Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marc Lewis, a prisoner at HMP Cardiff, on 25 September 2019

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

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 Marc Lewis died on 25 September 2019, after being found hanging in his cell at HMP Cardiff. He was 39 years old. I offer my condolences to Mr Lewis' family and friends.

Mr Lewis had been at Cardiff for less than 12 hours when he was found hanging. It was his first time in prison. The investigation found that Mr Lewis' risk of suicide and self-harm was assessed appropriately when he arrived at Cardiff and I am satisfied that staff could not have foreseen his actions.

I am concerned, however, that when Mr Lewis rang his cell bell in the early hours of 25 September, to complain that he was in pain and needed paracetamol, he was told that he would have to wait until the morning.

I am also concerned about delays in the emergency response when Mr Lewis was found hanging. There was a short delay in officers entering the cell because they sought permission from a senior officer, which was unnecessary. Once officers entered the cell, they failed to start resuscitation attempts, which were not started until a nurse arrived a few minutes later. I cannot say whether the delays affected the outcome for Mr Lewis, but we know that in an emergency situation, a delay of a few minutes may be critical.

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 **March 2021**

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Summary

Events

1. On 24 September 2019, Mr Marc Lewis was remanded in prison custody, charged with theft while in possession of a bladed weapon, and sent to HMP Cardiff. This was his first time in prison.

2. At his reception health screen, staff identified that Mr Lewis was showing signs of opiate withdrawal. They gave him medication for symptomatic relief and planned to review him the next morning for opiate replacement medication. Mr Lewis was placed in a shared cell for support, as it was his first time in prison. Mr Lewis was checked several times during the night, in line with standard practice at Cardiff for prisoners who were in prison for the first time.

3. Mr Lewis rang his cell bell at around 1.15am, and again 40 minutes later, and complained that he was in pain and needed paracetamol. An operational support grade (OSG) told him that he would have to wait until the morning when he could speak to a nurse.

4. An officer checked on Mr Lewis at around 4.07am and saw that his bunk was empty. He then noticed that the back of Mr Lewis' head was by the hand basin and his legs were stretched out. The officer rattled and then kicked the door to try to get a response. He woke Mr Lewis' cellmate and asked him if Mr Lewis was okay. His cellmate then became distressed and the officer realised that Mr Lewis was probably hanging. He radioed a medical emergency code and another officer joined him. He then radioed the Night Orderly Officer (NOO) for permission to enter the cell. The two officers went in and cut the ligature tied around Mr Lewis' neck. One of the officers checked Mr Lewis for a pulse but could not find one, while the other took Mr Lewis' cellmate out of the cell. A nurse arrived three and a half minutes later and started cardiopulmonary resuscitation (CPR).

5. Paramedics arrived at 4.21am and assisted with resuscitation. Their efforts were unsuccessful and, at 5.11am, the paramedics pronounced that Mr Lewis had died.

Findings

6. We consider that Mr Lewis' risk of suicide and self-harm was appropriately assessed when he arrived at Cardiff. We are satisfied that staff could not have foreseen his actions.

7. The OSG who responded to Mr Lewis' cell bell in the early hours of 25 September, should have contacted the night nurse who can issue paracetamol where appropriate.

8. There was a delay in entering Mr Lewis' cell when staff realised he was hanging. We consider that once two officers were at the cell, they should have gone in straightaway, without asking for permission from the Night Orderly Officer (NOO).

9. There was a delay in starting CPR. Officers should have started CPR as soon as they realised Mr Lewis was unresponsive, but instead they waited for a nurse to arrive, which caused a three and half minute delay.

