

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of Mr Edward Collier on  
17 November 2012 at HMP Cardiff**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is a report into the death of Mr Edward Collier at HMP Cardiff on 17 November 2012. Mr Collier appears to have strangled himself using a ligature made of bed sheets attached to taps in his cell. He was 26 years old and had arrived at the prison just the day before. I offer my condolences to family and friends.

The investigation was carried out by one of my investigators. Healthcare Inspectorate Wales (HIW) conducted a review of the Mr Collier's clinical care in custody. HMP Cardiff cooperated fully with the investigation.

Mr Collier had been released from prison on licence from an indeterminate sentence in January 2012. He was arrested on 15 November when he was charged with a violent offence against an ex-partner. He was recalled to prison. When he arrived at HMP Cardiff on 16 November, Mr Collier was not assessed as at risk of self-harm or suicide. He was placed alone in a single cell contrary to the prison's policy for new arrivals. He telephoned his new partner twice the next morning but said nothing which indicated any concerns. Later that evening, Mr Collier was found unresponsive in his cell. Cardiopulmonary resuscitation was attempted but he was pronounced dead shortly after.

While Mr Collier was only at Cardiff a very short time, and denied any thoughts of suicide or self-harm, the investigation has identified that factors known to increase such risks were not fully considered. For example he was a recalled prisoner and had been charged with an offence of domestic violence. Similarly, the prison's own suicide prevention policy highlights the increase in risk during early days in custody and requires that prisoners should normally be allocated a double cell for the induction period. Yet Mr Collier was given a single cell. While I accept that it would have been very difficult for staff at Cardiff to have predicted Mr Collier's death, this, and other cases we have investigated at the prison, emphasise the need for all known risk factors to be taken into account when assessing a prisoner's risk of suicide – and not to rely too much on personal presentation.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

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## SUMMARY

1. Mr Edward Collier was released from prison on licence on 24 January 2012. He reported regularly to his probation officer who thought he was settling well, but, on 15 November, he was arrested for an alleged violent offence against his ex-partner. His licence was revoked and he was recalled to custody. Mr Collier spent the night in police custody with no identified concerns. On 16 November, Mr Collier appeared in court and was remanded to HMP Cardiff.
2. Mr Collier told a senior officer in reception at Cardiff about his recall and that he was expecting to spend a significant length of time in prison. A nurse carried out a routine initial health screen which included a suicide screening tool. This indicated that Mr Collier had a slightly raised level of risk because he had been in care when he was a child and had previously been in custody. Overall, the nurse did not identify him as at risk of self-harm.
3. An officer went through initial induction procedures with Mr Collier. Mr Collier telephoned his new partner and the officer said he appeared cheerful. Mr Collier was given a single cell on the induction wing.
4. The next morning, Saturday 17 November, Mr Collier rang his partner twice and gave no indication of his intentions or that he was depressed. He asked her to phone the prison on Monday to arrange a visit. He collected his tea at about 3.45pm. As it was the weekend, prisoners were then locked in their cells until the following morning.
5. An officer carried out a roll count at 4.00pm. At the next roll count at 7.00pm, she saw Mr Collier on the floor of the cell. She called for help and she and other staff went into the cell. Mr Collier appeared to have strangled himself by tying bed sheets to the sink and taps and then around his neck. He was not breathing. An ambulance was called immediately officers and healthcare staff attempted cardiopulmonary resuscitation (CPR). The first paramedic arrived very quickly and continued the resuscitation attempt. CPR was unsuccessful and shortly after a paramedic team arrived, Mr Collier was pronounced dead.
6. Mr Collier had not been identified as at risk of harming himself when he arrived at the prison and it would have been difficult for staff to foresee his actions as he gave little indication of vulnerability. However, it is a concern that reception staff did not appear to consider that the fact that he had been recalled to prison and that he was charged with a domestic violence offence against his ex-partner, were both factors that might have increased his risk of suicide and self-harm. The early days in custody are also known to be a time of heightened risk yet, contrary to Cardiff's own suicide prevention strategy, Mr Collier was given a single cell. We also note that although Mr Collier had nominated his new partner as his next of kin, contrary to Prison Service guidance, the prison did not notify her first of his death. We make three recommendations about these matters.

