

**Prisons &
Probation**

Ombudsman
Independent Investigations

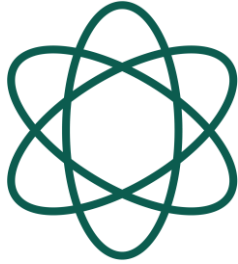
Independent investigation into the death of Mr Jarryd James, a prisoner at HMP Cardiff, on 20 May 2020

A report by the Prisons and Probation Ombudsman



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

OGL

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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 Jarryd James was found hanging in his cell at HMP Cardiff on 16 May 2020. He was resuscitated and taken to hospital but died there on 20 May. He was 22 years old. I offer my condolences to Mr James' family and friends.

During the night of 15/16 May, Mr James behaved erratically. Staff thought he may have taken psychoactive substances (PS) as he had been found under the influence of PS a few days before. The next morning, officers checked on Mr James frequently, though they did not see any signs that Mr James intended to deliberately harm himself. I am satisfied that officers monitored him appropriately.

I am concerned, however, that although a supervising officer asked for a nurse to check on Mr James, a nurse did not see him before he was found hanging.

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

Sue McAllister CB
Prisons and Probation Ombudsman

May 2021

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Summary

Events

1. On 5 May 2020, Mr Jarryd James was sentenced to six weeks in prison for racially aggravated assault and sent to HMP Cardiff.
2. When Mr James arrived at Cardiff, he told staff that he had no current mental health issues and no current thoughts of suicide or self-harm. He told staff that he had used crack cocaine 14 days before and had used cannabis the day before.
3. On 12 May, Mr James was found under the influence of psychoactive substances (PS). Staff monitored him until he recovered.
4. On 15 May, Mr James called his girlfriend several times, but she did not answer any of the calls. He left a message telling her to call him. He used expletives and sounded annoyed.
5. On the morning of 16 May, a Supervising Officer (SO) was briefed that Mr James had behaved erratically during the night and had damaged the glass in his observation panel. He went to Mr James' cell and saw him walking around his cell holding a piece of wood. He asked him to put the piece of wood down so he could enter the cell and speak to him, but Mr James refused. He said that people were out to get him. The SO asked a nurse (Nurse A) to check him. Nurse A told the investigator that she thought she had been asked to assess a Mr Jones and could not find the records, so she asked the SO to clarify the name. When she got no response, she assumed it was not urgent and took no further action. The SO had no recollection of the nurse asking him to clarify the name but said he would have done so if asked.
6. Officers checked Mr James frequently throughout the morning and made efforts to speak to him, but he continued to hold the piece of wood and refused to put it down. At 11.44am, an officer saw Mr James hanging from a ligature tied to the window frame. Officers went into the cell, cut the ligature and began cardiopulmonary resuscitation (CPR). Paramedics arrived at 11.47am and established a pulse. Mr James was taken to hospital and placed in intensive care. He died in hospital on 20 May.
7. Mr James' cause of death was given as hypoxic ischaemic encephalopathy due to asphyxiation (brain injury due to lack of blood flow).

Findings

8. We consider that the assessment of Mr James' risk of suicide or self-harm was assessed appropriately on his reception into Cardiff.
9. We are concerned that Mr James was not checked by a nurse on the morning of 16 May. We consider that Nurse A should have gone to the wing to confirm which prisoner she needed to assess. We also consider that the SO should have followed up his request to ensure Mr James was checked.

10. There is no evidence that Mr James was assessed by a nurse when he was found under the influence of PS on 12 May and the prison was unable to locate the PS monitoring charts.

Recommendations

- The Governor and Head of Healthcare should ensure that staff communicate appropriately to ensure that prisoners' welfare is checked as necessary.
- The Governor should share a copy of this report with the SO and arrange for a senior manager to discuss the Ombudsman's findings with him.
- The Head of Healthcare should share a copy of this report with Nurse A and discuss the Ombudsman's findings with her.
- The Governor and Head of Healthcare should ensure that when a prisoner is found under the influence of PS that:
 - a nurse should be called to assess them; and
 - PS monitoring charts are properly secured and scanned onto the prisoner's medical record.

