Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Khalid Abiaz a prisoner at HMP Swansea on 13 September 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
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Inclusive: *we value diversity*
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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 Khalid Abiaz arrived in HMP Swansea on 12 September 2016. The following morning, prison staff discovered him hanging in his cell. Staff entered and attempted to resuscitate Mr Abiaz but despite their best efforts he was pronounced dead. He was 40 years old. I offer my condolences to Mr Abiaz's family and friends.

Mr Abiaz had a long history of mental health problems, and although staff who assessed Mr Abiaz did not have access to sufficient information to form a full view of his risk factors, they did have access to the Person Escort Record (PER) which held some important pointers to those factors. With hindsight, I consider that greater weight should have been paid to the information held in the PER which should have been probed further, and less weight placed on the impressions staff formed from Mr Abiaz's initial reactions to being in custody. These were focussed on his immediate needs, not his significant underlying risks.

The emergency response was good but, not for the first time at Swansea, there was confusion in the use of the appropriate medical code which caused a short delay in an ambulance being called.

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 **May 2017**

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Summary

Events

1. On 12 September 2016, Mr Khalid Abiaz was remanded into custody, charged with possession of a bladed article. This was not his first time in custody. Mr Abiaz had a long history of mental health problems, but there was little detailed information available about these when he arrived at Swansea.

2. The person escort record (PER) form that accompanied Mr Abiaz into custody detailed that he had made threats to take his own life and had a history of self harm and violent behaviour. The reception officer who first dealt with Mr Abiaz said that he was immediately confrontational. He made threats about what he would do if he was not provided with tobacco and medication. The officer said that he ensured that Mr Abiaz was seen by the reception nurse, but had no immediate concerns regarding Mr Abiaz's risk to himself.

3. A nurse completed a healthscreen with Mr Abiaz and had access to the PER form. He recorded no immediate physical health issues, but recorded that Mr Abiaz had a history of mental health problems and had previously self-harmed. When asked, Mr Abiaz denied any current thoughts of harming himself. He referred Mr Abiaz to be seen by the GP and for an assessment by the mental health team. He was prescribed diazepam and provided with nicotine patches, as Swansea is a non-smoking prison. Mr Abiaz was said to become much calmer, and staff said that they had no concerns about him when he left the reception area.

4. Mr Abiaz was taken to B wing where an officer asked him about his previous self-harm and whether he had any such thoughts currently, which he denied. He said that Mr Abiaz gave no cause for concern and asked questions regarding prison procedure, which indicated that he was thinking of the future. He located Mr Abiaz in a single cell and said that he appeared settled.

5. On 13 September, at approximately 12:45am, a nurse arrived at the cell occupied by Mr Abiaz. She looked through the observation panel, saw Mr Abiaz at the back of his cell with a bed sheet tied around his neck and immediately raised the alarm using her radio to call a code red medical emergency. Staff responded immediately. When they gained entry to the cell, it was apparent that the medical emergency required a code blue (indicating a prisoner was unconscious or having difficulties breathing) and not code red (indicating bleeding or loss of blood) response. Staff updated the communications officer and an ambulance was requested at 12.59am.

6. Staff started cardiopulmonary resuscitation (CPR) and continued until the arrival of paramedics at 1.10am. Efforts to resuscitate Mr Abiaz continued, but at 1.38am paramedics pronounced him dead.

Findings

Management of risk of suicide and self-harm

7. In addition to the PER, information relevant to Mr Abiaz's risk to himself and others, including his mental health problems, was recorded while he was held in police custody and arrived at Swansea with Mr Abiaz. However, this was not read or considered during his time in reception. Staff were satisfied by Mr Abiaz's assurances that he did not intend to harm himself and by him becoming less agitated when his immediate requests were dealt with. They did not register or respond to the indications of underlying risk, which were present in the documentation and might have become apparent were Mr Abiaz's circumstances and history better understood.

8. Prison Service suicide and self-harm prevention procedures rely on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only a reflection of his state of mind at the time he is seen by the member of staff. Presentation should be considered as a single piece of evidence used to make a judgement of risk. All risk factors and available information should be collated and considered to ensure that a prisoner's level of risk is judged holistically.