Recommendations

- The Governor should ensure that when a prisoner reports pain during the night, staff inform the night nurse.
- The Governor should ensure that staff record all significant conversations with prisoners in the wing observation book.
- The Governor should share a copy of this report with the OSG and arrange for a senior manager to discuss the Ombudsman's findings with him.
- The Governor should ensure that, subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that the prisoner may be at risk.
- The Governor should share a copy of this report with the officers who found Mr Lewis hanging and arrange for a senior manager to discuss the Ombudsman's findings with them.
- The Governor should ensure that staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity when a prisoner is unresponsive; and that staff first on the scene provide basic life support until health professionals arrive, unless there are clear signs of death.
- The Governor should share a copy of this report with the Night Orderly Officer and arrange for a senior manager to discuss the Ombudsman's findings with him.

The Investigation Process

10. 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.

11. The investigator obtained copies of relevant extracts from Mr Lewis' prison and medical records. He interviewed 10 members of staff and one prisoner at Cardiff between 30 September and 12 December 2019.

12. Health Inspectorate Wales commissioned a clinical reviewer to review Mr Lewis' clinical care at the prison. The investigator and clinical reviewer jointly interviewed clinical and other staff.

13. We informed HM Coroner for South Wales Central of the investigation. We have given the Coroner a copy of this report.

14. We contacted Mr Lewis' mother, brother and partner to explain the investigation process and to ask if they had any matters they wanted the investigation to consider. Mr Lewis' mother and brother said that Mr Lewis had a history of mental health problems and had previously attempted suicide. They asked what support was provided, given his history. Mr Lewis' partner asked whether the police passed any information to the prison about Mr Lewis' mental health problems.

15. We have addressed their questions in this report and the clinical review.

16. We issued our initial report on 19 May 2020. However, we were subsequently sent a copy of a police statement made by an OSG about his interactions with Mr Lewis in the early hours of 25 September. We had previously been unaware of these events. We have revised our initial report and made additional recommendations in light of this new evidence. We have also made two additional recommendations about sharing our report with the staff involved.

Background Information

HMP Cardiff

17. 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

18. The most recent inspection of HMP Cardiff was in July 2019. Inspectors found that reception was relatively busy, but staff were generally relaxed and reassuring and prisoners were positive about their treatment on arrival. Inspectors noted that in the first night centre prisoners were seen by an induction peer representative (a prisoner) and had a private first night interview with an officer, which they found were generally good and focused on safety. Inspectors found that the first night centre was clean and bright, and cells were appropriately equipped. Inspectors noted that significantly more prisoners than in other local prisons felt safe on their first night.

19. Inspectors noted that information indicated that 51% of new arrivals reported drug problems. Inspectors found that all prisoners were screened in reception, but it could take up to two days for them to start methadone treatment.

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 31 August 2019, the IMB reported that self-harm remained a major concern although it acknowledged that the number of incidents of self-harm were skewed by a number of prolific self-harmers. The IMB noted that assurance checks of the process for supporting prisoners deemed at risk of suicide or self-harm highlighted that there were both areas of good practice and areas that needed improvement.

Previous deaths at HMP Cardiff

21. Mr Lewis was the seventh prisoner to die at Cardiff since October 2017. Of the previous deaths, one was self-inflicted, three were from natural causes and one was drug-related. There were no similarities between our findings in our investigations into the previous deaths and those in our investigation into Mr Lewis' death.

Key Events

22. On 22 September 2019, Mr Marc Lewis was arrested and taken into police custody charged with theft while in possession of a bladed weapon.

23. On 24 September, Mr Lewis was taken to Bristol Magistrates' Court, where he pleaded guilty and he was remanded into prison custody. As HMP Bristol was full, Mr Lewis was taken to HMP Cardiff where he arrived at 5.15pm. This was his first time in prison.

24. The paperwork that accompanied Mr Lewis included records of the medical treatment provided while he was in police custody, which included medication for drug withdrawal.

25. Mr Lewis' Person Escort Record (PER - a document that accompanies prisoners between police custody, court and prisons that sets out the risks they pose) contained no indication that police or court staff considered that Mr Lewis was at risk of suicide or self-harm.