## THE INVESTIGATION PROCESS

7. The Ombudsman's office was informed of Mr Collier's death on 17 November 2012. The investigator issued notices to staff and prisoners at Cardiff informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
8. Healthcare Inspectorate Wales (HIW) conducted a review of Mr Collier's clinical care and received copies of relevant medical and prison documents and the interview transcripts.
9. The investigator interviewed staff at Cardiff on 22 January and 5 February 2013. The investigator kept the deputy governor informed of emerging findings.
10. The investigator contacted Mr Collier's probation officer on 10 December and liaised with the investigating police officer during the course of the investigation. She also liaised with the coroner's officer and received a copy of the post-mortem report.
11. One of the Ombudsman's family liaison officers, contacted Mr Collier's father and his partner to tell them about the investigation. They had no specific issues they wished the investigation to consider.
12. A copy of the draft report was sent to the National Offender Management Service (NOMS). They reported that there were no factual errors and accepted all the recommendations'. The responses to the recommendations are repeated verbatim in the relevant section.
13. Mr Collier's father received a copy of the draft report as part of the consultation process. He explained that he found the report informative and helpful.

## **HMP CARDIFF**

14. HMP Cardiff is a local prison, predominantly serving the Welsh courts and the South West of England. It holds approximately 800 adult sentenced and remanded male prisoners.

### **Her Majesty's Inspectorate of Prisons (HMIP)**

15. The report of the most recent inspection of HMP Cardiff in February 2013 had not been published at the time of issuing this draft report. In interim feedback, the Inspectorate recognised that Cardiff had now improved systems to identify and support prisoners charged with or convicted of violent offences against a family member. This was in response to emerging findings from our investigations into recent deaths at the prison, including Mr Collier's.
16. At the time of the previous inspection in June 2010, the Inspectorate found that Cardiff provided an essentially safe environment. Following a number of deaths at the prison, the Inspectorate noted that suicide prevention work had been given an appropriately heightened focus. Early days in custody were assessed as satisfactorily managed, although reception staff struggled to deal with the number of prisoners they had to deal with.

### **Previous deaths at HMP Cardiff**

17. Since 2010, there have been five self-inflicted deaths at Cardiff, including Mr Collier's. Four out of the five deaths involved prisoners who were charged with offences involving domestic violence. We have been told that the prison has since introduced a new system to manage this risk factor.

## KEY EVENTS

18. Mr Collier was sentenced to a 60 month indeterminate sentence of imprisonment for public protection (IPP) sentence on 21 July 2005. (The IPP sentence was abolished in 2012. The court sets the minimum term of imprisonment a prisoner must serve before becoming eligible to be considered for release. After release, a prisoner is on licence and may be recalled to prison for an indefinite period until they demonstrate that they are no longer a risk to the public.) Mr Collier was released on licence from HMP Parc on 24 January 2012.
19. On 15 November, Mr Collier was arrested at his probation office for allegedly committing a violent offence against an ex-partner and for breaching his licence conditions. His licence was revoked. Mr Collier has a routine risk assessment for the night he spent in police custody and no concerns about his wellbeing were identified.
20. The police completed a Person Escort Record (PER) form (which is used to communicate information between criminal justice agencies when detained persons transfer between agencies.). Guidance notes on the back of the PER indicate that an “unexpected recall” should be highlighted under the section “suicide/self-harm risks”, but it was not. On the front sheet of the PER, he was described by police as a “domestic abuse aggressor”.
21. Mr Collier appeared at Cardiff and the Vale of Glamorgan Magistrates’ Court on 16 November and was remanded to HMP Cardiff. When he arrived at 12.30pm, a senior officer asked him whether he understood that he was also being recalled to prison because his licence had been revoked. He said that Mr Collier answered that he was expecting ‘something big’. The senior officer did not think that Mr Collier appeared particularly upset or that he was at risk of self-harm. There is no evidence that they discussed the background to the alleged offence.
22. As part of Mr Collier’s initial health screen at 2.00pm, a nurse (a mental health nurse) completed a routine suicide screening tool. She concluded that Mr Collier’s risk was slightly raised because he had spent some time in care as a child and had previously been in prison. She identified no other risk factors and recorded that Mr Collier denied any thoughts of self-harm. The nurse noted that Mr Collier made good eye contact, and said he was happy to approach staff if he had any problems. She told the investigator that Mr Collier was chatty and bubbly and that he had a sense of humour. She estimated that she was with him for about 20 minutes. She did not speak to him about his recall or the circumstances of the alleged offence and his relationship to the victim. She told the investigator that she had not been trained to identify these as particular risk factors.
23. A nurse also completed the healthcare part of the cell sharing risk assessment (CSRA – which is used to assess whether it is safe for a prisoner to share a cell). She recorded that Mr Collier was not a risk to other prisoners and could share a cell.