The Investigation Process

11. 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.
12. The investigator obtained copies of relevant extracts from Mr James' prison and medical records. He interviewed 14 members of staff and one prisoner during June and July 2020. Due to coronavirus restrictions the interviews were conducted by telephone.
13. Health Inspectorate Wales commissioned a clinical reviewer to review Mr James' clinical care at the prison.
14. We informed HM Coroner for South Wales Central of the investigation. The Coroner gave us Mr James' cause of death. We have given the Coroner a copy of this report.
15. We contacted Mr James' sister and grandfather to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. The family said that Mr James had mental health problems and asked about the support provided to him. These issues have been addressed in the report.

Background Information

HMP Cardiff

16. HMP Cardiff holds around 800 men, mostly from South East Wales. Many of the prisoners come on remand from local courts. Cardiff and Vale University NHS Health Board provides primary, physical and mental health services at the prison. Healthcare staff are on duty 24 hours per day.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Cardiff was in July 2019. Inspectors found that Cardiff had made significant progress since its previous inspection in 2016. Inspectors noted that over half of new arrivals reported having drug problems and that the flow of illicit drugs continued to be a major issue. Inspectors found that the prison had a comprehensive drug supply reduction policy and that security staff worked closely with other departments to implement it. However, inspectors also noted that the lack of a body scanner was a significant gap in the prison's defences. Inspectors found that too many cells were overcrowded as they held two people when they were originally designed for one. Inspectors noted that the need for mental health support was high with 65% of prisoners reporting mental health problems on arrival. Inspectors noted that the incidence of self-harm was far higher than in similar prisons.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 August 2019, the IMB reported that its main concerns included the high incidence of self-harm and the quantity of drugs coming into the prison, particularly psychoactive substances (PS).

Previous deaths at HMP Cardiff

19. Mr James was the seventh prisoner to die at Cardiff since May 2018. Of the previous deaths, four were from natural causes and two were self-inflicted. There were no significant similarities between our findings in our investigations into the previous deaths and those in our investigation into Mr James' death.

Psychoactive substances

20. Psychoactive substances or PS (formally known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for

precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

21. In July 2015, we published a Learning Lessons Bulletin about the use of PS 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 PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
22. HM Prison 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.

Key Events

23. On 5 May 2020, Mr Jarryd James was taken to HMP Cardiff to serve a six-week sentence for racially aggravated assault. This was not his first time in prison; his last period in custody was in August 2019.
24. A reception nurse noted that Mr James appeared fit and well, that he was polite and pleasant, and that he had no concerns about his physical health. She noted that he had tried to harm himself when in prison before when he banged his head on a wall and used a ligature, but this had been in 2015 and Mr James said that he had been suffering from paranoia and psychosis at the time. She noted that this information was recorded on Mr James' Person Escort Record (a document that accompanies prisoners between police custody, courts and prisons). The nurse also noted that Mr James said that he had no current mental health problems, that he was not receiving any medication, and that he had no thoughts of suicide or self-harm. He said that he had a history of crack cocaine misuse, which he had last used 14 days before. He also said that he used cannabis, which he had used the previous day.
25. Mr James then saw a reception officer. The reception officer told the investigator that before he saw Mr James, he checked his electronic prison records for any alerts, such as self-harm or disciplinary warnings. He said that he asked Mr James about the entry on his PER that he had used a ligature when in prison in the past, but Mr James said that he had not actually harmed himself then and that he had no current thoughts of self-harm. The reception officer estimated that he spent around five minutes with Mr James, and he had given him no cause for concern.
26. Following his interview, Mr James was taken to C Wing, Cardiff's reception and induction wing.
27. An officer on C Wing saw Mr James for a first night interview, and to explain certain prison processes such as fire precautions. The officer noted that Mr James' PER included reference to a possible previous incident of self-harm, so he checked Mr James' electronic records for any alerts, and he asked him if he had any current thoughts of suicide or self-harm. Mr James said that he had no thoughts of suicide or self-harm. As part of the first night process, Mr James was entitled to make a telephone call. He tried to telephone his girlfriend, but she did not answer.
28. Mr James was then moved to a shared cell with Prisoner A.
29. When Mr James' cell was unlocked on the morning of 6 May, an officer saw vomit on the floor and psychoactive substances (PS) on the table. Prisoner A said that the PS belonged to him and that he had vomited.
30. Later that morning, Mr James saw a mental health nurse for a second reception screening interview. Mr James reported no physical health problems and the nurse used a standard mental health questionnaire to explore his mental health. Mr James said he had no thoughts of harming himself, although he told the nurse that he felt he had let his family down. The nurse told the investigator that Mr James' overall score from the questionnaire was low and that he had no concerns about Mr James' mental health.
31. A caseworker from the prison substance misuse team told the investigator that she reviewed Mr James' records on the morning of 6 May and she saw from a computer

database that Mr James was supported in the community by the Gwent Drug and Alcohol Service (GDAS). The record showed that his engagement with GDAS was sporadic. The caseworker told the investigator that in the past, a member from her team would have visited Mr James to discuss his substance misuse problems and to explain the support the team could provide. However, under revised COVID-19 working practices, an information pack, tailored to his particular needs, was sent to him through the internal mail system.

