Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Leon Owens, a prisoner at HMP Swansea, on 19 September 2020

A report by the Prisons and Probation Ombudsman

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

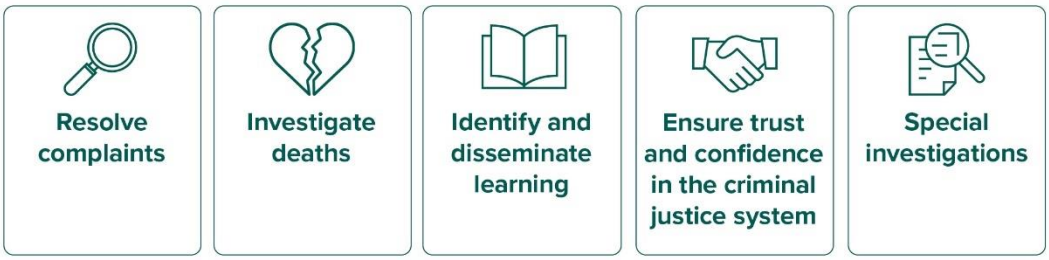
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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 Leon Owens died on 19 September 2020 after he was found hanging in his cell at HMP Swansea. He was 24 years old. I offer my condolences to Mr Owens' family and friends.

Mr Owens had been at Swansea for just over 10 weeks when he died. During that time, he was monitored under suicide and self-harm procedures (known as ACCT) on three occasions. On 17 September, staff started the last period of ACCT monitoring, which was ongoing when Mr Owens died.

There were failings in the management of the final period of ACCT procedures. I am concerned that at the case review held the day before Mr Owens died, his risk was poorly assessed, observations were reduced prematurely, and a decision was taken to move Mr Owens out of a safer cell into a cell on his own. There was no healthcare input to these decisions.

I also found failings in the operation of the key worker scheme at Swansea. Mr Owens was identified as a priority for key work, but his key worker never saw him because she was on night shifts and then off work.

There were also delays in the emergency response, though they were unlikely to have affected the outcome for Mr Owens.

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 **June 2021**

Contents

Summary 1

The Investigation Process.....3

Background Information.....4

Key Events.....6

Findings 14

Summary

Events

1. On 8 July 2020, Mr Leon Owens was sentenced to 12 months imprisonment for assault and sent to HMP Swansea. On 29 July, he received a further sentence of 16 weeks for assault.

2. Between 28 and 29 July, staff monitored Mr Owens under suicide and self-harm procedures (known as ACCT) when he became upset that his girlfriend had been told to stop contact with him.

3. On 5 August, Mr Owens told staff that he had taken an overdose of antidepressants because he was being threatened by another prisoner. On 13 August, staff moved him to another wing and stopped ACCT monitoring.

4. On 17 September, staff opened a third ACCT after Mr Owens barricaded himself in his room and staff found him with a bed sheet draped around his neck and tied like a scarf (but not attached to anything). He told staff he 'did not want to be here'. Staff moved him to a safer cell and observed him twice an hour.

5. A supervising officer (SO) held the first ACCT case review on 18 September. No members of healthcare attended. The SO reduced observations to one an hour and noted that Mr Owens should be moved from the safer cell into a cell by himself.

6. On 19 September, at approximately 8.40am, an officer found Mr Owens hanging from the cell window. The officer shouted for staff assistance. Two other officers arrived. They cut the ligature, lowered Mr Owens to the floor and started cardiopulmonary resuscitation (CPR). A fourth officer arrived and called a medical emergency code over his radio.

7. Healthcare staff arrived and took over CPR. Paramedics arrived and continued resuscitation attempts but were unsuccessful and declared Mr Owens' death at 9.30am.

Findings

8. We consider that the last period of ACCT monitoring was poorly managed. The SO who held the case review on 18 September failed to obtain healthcare input and did not properly assess Mr Owens' risk. He reduced the frequency of ACCT observations prematurely and moved Mr Owens from a safer cell to a standard cell on his own, without the protective factor of a cellmate. We are concerned that the SO recorded that a nurse had contributed to the case review when she had not done so, and that he did not contact the Crisis Team when they were expecting to have been invited.