26. When Mr Lewis arrived at Cardiff, a healthcare assistant saw him for a reception health assessment. He told the investigator that before assessing Mr Lewis, he told him to collect a meal, which he ate before the assessment. He said that during the assessment Mr Lewis maintained good eye contact and was very pleasant and polite.

27. Mr Lewis reported some use of crack cocaine and that he spent between £40 and £80 a day on heroin. The healthcare assistant noted some indications of withdrawal symptoms: Mr Lewis was restless, he said he had some bone or joint pain and he reported stomach cramps. The healthcare assistant sent a 'task' on the electronic medical record system for Mr Lewis to be prescribed medication for his symptoms. He noted that Mr Lewis had received medication in the past for depression, but his assessment was that Mr Lewis was mentally stable at interview and Mr Lewis declined a referral to the mental health team. Mr Lewis also said that he had never harmed himself and that he had no present thoughts of suicide or self-harm.

28. An officer told the investigator that he saw Mr Lewis to assess whether he was suitable to share a cell. He noted that Mr Lewis' offence was robbery and Mr Lewis said he was not homophobic or racist. The officer told Mr Lewis that if a person was safe to share a cell, the practice at Cardiff was to place prisoners who were in prison for the first time in a shared cell. He told Mr Lewis that this would provide him with support during his first few days in custody. He said that as with many others, Mr Lewis was a little apprehensive about sharing, but he accepted the reason. Following this, Mr Lewis was taken to C Wing, Cardiff's reception and induction wing.

29. A prisoner told the investigator that he worked as a peer mentor on C Wing to help support newly arrived prisoners. He said that he had also worked in the past as a Listener (a prisoner trained by the Samaritans to help prisoners in crisis). He said that two of his colleagues explained various prison processes to Mr Lewis, while he spoke to Mr Lewis in general about his background. Mr Lewis did not seem concerned that he was at Cardiff rather than Bristol and he told Mr Lewis that

Cardiff was a good prison with supportive staff. He said that they spoke for around ten minutes and Mr Lewis gave no signs that he might be at risk of suicide or self-harm.

30. Another officer then saw Mr Lewis for a first night interview. She told the investigator that she explained some prison processes to Mr Lewis, such as fire precautions and use of the emergency cell bell, and told him that he would have a full prison induction the next day.

31. The officer asked Mr Lewis whether he had ever harmed himself and he said that he had no history of self-harm and no current thoughts of suicide or self-harm. She then tried to contact Mr Lewis' partner. She said that she made four attempts to ring the number. The first two calls went to voicemail, the third call rang through until it timed out but on the fourth call Mr Lewis' partner seemed to end the call. She said that Mr Lewis acknowledged that he and his partner were not on speaking terms at that time, but she told him that her colleagues would try to make contact with her again in the morning. She said that Mr Lewis maintained good eye contact during the interview, and they had laughed a few times.

32. Following the interview with the officer, a nurse gave Mr Lewis medication to deal with the symptoms he had reported earlier to the healthcare assistant: paracetamol for pain relief, mebereverine for abdominal cramps, metoclopramide for nausea and vomiting and loperamide for diarrhoea.

33. Another officer then took Mr Lewis to his cell. The officer said that he recalled Mr Lewis because he was polite, well-spoken, and had an accent that he did not recognise. He said that it took two or three minutes to walk to the cell with Mr Lewis and he gave no indication that he might be at risk. Mr Lewis was later joined by a cellmate.

34. The first night officer checked on Mr Lewis at around 8.00pm, when he completed an evening roll check.

35. The second night officer checked Mr Lewis at around 10.00pm. This was a routine night time check made on all prisoners in prison for the first time. He said that when he opened the observation panel, Mr Lewis responded with a 'thumbs up' sign.

36. The second night officer checked Mr Lewis again at around 11.00pm, when Mr Lewis was talking and laughing with his cellmate.