24. An officer, who was working as an induction officer that day, completed the operational assessment part of the CSRA. It was already noted on the form that Mr Collier was a recalled prisoner and been remanded for another offence. The officer added that there were no self-harm issues and it was Mr Collier's first time at Cardiff. Mr Collier was assessed as a standard risk, which meant he was suitable to share a cell. The officer described Mr Collier as "chirpy" and said he had asked about taking part in education. The officer was nearby when Mr Collier telephoned his partner and described him as upbeat during the conversation. (This call was not recorded.)
25. At 2.33pm, an officer recorded that Mr Collier was taken to the induction landing, but declined to take part in the induction programme as he said he had no issues. He was given a single cell. There is no recorded explanation of why he was not allocated a shared cell, in line with Cardiff's policy for new arrivals.
26. The next morning, Saturday 17 November, Mr Collier rang his partner twice and spoke to her for ten minutes each time. These calls were recorded. In her police statement, she explained that their relationship was very new. She said that she sensed Mr Collier was not quite as upbeat as he had sounded when he rang the day before and when he had telephoned from the police station. Mr Collier asked his partner to ring the prison on Monday to arrange a visit. He also told her he had written her a letter the evening before. He did not talk about suicide or self-harm, but said that he had put her down as his next of kin because it felt right.
27. A healthcare assistant, completed Mr Collier's secondary health screen at about 10.00am during his wing round. He said that he asked Mr Collier if he had any mental health issues and physical health conditions. He recorded that Mr Collier had no issues and was fit and well.
28. A member from the chaplaincy department saw Mr Collier that morning as part of the induction process. She asked him a number of routine questions, including whether he felt suicidal and he said he did not. He asked to go on the list for the Sunday service. She forgot to ask him to sign the request form for the service, so she went back to his cell that afternoon. She had no concerns about him on either occasion.
29. Mr Collier collected his tea at about 3.45pm and returned to his cell with it. On Saturdays, prisoners are locked in their cells after they have collected their tea until the following morning. An officer carried out a roll check at 4.00pm and noticed nothing out of the ordinary.
30. At about 6.55pm, an officer started another roll check. She turned on the cell light and saw Mr Collier's feet on the floor in front of the cell door. She said that she thought that Mr Collier might have had a fit. She called to staff on the landing below, then radioed a code blue to indicate a life threatening emergency. She informed the manager responsible for the operational running of the prison that day, a senior officer, that staff were entering the cell.

She also asked healthcare staff to attend. The control log recorded that the code blue was called at 6.55pm. An ambulance was called at the same time. Two officers, who were working on the landing below, said they reached the cell door in seconds.