9. Staff did not immediately call a code blue when they found Mr Owens hanging and when interviewed seemed unsure of their priorities when responding to a medical emergency.

10. The control room records showed that there was a delay between the calling of the code blue and the calling of the ambulance, but we were told this was due to there being multiple clocks which showed different times.

11. Mr Owens was allocated a key worker as he was identified as a priority case under the special COVID-19 pandemic provisions, but he never saw her as she was on night shifts and then in COVID isolation.

12. We consider that not all staff received sufficient support after Mr Owens' death.

Recommendations

- The Governor should initiate an investigation into SO A's actions in relation to the ACCT case review on 18 September with a view to considering whether disciplinary action is appropriate.
- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national policy, in particular staff should:
    - keep accurate records of case reviews and who attended or contributed;
    - assess risk based on the prisoner's known risk factors, including any recent suicide attempts and incidents of self-harm, and not solely on what the prisoner tells them;
    - be mindful of the protective element provided by a cellmate and ensure that when a prisoner being monitored under ACCT is moved into a cell on their own, the reasons are fully documented;
    - set appropriate, meaningful caremap actions and mark them as complete only once they are actioned fully;
    - consult previous recent ACCT documentation.
- The Head of Healthcare should ensure a policy is in place to ensure members of the Crisis team query any ACCT reviews that they have been booked for but not subsequently asked to attend.
- The Governor should remind staff of the medical emergency response protocol and ensure they are clear that where codes are appropriate, they should be used immediately.
- The Governor should ensue that key establishment clocks are accurate.
- The Governor should ensure that during a restricted regime, key work is delivered in line with the Exceptional Delivery Model.
- The Governor should remind managers of the importance of offering support to all staff involved following a death in custody.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Swansea informing them of the investigation and asking anyone with relevant information to contact her.

14. The investigator obtained copies of relevant extracts from Mr Owens' prison and medical records.

15. The investigator interviewed 22 members of staff during November 2020. Healthcare Inspectorate Wales commissioned an independent clinical reviewer to review Mr Owens' clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff and some custodial staff. The clinical reviewer spoke to the Head of Healthcare independently. All the interviews were conducted by telephone due to the COVID-19 restrictions.

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

17. One of the Ombudsman's family liaison officers contacted Mr Owens' aunt to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked several questions about Mr Owens' health care and observations. We cover these issues in the report.

18. We shared aspects of this report with HM Prison and Probation Service (HMPPS) in line with our advance disclosure process.

19. Mr Owens' family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Swansea

21. HMP Swansea is a local prison that holds around 500 men and young adult men. Healthcare is provided by Abertawe Bro Morgannwyg University Health Board

HM Inspectorate of Prisons

22. The most recent inspection of HMP Swansea was in August 2017. Inspectors noted that in their survey, a third of prisoners said that they felt depressed or suicidal or had mental health problems on arrival. Inspectors noted that there had been four self-inflicted deaths since their previous inspection in October 2014, all within a week of arrival. Inspectors observed friendly interaction between reception staff and prisoners but found that reception risk assessments were not sufficiently rigorous and first night procedures were inconsistent.

23. A scrutiny visit in August and September 2020 noted continuing significant prisoner mental health needs and that ACCT procedures required improvement. In particular, inspectors noted that careplan actions were signed off too soon or not actioned quickly enough. 'Quality' conversations were not considered to always be of a reasonable standard and observation timings were often too predictable.

Independent Monitoring Board

24. 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 May 2017, the IMB noted that there had been two deaths in custody in the reporting period. The Board said that PPO recommendations were discussed in Safer Custody meetings but were not always implemented in a timely manner.

Previous deaths at HMP Swansea

25. Mr Owens was the third prisoner to die at Swansea since September 2018. One of the previous deaths was self-inflicted and the other was from natural causes. There are no similarities between our findings in this investigation and those made in our investigations into the previous deaths.