Night observations and monitoring

9. Swansea has in place a system whereby all new prisoners, regardless of whether they are detoxifying or identified as a risk, are monitored by nursing staff for the first three nights. This is a positive and welcome process which would benefit from being formalised.

Emergency response

10. On 13 September, staff responded promptly but the wrong emergency code was called. This resulted in a short delay before an ambulance was called. We do not consider that the delay had any adverse impact on the outcome for Mr Abiaz.

Recommendations

- The Governor and Head of Healthcare should ensure that reception staff identify, consider and record all the relevant risk factors and documentation of a newly arrived prisoner when determining their risk of suicide or self-harm.

- The Governor and Head of Healthcare should formalise and publish a policy for the night monitoring of newly-arrived prisoners at HMP Swansea.

- The Governor and Head of Healthcare should re-issue the guidance for staff of emergency medical codes and ensure that all staff are aware of the differences and expectations.

The Investigation Process

11. 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 responses were received.

12. HMP Swansea provided copies of relevant extracts from Mr Abiaz's prison and medical records.

13. Healthcare Inspectorate Wales (HIW) commissioned a review Mr Abiaz's clinical care at the prison.

14. The investigator, along with the appointed clinical reviewer, interviewed six members of staff at Swansea.

15. We informed HM Coroner for Swansea Neath & Port Talbot of the investigation. The Coroner has confirmed the findings of the post mortem and results from toxicology tests. These indicate that the cause of death was compression of the neck through suspension by ligature. Toxicology results indicated no prescribed or illicit drugs in Mr Abiaz's system.

16. Mr Abiaz had no nominated next of kin. Although he had a sister, believed to be living in Yemen, there was no contact information for her.

Background Information

HMP Swansea

17. HMP Swansea is a local prison serving the courts in the South Wales area. It holds up to 450 sentenced or remanded men. From 1 July 2016, ABMU Health Board has been solely responsible for providing healthcare services at Swansea.

HM Inspectorate of Prisons (HMIP)

18. The most recent inspection of HMP Swansea was conducted 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.

19. 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 as being 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.

Independent Monitoring Board

20. 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 2016, the IMB reported that it had previously expressed concern around the processing of ACCT documents. The Board was pleased that increased training along with consistent quality assurance checks was bringing about positive change. They commented that the Safer Custody Team had introduced a Smart Recovery course for men with mental health issues and were developing stronger links with a range of mental health agencies. However, the report said that the Board continued to be concerned about the lack of suitable private interviewing space in the Induction Wing. They said that it was unacceptable for men to be asked personal questions while sitting at a table on the wing landing where other men are milling about.

Previous deaths at HMP Swansea

21. Mr Abiaz was the seventh prisoner to take his life at Swansea since 2010. All seven prisoners died within their first week in prison. In the four deaths before that of Mr Abiaz, we made recommendations to Swansea about delays in calling an emergency code.

Assessment, Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as being 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

Mr Abiaz's background

23. Mr Khalid Abiaz had previously served a two year prison sentence for a violent offence. He had been released from HMP Holme House in 2015 and immediately detained under the Immigration Act and taken to Morton Hall Immigration Removal Centre. While at Morton Hall, Mr Abiaz had received treatment from the mental health team. Mr Abiaz remained at Morton Hall as a detainee until 14 July 2016, when he was released pending a review of his immigration status.

24. After his release from Morton Hall, Mr Abiaz was provided with housing in Erith, London as he was considered vulnerable due to mental health issues. On 29 July, Mr Abiaz's solicitor received a call from Mr Abiaz at 7.30am. After several failed efforts, she called back and spoke to someone who identified himself as a police negotiator who had been trying to get Mr Abiaz to come down from a rooftop since 1.00am. A short while later, the police advised that Mr Abiaz had agreed to come down and would be assessed by paramedics before being taken to hospital.