37. At around 12.15am, the second night officer responded to an emergency cell bell call from Mr Lewis' cell. Mr Lewis asked if he could have methadone and he told him that he would be seen by nurses in the morning for that. The officer said that Mr Lewis accepted the explanation and thanked him.

38. In his statement to police, an operational support grade (OSG) said that at around 1.15am, he responded to an emergency cell bell call from Mr Lewis' cell. Mr Lewis said that he was suffering from drug withdrawal symptoms and he asked for paracetamol, and for some food. He told Mr Lewis that he could not give him any food and that he did not have any paracetamol to give him and that he would need to speak to a nurse in the morning.

39. The OSG said that Mr Lewis rang his cell bell again around 40 minutes later when he asked for hot water. He told him that there was a kettle in his cell. Mr Lewis

said that he was in pain and he again asked for paracetamol and food. He told him again that he would have to wait until the morning. He wrote that he had no concerns about Mr Lewis' welfare and that he had no further involvement with him.

40. The first night officer made the next check on Mr Lewis at around 3.05am. Mr Lewis was sitting on the toilet and he raised his hand to acknowledge the check.

41. When the first night officer checked Mr Lewis at 4.07am, he saw that the cellmate was in bed, but Mr Lewis' bunk was empty. He then noticed the back of Mr Lewis' head at the level of the hand basin with his legs stretched out. He knocked on the door and rattled the door handle, but Mr Lewis did not respond. He then kicked the door and continued to rattle the door handle to wake the cellmate. When the cellmate woke, he asked him if Mr Lewis was okay. The cellmate then became very distressed which made him believe that Mr Lewis was hanging. He asked the cellmate to support Mr Lewis' body and to try to remove the ligature and he radioed a medical emergency code blue (used to indicate a prisoner is unconscious or having breathing difficulties).

42. The second night officer was nearby, and he arrived at the cell a few seconds later. The first night officer then radioed the Night Orderly Officer (NOO) for permission to enter the cell, which he granted, and the two officers went in (CCTV shows that the staff went into the cell around 45 seconds after the first night officer arrived at the cell).

43. The first night officer used his anti-ligature knife to cut the ligature, which Mr Lewis had made from a pullover and which he had tied to the basin tap. He checked Mr Lewis for a pulse but could not find one. He noted that Mr Lewis' skin was very grey and his tongue was swollen and protruding. He told the investigator that although he believed that Mr Lewis was already dead, he intended to start giving chest compressions, but at that point a nurse arrived and took over Mr Lewis' care.

44. The second night officer told the investigator that while the first night officer was examining Mr Lewis, he took the cellmate from the cell and stood with him on the landing until the NOO arrived. The NOO then told him to take the cellmate off the landing altogether and to give him support.

45. The NOO told the investigator that when he arrived, the first officer was still checking Mr Lewis. He said that he did not instruct him to start resuscitation, he said that the situation was "very fluid" and the nurse arrived only moments after he arrived.

46. A nurse was in the healthcare unit when she heard the code blue alarm. She and a healthcare assistant went from the healthcare unit to the first night centre. CCTV shows that they arrived around three and a half minutes after officers had first entered the cell. The nurse said that two officers and the NOO were present, but no one was actively treating Mr Lewis. She checked Mr Lewis and noted that he had no pulse; that his hands were cold, and his eyes were open and fixed. She also noted that his tongue was swollen, and his jaw was clenched. She checked Mr Lewis with a defibrillator, which advised that no shock should be given. Despite Mr Lewis' other signs, there were no indications of rigor mortis, so she commenced giving chest compressions with the healthcare assistant, and one of the officers also gave compressions. She said that she tried to insert an airway to give Mr

Lewis oxygen, but was unable to due to Mr Lewis' swollen tongue and his clenched jaw.

47. Ambulance paramedics were called when the code blue call was made, and they arrived at around 4.21am. The paramedics assisted with efforts to resuscitate Mr Lewis. Efforts continued until 5.11am, when the paramedics declared that further efforts should cease as Mr Lewis was dead.