26. There has been one further death since Mr Owens'. The cause of death has yet to be determined.

Assessment, Care in Custody and Teamwork

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will

occur. Regular multidisciplinary review meetings involving the prisoner should be held.

28. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

The key worker system

29. The key worker system is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework. This says:

- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
- Key workers must have completed the required training.
- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
- Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

Key Events

30. On 8 July 2020, Mr Leon Owens was sentenced to 12 months in prison for assault and sent to HMP Swansea. This was not his first time in prison.

31. An officer carried out Mr Owens' reception screening and reviewed the Suicide and Self Harm (SASH) form which arrived with him. The SASH form noted that Mr Owens had told escort staff he had tried to jump off a bridge the week before, and that in October 2019 he had been in a coma after a taking a paracetamol overdose. Mr Owens told the officer that he was 'okay now' but did have mental health issues. She asked the mental health Crisis team to review Mr Owens.

32. A mental health nurse saw Mr Owens. She noted that Mr Owens was currently under the care of a community mental health team (CMHT) and that he had a personality disorder and a mental and behavioural disorder due to harmful alcohol use. Mr Owens told the nurse he had taken an overdose of olanzapine (an antipsychotic) in October 2019. He said he was no longer on any medication but had previously been on olanzapine and sertraline (an antidepressant) which he had stopped because of the side effects. He said he had an outstanding appointment with the CMHT.

33. The mental health nurse noted that Mr Owens described his mood as 'shit' and that he was concerned he might be bullied by whoever he shared a cell with. She noted that his concerns had been passed to wing staff and that he was now pleased about his cellmate. She considered Mr Owens showed no psychotic symptoms and that he displayed evidence of wanting to improve his circumstances (by discussing future employment options). He said he had no thoughts of suicide or self-harm. She noted that she would book an appointment for Mr Owens to attend Lighthouse (the prison's counselling service) for further mental health support if needed. She did not consider it necessary to open an ACCT.

34. A nurse carried out the initial health screen, including a Clinical Opiate Withdrawal Scale (COWS) assessment. Mr Owens said his alcohol intake was 48 units a week. She noted that Mr Owens appeared to be fit and well.

35. On 9 July, a nurse carried out Mr Owens' second health screen. He considered aspects of Mr Owen's mental health, specifically his feelings around depression and anxiety. Mr Owens said he had no current thoughts of suicide or self-harm and would usually speak to someone if he felt his mental health was deteriorating. Regarding anxiety, Mr Owens felt tense and agreed he was frightened something awful was going to happen most of the time. He had a low depression score but registered 'high' on the anxiety score. They also discussed Mr Owens' alcohol intake and the nurse referred Mr Owens to a GP for detox medication and to the mental health team because of the outstanding community mental health appointment.

36. A prison GP prescribed Mr Owens diazepam, promethazine and thiamine – medications to help with alcohol detoxification.

37. A mental health nurse saw Mr Owens at the nurse's request. She noted that they discussed his previous prescriptions and the side effects they had caused. Mr Owens said he had stopped taking risperidone because it gave him restless legs.

She said she would ask the GP to consider re-prescribing it, but alongside medication to combat side effects.

38. A prison GP noted she had received the request but did not want to prescribe risperidone as Mr Owens had not had any since March. She told the investigator that it is not something GPs would routinely prescribe anyway because it is an antipsychotic. Mr Owens was due to see a psychiatrist and if the psychiatrist was happy for it to be prescribed, she would happily do so. (On 31 July, she prescribed sertraline instead and paracetamol for back pain.)

First ACCT 28 - 29 July

39. On 28 July, an officer started suicide and self-harm monitoring (known as ACCT) because Mr Owens was upset after his girlfriend had told him that the probation service had advised her to stop contact with him.

40. On the same day, another officer made a key worker entry on Mr Owens' prison record (NOMIS). She noted that Mr Owens' key worker was unavailable, but she had been asked by a colleague to talk to Mr Owens because an ACCT had been opened. (The prison told us that the colleague was in fact the allocated key worker.)