31. An officer found it difficult to open the door fully because Mr Collier was in front of it. The officers could see that he had tied sheets round the sink taps and his neck. When they got into the cell, an officer tried to cut the sheets with her anti-ligature knife but they had been twisted too tightly. The officer lifted Mr Collier's head while the officer tried to remove the sheets from around his neck. The sheets had been tied in a figure of eight twice round the taps. The officer untangled the sheets from the taps and then removed them from Mr Collier's neck. Once released, staff lay Mr Collier on the floor. He was cold and not breathing. A senior officer arrived and moved Mr Collier from the cell onto the landing, with the officer's help, so that there would be more room to administer cardiopulmonary resuscitation (CPR).
32. The senior officer checked Mr Collier's airways, confirmed that he was not breathing and started chest compressions. Two healthcare assistants, arrived about five minutes after the code blue was called with emergency equipment. One of the healthcare assistant checked for signs of life, then inserted an airway and started to administer oxygen via an amubag. The healthcare assistants and the senior officer continued CPR until the first response paramedic arrived at 7.05pm. The senior officer assisted the paramedic until a paramedic team arrived at 7.20pm. CPR was unsuccessful and Mr Collier was pronounced dead at 7.29pm.
33. The prison's family liaison officer, and the Governor of Cardiff, went to Mr Collier's father's home at 10.00pm to break the news of his death. The family liaison officer visited again the next morning to explain the role of the family liaison officer and later met Mr Collier's partner, his nominated next of kin. The prison offered a contribution to reasonable funeral expenses in line with national guidelines.

### **Support for prisoners**

34. The Governor issued a notice announcing Mr Collier's death, and expressing his condolences. The notice told prisoners of the support available from officers, the chaplaincy and Listeners (prisoners trained by the Samaritans to provide confidential support for other prisoners).

### **Support for staff**

35. A hot debrief was held to support those involved in the emergency response. The officers were offered the support of the staff care team.

## ISSUES

### Clinical care

36. In the clinical review, HIW concludes that Mr Collier showed no signs of depression or mental illness and there was no evidence of previous self-harm. He was appropriately assessed by healthcare staff in reception, and the next day in the induction unit. There was no evidence that Mr Collier intended to harm himself. The clinical reviewer makes no recommendations in relation to the clinical care of Mr Collier and concludes that his death could not have been foreseen by healthcare staff.

### Assessment of risk

37. Mr Collier arrived at Cardiff with no risk factors indicated on his escort record. The police had not highlighted that he his unexpected recall was a risk factor despite guidance on the back of his escort record. However, reception staff at HMP Cardiff were aware that he had been recalled to prison and the supervisor officer said that Mr Collier assured him that he understood the implications of being recalled.
38. Prison Service Instruction (PSI) 62/2011 - Safer Custody describes licence recall as a known trigger that might increase the risk of suicide or self-harm. The uncertainty about how long a prisoner will spend in prison can be a source of distress. Prisoners who have been recalled must have their recall documents given to them to explain why they have been recalled, and offer them the chance to appeal against the decision. As he had just arrived Mr Collier would not have received these papers before he died, but he seems to have understood the seriousness of his situation and suggested to a supervisor officer that he expected to be facing a long time in prison. Despite this, Mr Collier did not give staff any indication that he was particularly upset. Mr Collier's probation officer said she had never known him harm himself, or threaten to, and she did not consider him at risk of suicide.
39. Cardiff's Local Suicide Prevention Strategy states that:
- “Where a prisoner:
- Has had a change of circumstances at court or by video link
  - Is a failed appellant
  - Is recalled on licence
- “Reception staff must inform the Wing Manager where the prisoner is to be located informing the individual of these facts.”
40. Mr Collier was seen by a nurse on reception, as is routine for all new prisoners. The nurse completed a suicide screening tool, but this did not include licence recall as a risk factor or an offence of violence against a partner. The nurse said she was unaware that these were recognised risk

factors. Although reception and induction officers knew that Mr Collier had been recalled to prison, they did not consider this was a particular risk factor.