48. Mr Lewis' cellmate was interviewed by the police following Mr Lewis' death. He said that Mr Lewis was already in the cell when he was taken there, and he could see that Mr Lewis had symptoms of drug withdrawal. He said that Mr Lewis was very restless and kept saying that he needed methadone. Mr Lewis also spoke to officers saying that he needed methadone, but they explained that he would have to wait until the morning. Mr Lewis accepted this explanation and the cellmate said nothing occurred during the evening to suggest Mr Lewis might be at risk of harming himself.

49. The cellmate said that he had fallen asleep at some time after 9.00pm but had then been woken by an officer banging on the door asking him where Mr Lewis was. He saw he was not in bed and then saw him hanging from a ligature next to the hand basin. He said that he supported Mr Lewis' body until staff came into the cell to release the ligature. He said that it seemed to him that Mr Lewis was dead. (The cellmate declined to speak to the PPO investigator. He explained that he found it too distressing to have to keep explaining to different people what had happened that night.)

Contact with Mr Lewis' family

50. At 10.00am, a family liaison officer (FLO), together with a prison manager and a prison chaplain, visited the home Mr Lewis shared with his partner. There was no answer from the home, but a neighbour told the FLO that Mr Lewis' partner was away, and they did not know when she would be back.

51. The FLO and prison manager decided that they should telephone her. When the FLO telephoned, Mr Lewis' partner said that she was on holiday in Portugal with a friend. The FLO decided that she had no alternative but to tell Mr Lewis' partner the news. Mr Lewis' partner became upset and she passed her phone to her friend. The FLO was able to give the friend a little more information about the circumstances of Mr Lewis' death. The friend told the FLO that Mr Lewis had a brother and she said she would telephone him with the news.

52. Mr Lewis' partner's friend telephoned the FLO 15 minutes later with Mr Lewis' brother's address and said that he had asked for a visit. The FLO and her colleagues spent time with Mr Lewis' brother and he asked them to help break the news to their mother. The staff then visited Mr Lewis' mother and spoke to her about her son's death.

53. The prison contributed to the cost of Mr Lewis' funeral in line with national instructions.

Support for prisoners and staff

54. One of Cardiff's functional heads debriefed the staff who were involved in the response when Mr Lewis was found. The staff care team also offered support.

55. The prison posted notices informing other prisoners of Mr Lewis' 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 Lewis' death.

Post-mortem report

56. The post-mortem report was not available at the time of issuing our initial report.

Findings

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

57. Mr Lewis' family said that Mr Lewis had a history of mental health problems and had attempted suicide in the past. They asked if the police passed on information to HMP Cardiff and asked what support he received there.

58. The information that accompanied Mr Lewis when he arrived at Cardiff contained no warnings that he might be at risk of suicide or self-harm. He received a standard health assessment with a healthcare assistant at Cardiff and he was interviewed by several officers, including an officer on the first night centre. All the staff considered that Mr Lewis showed no signs that he might be at risk of suicide or self-harm. Both the prisoner peer mentor and the cellmate had no concerns about him either.

59. The clinical reviewer considered that Mr Lewis' mental health needs were appropriately assessed at his reception health screen, and steps were taken to assess any previous history of self-harm and any current thoughts. We consider that Mr Lewis' risk of suicide and self-harm was assessed appropriately at Cardiff and there were no indications that he was at risk. We consider that staff could not have foreseen Mr Lewis' actions.

Mr Lewis' requests for pain relief

60. During the early hours of 25 September, at around 1.15am and 1.55am, Mr Lewis rang his cell bell and asked the OSG for paracetamol to help him with his drug withdrawal symptoms. The OSG told Mr Lewis that he would have to wait until the morning.

61. The role of a prison night nurse includes visiting prisoners reported to be in pain and issuing certain medication, including paracetamol, where appropriate. The OSG should have contacted the night nurse to inform her about Mr Lewis' request for medication.