32. In the following days, further quantities of illicit substances were found in the cell Mr James shared with Prisoner A: PS was found on 7, 9 and 10 May and tobacco was found on 9 May. Mr James was found guilty of possessing PS at an adjudication hearing on 10 May and he was punished with the loss of privileges for 14 days.
33. On 11 May, Mr James and Prisoner A were moved to cell F1-7, a shared cell on the ground floor of F Wing. (F Wing was used for prisoners needing support for drug misuse problems and F1 was used for prisoners still within their first 14 days in custody and who needed to be quarantined from other prisoners due to COVID-19). The SO told the investigator that thought was given to separating Mr James and Prisoner A and moving them to single cells, but the wing was crowded so they were initially kept together.
34. On the morning of 12 May, an officer went to cell F1-7 and saw that both Mr James and Prisoner A were heavily intoxicated. He called for assistance and when staff went into the cell, they found smoking paraphernalia and a quantity of unused PS. When prisoners are suspected of being under the influence of PS, they should be checked by a nurse and staff should monitor them using an observation chart until they recover. Mr James' records do not contain any evidence that a nurse was called to check him. The investigator was told that observation charts were completed from 12 to 14 May, but the charts could not be found.
35. At around 10.30am on 13 May, Mr James and Prisoner A were separated. Prisoner A was moved to a single cell and Mr James remained as the sole occupant of cell F1-7. Prisoner A told the investigator that he knew Mr James from previous times they had been in prison together. He said that Mr James spoke about missing his family and said he was feeling suicidal because he was unable to contact his girlfriend. He did not pass this information on to staff. He said Mr James also told him that he suffered from Attention Deficit Hyperactivity Disorder (ADHD).
36. On 15 May, the prison's substance misuse team sent Mr James some further information about the support available. (This was sent after the team received reports about Mr James' PS use on 12 May.)
37. Mr James tried several times to telephone his girlfriend. Each time, the call was diverted to her voicemail. Mr James left only one message, which he did on the morning of 15 May. He used expletives and asked her to answer his call. (The investigator's opinion was that Mr James sounded annoyed but did not sound distressed.)

Events of 16 May

38. The SO told the investigator that he arrived on duty on 16 May at around 8.30am and was briefed that Mr James had appeared confused during the previous night and had damaged the reinforced glass of his observation panel. He went to Mr

James' cell and saw him walking around the cell holding a piece of wood in his hand. He asked Mr James to put the piece of wood down so he could come into the cell to speak to him. Mr James refused and said that he would not allow anyone to come into the cell. He also made a comment that there were people who were "going to get him". He asked Mr James if he was in debt to other prisoners, but Mr James said he was not in debt. He told two officers to make periodic checks on Mr James and he then telephoned a Custodial Manager (CM).