41. Mr Collier was charged with a violent offence against his ex-partner. It was noted on his PER that he was domestic abuse aggressor and therefore considered to be a risk of violence. PSI 64/2011 highlights that prisoners charged with a violent offence against another person, especially against family members or partners are at an increased risk of suicide. This is reflected in Cardiff's suicide prevention policy, where it is required that the person completing the initial health screen is aware of the suicide and self-harm risk associated with prisoners charged with violence towards a family member. Although it is not necessarily the case that an ex-partner would be regarded as a family member, they had been in a close personal relationship and the reference to domestic abuse on the PER should have prompted further consideration of Mr Collier's risk. The PSI indicates an increased risk for any prisoner charged with violence against another person so this should have been considered irrespective of the current status of the relationship. Despite these provisions in national and local guidance, there is no evidence that anyone spoke to Mr Collier about the circumstances of his alleged offence or his victim.
42. Healthcare staff and officers accepted Mr Collier's assurances that he was not upset about being in prison, and had no thoughts of self-harm. While it is possible that a full consideration of the risk factors would still have reached the conclusion that Mr Collier was not at serious risk, it is a concern that insufficient weight was given to known risk factors when Mr Collier's level of risk was being assessed. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff take account of all known potential risks and triggers when assessing a prisoners risk of self-harm or suicide.**

### **Single accommodation for prisoners on induction**

43. PSI 74/2011 Early Days in Custody recognises that the first night in custody is one of the most stressful times for a prisoner. HMP Cardiff's Suicide Prevention Strategy states:

"staff in reception will have completed a CSRA form, but unless there are strong indications, prisoners on induction will be located in shared accommodation. This offers time for more in-depth assessment of the prisoner's vulnerability and needs".
44. Mr Collier was alone in a single cell during his first night in custody and therefore was alone the next day. He had been assessed by a nurse and reception officer as suitable to share a cell and there is no recorded reason why he was not allocated a shared cell in line with Cardiff's written policy. Staff interviewed during the investigation could offer no explanation. We make the following recommendation:

**The Governor should ensure that newly arrived prisoners are allocated shared cells for their induction period, unless there are clearly recorded reasons to justify a single cell.**

#### **Contact with Mr Collier's next of kin**

45. Mr Collier had specifically chosen to nominate his partner as his next of kin when he arrived at HMP Cardiff the previous day. PSI 64/2011 Safer Custody says:

*“Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death.”*

46. The appointed family liaison officer, told the investigator that he was not involved in the decision about who to break the news to, and he was instructed to visit Mr Collier's father, rather than the nominated next of kin. There is no record of who made the decision to overlook Mr Collier's wishes or why it was decided his decision was made. We make the following recommendation:

**The Governor should ensure that staff follow the guidance when contacting the named the next of kin after a death in custody.**

## RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that staff take account of all known potential risks and triggers when assessing a prisoners risk of self-harm or suicide.

Accepted. Following further investigation into trigger points, and in an effort to ensure risk is managed and minimised effectively, a self harm tool has been developed. The tool is attached to the first night induction booklet and offers specifically trained staff a further insight into the risk of self harm posed by the prisoner. It identifies known triggers whilst still maintaining professional discretion.

2. The Governor should ensure that newly arrived prisoners are allocated shared cells for their induction period, unless there are clearly recorded reasons to justify a single cell.

Accepted. Further investment has been allocated to ensure that sufficient cells with double bunk accommodation are available on the first night centre. All prisoners deemed to require a shared cell following assessment from both qualified staff, and healthcare professionals, will be allocated accordingly. There will always be cases where a shared cell will not be appropriate and we are reliant on information and professional judgement to provide a safe and secure environment for those in our care.

3. The Governor should ensure that staff follow the guidance when contacting the named the next of kin after a death in custody.

Accepted. HMP Cardiff contingency plans instruct the Duty Governor to inform the next of kin in the event of a death in custody. The contingency plans have been further updated to provide cross reference with hard copies to ensure the correct next of kin is informed in a timely manner.