25. Mr Abiaz was taken to Bexleyheath police station en route to hospital. His solicitor says the police told her that Mr Abiaz had stated that he was out of medication and hearing voices telling him to take his own life. At one point Mr Abiaz wrapped a TV aerial cable around his neck and threatened to jump, and had a 10 inch kitchen knife, with which he had threatened to cut his throat.

26. On 1 August, Mr Abiaz was granted technical bail until 3 October. Police started to interview Mr Abiaz but had to stop as he was not deemed fit. He was transferred under Section 2 of the Mental Health Act at Oxleas House.

27. While at Oxleas House, the forensic psychologist completed an assessment with Mr Abiaz. Mr Abiaz said that in the weeks prior to his immigration detention he had been smoking 'Spice', a new psychoactive substance (NPS) and chewing khat, a banned class C drug. She stated that Mr Abiaz's recent behaviour made him a significant risk to both himself and to others. He had made threats to kill himself and others and she recorded that, in her view, those threats should be taken seriously. It was also her view that this related to the stress caused by his immigration status.

28. On 7 August, Greenwich police told the solicitor that Mr Abiaz had been charged with a public order offence, and remanded to HMP Belmarsh. Mr Abiaz had made threats to kill while at Oxleas House. Mr Abiaz was assessed before going to court on 9 August. The psychiatrist at the court was unable to identify any mental illness and advised that Mr Abiaz register with a GP and continued taking anti-psychotic medication to control his behaviour. Mr Abiaz appeared in court where he pleaded guilty to the charge and was fined. As he had spent a number of days in custody, he was released from court.

29. Mr Abiaz was homeless, and efforts were made to try and find him accommodation. On 11 August, the solicitor contacted Mr Abiaz to inform him that shared accommodation had been found for him in Rochdale. A short while

later she was contacted by British Transport Police. Mr Abiaz had been detained under the Mental Health Act and taken to hospital after threatening to jump in front of a train at a station.

30. On 17 August, Mr Abiaz was discharged from hospital, as doctors considered that he did not require hospitalisation. Staff from the Immigration Enforcement collected Mr Abiaz that morning and conveyed him to the address in Rochdale. On 23 August, Mr Abiaz was detained again under the Mental Health Act after barricading himself in at the address in Rochdale and threatening to take his own life. Again Mr Abiaz said that he was hearing voices and had run out of his medication. Mr Abiaz was discharged again from hospital on 26 August and was again homeless. On 31 August, Mr Abiaz contacted his solicitor and told her that he was travelling to Cardiff.

31. On 7 September, Mr Abiaz was asked to leave the address where he was staying in Cardiff and became homeless again. His solicitor referred Mr Abiaz to the City Council, but was told that as there were mental health issues she would need to contact the community mental health team and submit a referral, which she did. She was told that there was little that could be done and advised that Mr Abiaz could contact the homelessness team at the council and attend hospital the following morning.

32. On 8 September, Mr Abiaz attended a local clinic to obtain medication but staff told him that they were unable to provide this. Mr Abiaz produced a knife and made threats to harm himself. Police detained Mr Abiaz under section 136 of the Mental Health Act and escorted him to hospital where he was assessed and the decision taken that he did not meet the requirements for sectioning under the Act. Mr Abiaz was taken to the police station, but released without charge in error.

33. Mr Abiaz was re-arrested on 10 September. When interviewed, he accepted that he had a bladed article which he had been holding to his throat. He told police that he had been hearing voices which had been telling him to kill himself. The arrest record indicates that on 8 September, Mr Abiaz had stated his intent to take his own life while in police custody. As a result, he had been checked every 30 minutes and located in a camera cell. When assessed in police custody on 10 September, he stated that he had previously cut his throat and attempted to hang himself, but was unsure if he currently felt suicidal.

34. On 12 September, Mr Abiaz appeared at Magistrates' Court. He was assessed by the court psychiatric nurse, who recorded that she had no concerns about his mental health. The magistrate was aware of Mr Abiaz's history and was not prepared to sentence him without a probation report. Mr Abiaz had no bail address and was therefore remanded into custody until 26 September.