39. The CM told the investigator that the SO contacted him at around 8.50am to say that Mr James had possibly taken PS and was acting bizarrely. He checked Mr James' electronic record which showed that Mr James had taken PS in recent days. From the SO's description, he thought it possible that Mr James had taken more PS, although his presentation was not at the extreme end of the potential effects of PS. From the description there seemed no particular reason for him to check personally on Mr James, but he advised the SO to liaise with the nurses dispensing medication on F Wing and to let him know if there were any significant developments. In a statement made after Mr James' death, the CM noted that Mr James was not considered to have been at risk of self-harm that morning.
40. The SO told the investigator that after speaking to the CM, he asked a nurse to check Mr James. He also got his staff to pull an upright freestanding table tennis table in front of Mr James' cell door to prevent Mr James from smashing the glass observation panel onto the landing. He said the table would also limit the chances of other prisoners passing illicit substances to Mr James. (From his observation of the CCTV footage, the investigator concluded that the position of the table would not have prevented Mr James from looking out of his cell and nor would it have blocked light coming in through the observation panel.)
41. Two nurses were on F3, the third-floor landing of F Wing, dispensing methadone and the SO spoke to them at around 9.45am to ask them to check Mr James. As Nurse A was a mental health nurse, she agreed with the other nurse that she would make the check. She told the investigator that she understood the prisoner's surname to be Jones, and she tried to find his healthcare record before going to see him. However, she could not find him on the system, and she asked the SO to confirm the name. She said that the SO did not come back to her, so she concluded that it was not urgent, and she did not go to F1 to look for the prisoner.
42. The investigator asked the SO whether Nurse A asked him to clarify Mr James' name. He said that he could not recall this, but said that if he had been asked, he would have clarified the name. He added that Nurse A would not have been allowed to go into the cell while Mr James was holding the piece of wood, she would only have been able to check him through the observation panel.
43. The SO said that he spoke to Mr James several further times that morning. Mr James continued holding the piece of wood, which he would not put down. He said that Mr James was not otherwise acting aggressively. He said that nothing occurred during the remainder of the morning to make him believe that he needed to obtain further advice from either the CM or a nurse.
44. CCTV footage of F1 was unavailable before around 8.30am. The investigator observed the available footage and noted that staff checked Mr James 13 times between 9.02am, and when he was found hanging at 11.44am. On seven occasions, staff spent time talking to Mr James; a number of these were brief

interactions. But, at 9.06am, two officers spoke with Mr James for seven minutes; at 9.31am, the SO spoke with Mr James for five minutes and at 11.20am, he spoke with Mr James for three minutes. The last time Mr James was checked before he was found hanging was at 11.25am, when he was checked by another officer.

45. One officer told the investigator that Mr James did not make much sense when he tried to talk to him, but Mr James said that there were people on the landing who were trying to get at him and that the police were going to come into his cell and stab him. Another officer said that Mr James threatened him several times, which included a threat to throw boiling water over him.
46. CCTV footage also shows that at about 10.50am, a prisoner cleaner spoke to Mr James for around 30 seconds. The investigator asked Cardiff to arrange an interview with this prisoner. However, the prisoner declined to be interviewed. He said that he spoke to Mr James, but he could not recall anything specific about their conversation.
47. One of the officers told the investigator that he went to check Mr James at 11.44am and saw him at the back of the cell hanging from a ligature tied to the window bars. Mr James' feet were off the floor. He shouted for staff assistance and radioed a medical emergency code blue, adding that Mr James had used a ligature and that it was urgent. (A code blue call indicates that a prisoner is unconscious or having breathing difficulties. It alerts healthcare staff and tells the control room to call an ambulance immediately.)
48. The officer unlocked the cell and he and another officer had to push past furniture that Mr James had piled up against the door. One of the officers supported Mr James' body and the other officer cut the ligature. They lowered Mr James to the floor and cut the remnant of the ligature from his neck. One of the officers then began cardiopulmonary resuscitation (CPR).
49. After the officer had given the first series of chest compression, the SO gave the next set followed by a physical education and first-aid instructor. Nurses arrived and a defibrillator and oxygen were brought to the cell. The first-aid instructor inserted an airway into Mr James to help deliver oxygen. Officers continued to take turns in giving chest compressions. Each time they checked Mr James with the defibrillator it instructed that a shock could not be given and that chest compressions should continue. The nurses made various checks on Mr James and gave him an injection of adrenalin to try to restart his heart.
50. Ambulance paramedics arrived at Mr James' cell at 11.47am. The paramedics assisted with the efforts to resuscitate Mr James and they established a pulse. Mr James was taken to the University Hospital of Wales at around 12.30pm and was placed in intensive care. He went to hospital without restraints and he was granted release on temporary licence later on that day. Mr James remained in intensive care until he died at 6.40pm on 20 May.

Contact with Mr James' family

51. The Governor telephoned Mr James' father at 1.00pm to inform him that his son was seriously ill in hospital. She also spoke to one of Mr James' sisters.
52. Cardiff contributed to the cost of Mr James' funeral in line with national instructions.

Support for prisoners and staff

53. The Deputy Governor debriefed the staff involved in the response when Mr James was found hanging. The staff care team also offered support.
54. The prison posted notices informing other prisoners of Mr James' death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr James' death.

Cause of death

55. Toxicology tests showed that the only substances detected in Mr James' blood were very low levels of diazepam and nordiazepam, indicative of prior therapeutic use or abuse of diazepam. No PS was found.
56. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The hospital doctor gave Mr James' cause of death as hypoxic ischaemic encephalopathy secondary to asphyxiation (brain injury due to lack of blood flow).

