substances. It identified the need for better awareness of the dangers of these substances, the need for an effective drug supply and demand reduction strategy and better monitoring by drug treatment services.

61. Mr Weeks was known to be involved with drugs at Cardiff. While there was no security intelligence to indicate that Mr Weeks had taken illicit substances, and he gave no indication that he was under the influence of an illicit substance before his death, we note that toxicology tests found psychoactive substances in his blood. It is possible that this influenced his decision to take his own life. It is important that Cardiff focuses on the prevalence and dangers of psychoactive substances and does all it can to eradicate their use. We make the following recommendation:

    The Governor should ensure that there is an effective and joined-up

strategy to reduce the supply of and demand for illicit substances, and that staff remain alert for signs of their use.

Resuscitation

62. European Resuscitation Council Guidelines for Resuscitation 2015 which were shared with prison managers in September 2016 say that, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines define examples of futility as including the presence of rigor mortis. The British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 on making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of an individual's situation. These decisions should never be dictated by 'blanket' policies. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.

63. The officers who found Mr Weeks could find no signs of life, believed that he was already dead, and did not start CPR. When the nurse arrived, she also thought that Mr Weeks was already dead but told the officers that they should try to resuscitate Mr Weeks and assisted them in their efforts.

64. During our investigation, staff spoke of their desire to "preserve life" which we and HIW commend. We recognise that making a decision about whether to resuscitate or not is difficult in a distressing and stressful situation. However, we agree with HIW's findings that the attempt to resuscitate Mr Weeks was inappropriate. We agree with HIW that staff need training, guidance and reassurance about the circumstances when it is acceptable not to perform CPR, to minimise the distress for them and lack of dignity for the deceased. We repeat the recommendation that we made to Cardiff in 2013, which the prison agreed to implement at the time:

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

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PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
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