Time at HMP Swansea

35. A person escort record (PER) was completed and accompanied Mr Abiaz to Swansea. The PER is a document providing information about the person being escorted and also details any risk information. Mr Abiaz's PER stated:

    '*Magistrates Court – Possession of bladed article. Suicide/Self-Harm – States to kill himself. Threats to murder staff at Oxlea (2016.) Violence/Risk to others – Spits at officers (2013.) Conceals weapons or other items – Possess large knife. Stalker/Harasser/Intimidation - Stated he had guns in Peckham (2009.) Mental health – Alleges mental health issues*.'

36. The officer working in reception when Mr Abiaz arrived at Swansea initially spoke with him on his arrival.

37. The officer said that he read the PER, but did not recall the police custody record. He said that he recalled that Mr Abiaz had some markers for self-harm on his PER, besides other historical information. He said that when he called Mr Abiaz to the desk he was initially quite aggressive. When he asked Mr Abiaz his name, Mr Abiaz immediately responded by saying, 'I want a single cell, I want my tobacco, and I want my medication or I am going to cut myself'. He explained to Mr Abiaz that he would have to see the nurse first as he was not qualified to assess his mental health needs. He said that he would deal with other procedures, such as his cell sharing risk assessment (CSRA).

38. Mr Abiaz did not reply, and the officer described him as quite "standoffish". He then completed the rest of the initial paperwork, and spoke with the duty governor who was in reception.

39. The duty governor said that Mr Abiaz was initially very agitated when he arrived, and raised issues about medication. He said that Mr Abiaz was being demanding and making threats if he did not receive his medication. He said that he asked Mr Abiaz to see the nurse, following which he would then speak with him.

40. A nurse completed the initial health screen with Mr Abiaz. The PER form and police record would have been available to him. He recorded that Mr Abiaz had a diagnosis of schizophrenia and post traumatic stress disorder. Mr Abiaz stated that he had no physical health problems. The nurse recorded that confirmation of the medication Mr Abiaz had been prescribed was required. A urine sample taken by him indicated that Mr Abiaz was negative for both methadone and opiates, but positive for benzodiazepines. Mr Abiaz said that in the community, he was prescribed 15mg Olanzapine (an antipsychotic,) 45mg Mirtazapine (an anti-depressant,) and 5mg Diazepam (used to treat anxiety).

41. The nurse recorded that Mr Abiaz had previously self-harmed. When asked, he denied having any current thoughts or feelings of harming himself. He also recorded that Mr Abiaz had threatened to be disruptive in order to get medication at reception. He was able to prescribe Mr Abiaz diazepam and provided him with nicotine patches. (Swansea is a smoke-free prison.) He made a referral for Mr Abiaz to be seen by the primary care mental health team, mental health in-reach

team (to confirm his care in the community) and to the GP to assess his physical health and medication.

42. When the health assessment was completed, Mr Abiaz was returned to the reception area where the duty governor and officer spoke to him. The duty governor said that after seeing the nurse and having had his medication issues resolved, Mr Abiaz presented as calmer and was able to converse without becoming agitated. The officer said that as Mr Abiaz returned from seeing the nurse, he told him he had sorted out his medication. He also appeared much calmer.

43. The duty governor said that he had not read any of the documentation that arrived with Mr Abiaz; the officer said he had seen the PER but not the information from the police; and it is unclear what documentation was seen by the nurse. Neither the duty governor nor the officer considered opening an ACCT. Both said that Mr Abiaz had initially made threats about what he would do if he did not receive his medication. However, when he was spoken to after seeing the nurse, they said he displayed a completely different demeanour; his issue with medication had been resolved, and he stated he was fine. All the staff that dealt with Mr Abiaz in reception were of the opinion that there were no reasons to open an ACCT.

44. An officer was on duty on B wing and told the investigator that he recalled Mr Abiaz arriving at 8.30pm – 8.45pm. He explained that the usual process is that new prisoners will be seen first by an 'Insider.' Insiders are prisoners trained to assist in the induction process and provide support and advice to new prisoners. Once Mr Abiaz had spoken with the insider, the officer completed an induction interview with him.