Findings

Assessment of Mr James' risk of suicide and self-harm

57. The information that accompanied Mr James into Cardiff included a Person Escort Record (PER) that showed he had attempted to harm himself with a ligature when in prison. However, this had been in 2015. Mr James was assessed by a reception nurse and a reception officer. Both noted the entry on the PER and asked Mr James whether he had current thoughts of suicide or self-harm. He told them he had no such thoughts. The reception nurse's record indicated that Mr James interacted well with her and the reception officer said that Mr James gave him no cause for concern.
58. Mr James' risk of suicide and self-harm was also explored by staff on the first night centre that day, and by a mental health nurse on the following morning. Again, Mr James said that he had no thoughts of suicide or self-harm.
59. When F Wing staff arrived on duty on the morning of 16 May, they were told that Mr James had appeared confused since the previous evening and had damaged his cell. Staff suspected that he may have taken PS. The SO checked on Mr James and asked his staff to make periodic checks on him: CCTV footage confirmed that staff made frequent checks on him through the morning.
60. We consider that Mr James' risk of suicide or self-harm was assessed appropriately at Cardiff and there was no reason to start suicide and self-harm monitoring when Mr James arrived at Cardiff, or on 15/16 May. Staff nevertheless made frequent checks on Mr James after he behaved erratically during the night of 15/16 May. We consider this was good practice.
61. We note that the toxicological analysis of Mr James' blood found no evidence of PS. However, we are aware that not all types of PS can be detected so it remains possible that Mr James did take PS before he died.

Staff communication

62. When the SO asked Nurse A to check Mr James due to his unusual behaviour, it appears that she misheard 'Mr James' as 'Mr Jones', so she could not find his records. She said that she asked the SO to clarify the name and as he did not do so, she concluded that the request was not urgent. The SO said that he could not recall her seeking clarification, but had she done so he would have confirmed Mr James' name.
63. We consider that there was an onus on both members of staff to ensure that Mr James was checked. Nurse A should have checked again with the SO if he did not return to her with Mr James' correct details, or she could otherwise have simply walked down to the ground floor and checked with another officer. While the SO had no recollection of her asking for clarification, he did not follow up with her that she had checked on Mr James, which we consider he should have done.
64. If Nurse A had gone to see Mr James, she would not have been allowed to go into his cell but could only have tried to assess him by speaking through his cell door. The clinical reviewer has commented that an assessment by a nurse would have

been limited and would not have changed the outcome. Even so, we make the following recommendations:

The Governor and Head of Healthcare should ensure that staff communicate appropriately to ensure that prisoners' welfare is checked as necessary.

The Governor should share a copy of this report with the SO and arrange for a senior manager to discuss the Ombudsman's findings with him.

The Head of Healthcare should share a copy of this report with Nurse A and discuss the Ombudsman's findings with her.

Loss of PS monitoring charts

65. The investigator was told that when a prisoner uses PS at Cardiff, a nurse should be called to check them, officers should monitor them until they recover, and the officers' observations should be recorded on monitoring charts. Once the prisoner has recovered, the monitoring charts should be sent to healthcare staff for the charts to be scanned onto the prisoner's medical record. Mr James' medical record contains no entry to show that a nurse checked him on 12 May. The investigator was told that PS monitoring charts were completed for Mr James for 12 to 14 May, but that they were not scanned onto his medical record and the original documents could not be found. We make the following recommendation:

The Governor and Head of Healthcare should ensure that when a prisoner is found under the influence of PS that:

- **a nurse should be called to assess them; and**
- **PS monitoring charts are properly secured and scanned onto the prisoner's medical record.**

Clinical care

66. The clinical reviewer noted that Mr James had a history of impulsive attempts at self-harm and possibly untreated Attention Deficit Hyperactivity Disorder (ADHD). The clinical reviewer found that the initial nursing assessments when Mr James arrived at Cardiff were timely and of a good standard. She noted that there was no evidence from the assessments, observations and conversations to suggest that Mr James was at risk of harming himself on 16 May.

67. The clinical reviewer noted that it was unclear whether Mr James was psychotic or under the influence of PS during the period before he was found hanging. The clinical reviewer praised staff for their determined efforts to resuscitate him. However, she also noted the breakdown in communication between the SO and Nurse A.

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