Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Phillip Parry, a prisoner at HMP Swansea, on 20 July 2015

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

Our vision

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

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Phillip Parry was found hanged in his cell at HMP Swansea in the early hours of 20 July 2015. He was 50 years old. I offer my condolences to Mr Parry's family and friends.

Mr Parry hanged himself on his second night at the prison. Escort documents noted that he had harmed himself some years previously and suffered from depression but Mr Parry said that this was not the case. I am satisfied that reception staff appropriately asked him about these issues and had no obvious reason to consider that he might be at raised risk of suicide. Although Mr Parry was worried about the length of sentence he might get if he were convicted, he did not appear to be unduly anxious and no one who saw him during his short time at the prison had reason to believe he was at risk. I do not consider that staff at Swansea could have anticipated or prevented his actions.

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 **April 2016**

Contents

Summary

Events

1. On 18 July 2015, Mr Phillip Parry was remanded to prison charged with drug offences. He had said he would be in danger from his co-accused at HMP Cardiff, so he was taken to HMP Swansea.

2. Mr Parry's escort records indicated that he had harmed himself by cutting his wrists seven years previously and that he suffered from depression. At an initial health screen, Mr Parry said this was incorrect and he had never harmed himself. He said he had been depressed after the death of his son, 20 years before, but had never been diagnosed or treated for depression. He gave no indication of having any specific problems at the time and staff saw nothing to indicate he was at risk of suicide and self-harm. Mr Parry had been in prison before. Although this was some years previously, he appeared to understand the system and he asked induction officers whether he could be given specific prison jobs he would like to have. Mr Parry met some prisoners he knew and none of them saw any signs that he was depressed of likely to kill himself. He shared a cell and appeared to get on well with his cellmate.

3. The next day, an officer interviewed Mr Parry for a basic custody screen (to identify immediate and resettlement needs) and had no concerns about him. Mr Parry declined a second, more detailed health assessment. Although he was worried about the length of sentence he might get if he was convicted, he did not appear unduly anxious. He chatted to his cellmate that evening. At midnight, a nurse checked Mr Parry and his cellmate, as is routine for new arrivals, and noted no problems. Mr Parry's cellmate then went to sleep but, woke up at 1.30am and found Mr Parry had hanged himself from the window bars. He alerted staff, who tried to resuscitate Mr Parry. Paramedics arrived quickly and took over emergency treatment but could not resuscitate him. At 1.55am, paramedics recorded that Mr Parry had died.

Findings

4. Mr Parry was at Swansea for only two days and gave no indication that he was at risk of suicide or self-harm. Staff discussed with him the information that he had previously self-harmed and that he suffered from depression, but he denied having harmed himself before and said he was not currently depressed. They did not consider he was at risk of suicide. His cellmate, and other prisoners who knew him, did not see any sign that he was depressed or had any intention of killing himself. There was nothing about his demeanour on the evening of 19 July to indicate his intentions. We consider that staff at Swansea could not have predicted or prevented Mr Parry's actions.

5. The officer who initially responded to Mr Parry's cellmate's shouts for help did not radio an emergency medical code immediately, but we are satisfied that there was no undue delay in the emergency response. A nurse and the night manager were at the cell almost immediately and the night manager requested an ambulance. The nurse began emergency treatment immediately and paramedics arrived very quickly.

The Investigation Process

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

7. The investigator visited Swansea on 23 July 2015. He obtained copies of relevant extracts from Mr Parry's prison and medical records.

8. The investigator interviewed five members of staff and three prisoners at Swansea in July and November and two members of staff by telephone in December. He was unable to speak to the reception officer who interviewed Mr Parry when he arrived, as he was on long-term sick leave.

9. Healthcare Inspectorate Wales reviewed Mr Parry's clinical care at the prison.

10. We informed HM Coroner for Swansea and Neath Port Talbot of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Parry's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. We did not receive a reply.

12. Mr Parry's partner received a copy of the initial report. Her comments have been reflected in this final report. NOMS received a copy of the initial report and did not have any comments.

Background Information

HMP Swansea

13. HMP Swansea holds approximately 450 adult male prisoners. It receives sentenced or remanded men from courts mainly in the South Wales area.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Swansea was in October 2014. Inspectors reported that the prison was a reasonably safe place. Reception arrangements were reasonably good but induction was sometimes too rushed and first night interviews were not held in private. A high proportion of prisoners felt safe on their first night and there were enhanced checks for all new arrivals. Incidents of self-harm were low for a local prison, but inspectors noted that that there had been a number of serious incidents of self-harm in the previous six months, shortly after prisoners had arrived, and were not assured that the prison had identified this or established whether there was a pattern. Since the last full inspection there had been four self-inflicted deaths at the prison, all within three weeks of the prisoner's arrival, but inspectors found that the prison had not acted on all the learning points from Prisons and Probation Ombudsman investigation reports.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2015, the IMB reported that despite problems such as a lack of interview rooms, staff in the prison's first night centre appeared to have excellent relationships with prisoners and spent time with new arrivals until they were settled into prison life.