45. The officer said that he asked Mr Abiaz whether he had been in custody before and whether he understood how to access support, should he require it. Mr Abiaz replied that he did. He said that he noticed from Mr Abiaz's first night risk assessment documentation that he had previously self-harmed. He asked Mr Abiaz whether he had any current thoughts of self-harm and recorded that Mr Abiaz replied that he did not. He provided him with an e-cigarette.

46. The officer said that he asked Mr Abiaz if he had any questions, and his only response related to the availability of another e-cigarette. He asked Mr Abiaz whether he was happy and Mr Abiaz replied that everything was alright. He and another prisoner then helped Mr Abiaz carry his bedding and other belongings to his cell. He said that he showed Mr Abiaz to his cell and left the door open to allow him access to the telephone, should he wish to use it.

47. The officer said that Mr Abiaz then called him and said that the television aerial in the cell was not working, so he moved Mr Abiaz to another cell and tuned the television for him. He said that during the time he spent with Mr Abiaz, he saw nothing to indicate that Mr Abiaz was at risk and he had no concerns about him.

48. The officer said that he secured all prisoners in their cells before the night staff arrived for duty at around 9-9.30pm.

49. On the night of 12 September, an Operational Support Grade (OSG) was on duty covering A, B and C wings. He said that other staff had already completed a roll check when he came on duty and he had no reason to check on Mr Abiaz during the night. CCTV shows him carrying out his duties on the wing and checking those prisoners who were subject to suicide and self-harm monitoring.

50. It is a requirement at HMP Swansea for the nurse covering night duty to carry out observations on all new prisoners during their first three nights in custody. Although nursing staff are aware of this requirement, the investigator was told that there is no formal policy or official instruction to support this. Three checks are required during the night between midnight and 5.00am.

51. The nurse on night duty explained that the checks are visual and non-intrusive. She said that she arrived at the cell occupied by Mr Abiaz at around 12.45am. She saw Mr Abiaz standing at the back of his cell with a bed sheet tied around his neck and immediately raised the alarm using her radio and calling a code red emergency code. A code red indicates that a prisoner is bleeding, while a code blue indicates to staff a prisoner who is either unconscious or who has respiratory problems. When staff call a code blue, an emergency ambulance should immediately be called. This is not the case with a code red.

52. Officer A told the investigator that he was in the centre office when the emergency code red was announced over the radio, at approximately 12.55am. He said that a Custodial Manager (CM) was also in the centre and they went onto B wing and began making their way to the landing. He said that as he got closer he could hear banging. He said that as he approached the cell, a nurse had unlocked the door and the OSG was kicking the door to gain access, as Mr Abiaz had placed his locker behind the door. Officer B was also present.

53. As Officer A reached the cell, staff gained access and he went into the cell behind the OSG. The OSG then supported Mr Abiaz and Officer B tried to cut the sheet from the window, but was unable to do so. Officer A then took over, and told the investigator that as he took hold of the sheet it unravelled from around Mr Abiaz's neck and it was apparent that it had not been tied, but wound round tightly. He also pointed out to the nurse that it was a code blue situation, not a code red. At this point, the communications officer was updated and informed that it was a code blue emergency. The communications log indicates that the initial call from the nurse was made at 12.55am and was updated that it was in fact a code blue at 12.59am, when an ambulance was requested.

54. Staff started CPR and continued until the arrival of paramedics at 1.10am. Efforts to resuscitate Mr Abiaz continued but, at 1.38am, paramedics pronounced him dead.

Support for prisoners and staff

55. After Mr Abiaz's death, a governor debriefed the staff involved in the emergency. He offered his support and that of the staff care team.

56. The prison posted notices informing other prisoners of Mr Abiaz's death on 13 September, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm prevention in case they had been adversely affected by Mr Abiaz's death.

Family liaison

57. Following Mr Abiaz's death, the prison contacted both the Somali Consulate in England and Scotland in an attempt to identify a next of kin. They also contacted his legal representatives, but both attempts were unsuccessful in providing contact details.

58. In the absence of identifiable next of kin, the prison Imam liaised with a local funeral director to arrange the funeral, which both he and a prison manager attended. The prison met the full costs of the funeral.