62. The OSG made no entries in the wing observation book about his conversations with Mr Lewis, which meant that other staff would have been unaware of his requests for paracetamol. The investigator was unaware of the OSG's interactions with Mr Lewis until he was sent his police statement. We make the following recommendations:

    The Governor should ensure that when a prisoner reports pain during the night, staff inform the night nurse.

    The Governor should ensure that staff record all significant conversations with prisoners in the wing observation book.

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

Emergency response

63. When the first night officer checked Mr Lewis' cell at 4.07am, he realised that Mr Lewis was probably hanging and he called a medical emergency code blue. the second night officer arrived quickly and the first night officer contacted the Night Orderly Officer (NOO) for permission to enter the cell.

64. Prison Service Instruction (PSI) 24-2011, which provides instruction on management and security of prisons at night states that under normal circumstances, authority to unlock a cell at night must be given by the NOO and no cell will be opened unless a minimum of two or three staff are present, one of whom should be the NOO. However, the PSI goes on to say:

> "Staff have a duty of care to prisoners, themselves and to other staff. The preservation of life must take precedence … Where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the NOO … and an individual member of staff may enter the cell on their own …"

65. The PSI goes on to say that staff should not take action that they feel would put themselves in unnecessary danger, that staff must make every effort to first gain a verbal response from the prisoner, that they must make a rapid dynamic risk assessment on whether to enter the cell immediately or wait for assistance, and that they must inform the communications room before entering the cell.

66. Mr Lewis was in a shared cell and we accept that it may not have been appropriate for the first night officer to enter the cell alone. However, once the second night officer arrived, we consider that the two officers should have opened the cell without seeking permission from the NOO. Although the situation was not entirely clear, the first night officer thought Mr Lewis was hanging and called a medical emergency code. He thought that Mr Lewis' life was at risk and therefore, once it was safe to do so (once the second night officer arrived), he should have entered the cell. We note that staff entered the cell within around 45 seconds so there was very little delay, but we nevertheless make the following recommendation:

The Governor should ensure that, subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that the prisoner may be at risk.

The Governor should share a copy of this report with the officers who found Mr Lewis hanging and arrange for a senior manager to discuss the Ombudsman's findings with them.

67. When the officers entered the cell, they cut the ligature and, while the second night officer took the cellmate away from the cell, the first night officer checked Mr Lewis for signs of life. The NOO arrived soon after, but the nurse did not arrive until three and a half minutes after the officers first went into the cell. When she arrived, she saw that none of the officers were actively treating Mr Lewis.

68. Both the first night officer and the NOO said in their interviews that the position was "very fluid" and suggested that they might have been at the point of attempting resuscitation when the nurse arrived. We consider that the officers had had sufficient time well before the nurse's arrival to have checked Mr Lewis for signs of life and to have started resuscitation. From the descriptions given of Mr Lewis, it is

possible that starting resuscitation earlier might have made no difference for him. However, we do know that in an emergency situation, a delay of a few minutes could be vital. We make the following recommendation:

The Governor should ensure that staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity when a prisoner is unresponsive; and that staff first on the scene provide basic life support until health professionals arrive, unless there are clear signs of death.

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

Contact with Mr Lewis' family

69. PSI 64/2011, which provides instructions on actions following a death in custody, says that 'wherever possible', prison staff must visit in person the next of kin or nominated person to break the news of the death.

70. Following Mr Lewis' death, staff visited the home he shared with his partner where they learned she was away from home with no indication of when she might return. In the circumstances we consider that it was reasonable for the staff to telephone the partner, who they then discovered was abroad.

Clinical care

71. The clinical reviewer found that Mr Lewis' care at Cardiff was equivalent to that which he could have expected to receive in the community. In particular, he was provided with rescue medication for his drug withdrawal symptoms and was referred appropriately for follow-up assessments. (The clinical reviewer was unaware that Mr Lewis had complained to the OSG that he was in pain.)

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