Previous deaths at Swansea

16. Since 2010 there have been five self-inflicted deaths at Swansea, including Mr Parry's. In a report into a death in June 2012 we noted that staff did not use an appropriate medical emergency code.

Key Events

17. On 18 July 2015, Mr Phillip Parry was remanded to prison charged with drug offences. He was due to reappear in court on 3 August. Mr Parry was taken to HMP Swansea, arriving there at approximately 12.25pm.

18. Mr Parry had been in prison some years before. He had been released from his most recent sentence in 2007. The escort papers that arrived with him from court said that he had cut his wrists seven years previously and suffered from depression, but there were no indications of any current risk of suicide or self-harm.

19. At an initial health screen, Mr Parry told a nurse that he did not drink or take drugs, had not suffered any recent physical injury, and had no concerns over his health. He said he had never been treated or prescribed medication for mental health problems. He said that he had never harmed himself before and had no current thoughts of self-harm. The nurse asked Mr Parry about the information in his escort record, that he suffered from depression and had previously cut his wrists. Mr Parry said that the information was incorrect, and he had never harmed himself. (There was no other mention of Mr Parry harming himself in any of the other records that we saw.) Mr Parry said that he had felt depressed some years previously after his son died, but had never been diagnosed or treated for depression. He said that he had not seen a doctor for many years and felt fine. The nurse detected no signs of low mood, and had no concerns about Mr Parry. Because of the reference on his escort record to depression and self-harm, the nurse noted that at his secondary health assessment, the nurse should consider whether he needed to be referred to the mental health team for an assessment.

20. The nurse completed the healthcare section of Mr Parry's first night suicide/self-harm screening assessment. He noted that Mr Parry had said that he felt that he had previously suffered from depression, but this had not been diagnosed. An officer completed the next section. Neither considered that Mr Parry needed to be monitored as at risk of suicide or self-harm.

21. Mr Parry was assessed as suitable to share a cell. They did not know each other but had arrived at the prison together that afternoon. His cellmate had not been in prison before, and told the investigator that Mr Parry had explained prison procedures to him.

22. A prison chaplain spoke to Mr Parry as part of his induction. He recorded Mr Parry's religion as Islam. He told the investigator that Mr Parry was not very talkative, but answered the questions he asked him.

23. An officer interviewed Mr Parry, as part of first night procedures and took Mr Parry through a standard list of rules and prison compacts. Mr Parry told him that he had been in prison before and asked whether it would be possible to get a job working on the food servery or as a wing cleaner. The officer gave Mr Parry the number he needed to use the prison telephone system. (Records show that he did not make any phone calls.) The officer said that he informed Mr Parry of support services, such as Listeners (prisoners trained by the Samaritans to support prisoners in distress), access to a dedicated phone to the Samaritans phone, and to talk to staff. Mr Parry said that he had no thoughts of harming himself.

24. The cellmate told the investigator that when they were locked in their cell that evening, he and Mr Parry talked for some time. Although Mr Parry said he was concerned that he might face a long sentence of between 12-14 years, the cellmate did not think that he appeared depressed or very anxious.

25. At Swansea, a member of the healthcare team briefly checks the wellbeing of all new arrivals three times during the night for their first three nights at the prison. A nurse checked Mr Parry and his cellmate during the night, and did not note any problems.

26. On 19 July, a nurse went to the induction wing to the first night centre to see new prisoners for secondary health assessments (a more detailed assessment than the initial health screen.) Mr Parry declined a further assessment, as he was entitled to do. The nurse explained the purpose of the further screen and told Mr Parry that he could speak to the doctor if he wanted to see him. Mr Parry said that he was fine, had nothing to add from the previous day, and did not need to see a doctor. The nurse had no concerns about Mr Parry.

27. In the afternoon, an officer saw Mr Parry for a basic custody screening, which is used to identify the immediate and resettlement needs of new prisoners. He noted that Mr Parry co-operated well. He said that he was dyslexic and had difficulty reading and writing. He said that he did not use drugs, but had been selling them to increase his income. Mr Parry said he knew that he was facing a potentially long prison sentence, and was upset that he had let his family down and would be separated from his partner and daughter and the effect this would have on their relationship. He told the officer that 25 years previously his son had been diagnosed with leukaemia, from which he had died after five years. He thought that he had suffered depression after this, but had preferred to deal with it himself, rather than taking medication. He said that he had had suicidal thoughts when his son had died, but had overcome that and had had no such thoughts since. The officer explained the support networks available, but Mr Parry said that he had no thoughts of harming himself. The officer had no concerns about him.

28. Mr Parry asked an operational manager, who was on the wing at the time, how long he could expect to serve if he was given a 14 year prison sentence. Mr Parry thought he would have to serve two-thirds of the sentence in prison, but the operational manager told him that he could be released when he had served a minimum of half the sentence.