Post-mortem report

59. The post mortem and toxicology was carried out, the results of toxicology are still awaited but initial post mortem finding have indicated that cause of death was hanging.

Findings

Management of risk of suicide and self-harm

60. When Mr Abiaz arrived at Swansea he was accompanied by a PER form and a police custody record. The PER indicated previous self-harm, mental health issues and violent behaviour. The PER was read by the reception officer, but he did not read the police record. No other staff read the PER or other accompanying information. Mr Abiaz was assessed several times in the reception and induction wing at Swansea. He had a reception health screen interview with a nurse, an induction interview with an officer Ludwig, and was spoken to by a governor and another officer. We believe that this was a good level of engagement.

61. However, despite this, and notwithstanding the availability of various pieces of information, which indicated Mr Abiaz's troubled history, none of the staff assessed Mr Abiaz as being at risk of suicide or self-harm. For this reason, no additional monitoring was implemented. Staff addressed Mr Abiaz's immediate needs and were reassured by the change this brought to his presentation. They did not follow up the markers contained in the PER which indicated Mr Abiaz's significant underlying risk factors.

62. PSI 64/2011, which governs safer custody procedures, indicates a number of factors that may increase risk, including, early days in custody and offences of violence. It may not have been immediately apparent from the court papers that Mr Abiaz's charges related to him threatening to take his own life, but it would have been helpful if the circumstances of his offence and background had been explored with him, not least as any charges of violence can indicate the risk of suicide.

63. Prison Service suicide and self-harm prevention procedures rely on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only a reflection of their state of mind at the time a member of staff sees them. Presentation should be considered as a single piece of evidence used to make a judgement of risk. All risk factors and all available information should be collated and considered to ensure that a prisoner's level of risk is judged holistically. Those staff that dealt with Mr Abiaz stated that they had not seen or read the documentation completed while Mr Abiaz was in police custody and some had not seen the PER form. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that reception staff identify, consider and record all the relevant risk factors and documentation of a newly arrived prisoner when determining their risk of suicide or self-harm.

Night observations and monitoring

64. The Healthcare Lead at Swansea explained that the requirement for the night nurse to check on new prisoners was an extension of the existing policy for conducting observations on those prisoners identified on reception as undergoing detoxification from drugs or alcohol.

65. She explained that guidance had been issued in 2010, requiring all prisoners who were detoxifying to be checked three times during the night, for the first three nights. She said that following an incident at HMP Cardiff in 2012, it was decided that night monitoring would be extended to cover all new prisoners, regardless of whether or not they were undergoing detoxification. The night nurse conducts these checks, which are recorded on the medical computer system, SystmOne.

66. It is positive that Swansea has such a system for monitoring all new prisoners, regardless or not of whether any risk has been identified. However, like any process there should be a formal policy, which sets out the expected actions of staff. We make the following recommendation:

The Governor and Head of Healthcare should formalise and publish a policy for the night monitoring of newly-arrived prisoners at HMP Swansea.

Emergency response

67. When a nurse discovered Mr Abiaz, she immediately called an emergency medical code. However, she called a code red rather than a code blue. The control room at Swansea will automatically request an emergency Ambulance when a code blue is called, but will await an update from medical staff in respect of a code red. This error led to a delay of four minutes and although we do not consider this had any impact on the outcome for Mr Abiaz, in other situations it might be critical.

68. It is essential that all staff know understand the emergency coding system and the differences between the two codes. For that reason we make the following recommendation:

The Governor and Head of Healthcare should re-issue the guidance for staff of emergency medical codes and ensure that all staff are aware of the differences and expectations.

Clinical care

69. The clinical reviewer completed the review into the medical care provided to Mr Abiaz at Swansea on behalf of Healthcare Inspectorate Wales (HIW). His report says that it was apparent that all those involved in his care and detention acted in a professional and sensitive manner toward Mr Abiaz.

70. HIW have made a number of recommendations for the healthcare team at Swansea in their report and an action plan has been produced to address these by the health board.

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