29. That evening, at approximately 7.00pm, an officer unlocked the cell for a nurse to give the cellmate some medication. The officer told the investigator that he spoke to Mr Parry briefly at the time, and there was nothing about his demeanour that gave him any cause for concern.

30. At about 11.00pm, an officer found Mr Parry standing at the cell door waiting for her, when she responded to the cell bell. Mr Parry smiled and apologised for pressing the bell when he had meant to put the light on. (The light switch and cell bell switch are next to each other and officers said that prisoners frequently press the cell bell by mistake.) She saw nothing that concerned her about Mr Parry.

31. The cellmate said that he and Mr Parry had chatted throughout the evening. At around midnight, a nurse checked them and found them still talking. Mr Parry was also writing something at the time. She commented about them being still awake,

and said Mr Parry smiled and said they were going to sleep shortly. Both men seemed relaxed. She had no reason to be concerned about either of them and said goodnight. Shortly afterwards, they switched their light off and went to bed.

32. Some time shortly after 1.30am, the cellmate said he woke up and switched the light on. When he did, he saw Mr Parry had hanged himself by a torn sheet attached to the window bars. He pressed the cell bell, and began to bang on the door and shout for help.

33. An officer went to answer the cell bell and heard the cellmate banging and shouting. When he got to the cell, he opened the door observation panel and saw Mr Parry hanging. He radioed for urgent assistance, and shouted to a nurse, who was nearby that there was a code blue emergency. (A code blue indicates circumstances such as when a prisoner is unconscious or not breathing.) She had heard the cellmate shouting and thought there was a serious problem so had collected an emergency bag and defibrillator and went immediately to the cell with the night manager, who was also nearby. The night manager opened the cell, cut the sheet and lowered Mr Parry to the floor, with the help of other officers who had arrived. He radioed for an ambulance. The control room records show that they requested an ambulance at 1.36am.

34. The nurse checked Mr Parry and could not find any signs of life. She attached the defibrillator but this found no shockable heart rhythm so she, assisted by officers, started cardiopulmonary resuscitation. At 1.45am, paramedics arrived and took over emergency treatment. At 1.55am, paramedics recorded that Mr Parry had died.

35. Mr Parry had left two notes, one addressed to his partner and one to his sister. He said he could not face a long sentence away from his family, and apologised for what he had done.

Contact with Mr Parry's family

36. An officer was appointed as the prison's family liaison officer. He went to Mr Parry's partner's home and, at 7.30am, informed her of his death. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

37. After Mr Parry's death, a governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

38. The prison posted notices informing other prisoners of Mr Parry's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Parry's death. Staff gave additional individual support to the cellmate.

Post-mortem report

39. Toxicology tests showed that there were no drugs or alcohol in Mr Parry's system when he died and no disease that contributed to his death. The cause of death was given as hanging.

Findings

Assessment of risk of suicide and self-harm

40. When Mr Parry arrived at Swansea, the escort record noted that he had harmed himself some years previously and had suffered from depression. There was no additional evidence of this. A nurse and an officer both asked him about the information in the escort record. Mr Parry said that he had never harmed himself and had never been formally diagnosed with depression, although he thought he had been depressed when his son died, many years previously. He talked about his family and said that he had outside support and had things to live for. He was understandably concerned about the length of sentence he was facing, but gave no indication that he was unduly anxious, to the extent that anyone considered he was at risk of suicide.

41. We consider that reception staff appropriately discussed the information in the escort record with Mr Parry and considered his risk of suicide and self-harm. We are satisfied that there was little to indicate that Mr Parry was at heightened risk of suicide or that he needed to be monitored under Prison Service suicide and self-harm prevention procedures. We do not consider that staff could have foreseen or prevented his actions on 20 July.

Clinical care

42. Healthcare Inspectorate Wales (HIW) found that Mr Parry's received an appropriate standard of healthcare at the prison and that there was no reason for healthcare staff to identify that he was at heightened risk of suicide. There were no indications that he had any mental or physical health problems. HIW considered that the standard of healthcare Mr Parry received at Swansea was above that he could have expected in the community, as healthcare staff saw and assessed him, even though he did not have any identified health problems.

Emergency response

43. Prison staff are expected to use a medical emergency code blue (or equivalent) in situations such as when a prisoner is found hanged. This should alert other staff to the nature of the emergency so that they bring appropriate equipment and prompt the control room to call an ambulance. When an officer (who had been in post for only a few weeks) saw Mr Parry hanging, he radioed for urgent assistance but told the investigator that in the stress of the moment he stumbled over his words and did not use the words "code blue" in his radio message.

44. However, the officer shouted to a nurse that it was a code blue emergency, and there was no delay in emergency treatment. The night manager arrived at the cell within seconds of the officer calling for help and asked the control room to call an ambulance as soon as he had cut the sheet by which Mr Parry was hanging. The delay was less than a minute and unlikely to have affected the outcome for Mr Parry, as staff began cardiopulmonary resuscitation immediately and ambulance staff arrived quickly. HIW noted that the resuscitation attempt was appropriate. We therefore make no recommendation.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100