41. The officer noted that Mr Owens had spoken to his partner and both probation and Social Services had told her that they were stopping her from having contact with him. Mr Owens was devastated and said his calls with her were the one thing that kept him going. She told Mr Owens that he needed to find out what had been said to his partner. Mr Owens said he was hoping to use this sentence to get his life together, including addressing his alcohol misuse and his relationship. He said that although he was feeling low, he had no intention of acting on these feelings and would make sure he spoke to staff if he needed support. She said she would let Mr Owens know if she got any further information but said that this might not happen immediately.

42. A supervising officer (SO) completed the Immediate Action Plan and arranged for Mr Owens to be observed once an hour with two quality conversations a day.

43. On 29 July, Mr Owens was sentenced to a further 16 weeks for assault.

44. The same day, an officer carried out the ACCT assessment interview. Mr Owens said he was low in mood and stressed and told the officer about the conversation with his girlfriend and that his mental health was not good. Mr Owens said he had an appointment booked with the mental health team for two weeks' time. He said that the issue with his girlfriend was his main problem and that, in general, he was focused on the future and improving things. He mentioned wanting to do courses and engaging with alcohol services. He denied any thoughts of suicide or self-harm.

45. A SO chaired the first case review that afternoon. A member of healthcare staff was present (along with other staff). The SO noted that Mr Owens said he felt a lot better than the day before, although he still felt low about not being able to contact his girlfriend. He said he had no intention of harming himself and asked to see the prison's counselling service 'Lighthouse'. He also expressed an interest in joining the dads' workshop. Healthcare staff said they were arranging for his community

medication to continue and they would work to find a variant that did not cause him side effects.

46. The SO completed a care map with actions: to book an appointment for Mr Owens to see mental health, to provide a distraction pack to tackle overthinking and to submit an application to the dads' workshop. The SO noted that all the actions had been completed and stopped ACCT monitoring.

47. After the case review, an officer noted on NOMIS that she had received an email from the probation service saying they had advised Mr Owens' girlfriend not to have contact with him. They were concerned about violence within their relationship, his alcohol use and the potential impact on his girlfriend's child. Mr Owens accepted the information and agreed to attend a video conference which probation wanted to set up.

Second ACCT 5 - 13 August

48. On 5 August, an officer opened an ACCT after Mr Owens told him that he had taken an overdose of antidepressants and he wanted to leave the wing because he was being threatened by another prisoner.

49. A SO completed the Immediate Action Plan. He set observations at one an hour with three quality conversations a day. He arranged for Mr Owens to be seen by healthcare.

50. On 6 August, a SO carried out the ACCT assessment interview. Mr Owens said he was being bullied by prisoners on the wing because of his offence and by another prisoner who he had had previous issues with outside prison. He said he had taken the medication intending to overdose and that he had self-harmed by cutting himself since he was 15.

51. A SO chaired the first case review that afternoon. A mental health practitioner was present (along with other staff). The SO noted that when asked what had led to the attempted overdose, Mr Owens said that another person on his wing who was aware of his offence, had been making veiled threats towards him.

52. Mr Owens spoke to the mental health practitioner at length about his issues. The practitioner told Mr Owens that he would be reviewed by the Lighthouse Clinic, but that Crisis were always available for him to talk to. They discussed Mr Owens' medication, and the practitioner said that he would approach the prison GP with a view to increasing it. (The practitioner did not update SystmOne about his ACCT input. He told the investigator that this was because he was relatively new and had initially had problems using SystmOne which are now resolved.)

53. Mr Owens also spoke about his relationship with his girlfriend. A SO noted that he was quite upbeat about the future while fully understanding why he could not have contact with his girlfriend at that time. He said he was very keen to try to improve things in the future and prove to probation that he was fit to see his partner. He understood the impact of alcohol on his behaviour and said he was trying to work on that; he said he was willing to be assessed by a counsellor. (The counsellor was emailed after the review.)

54. The SO asked Mr Owens if historically his self-harm had been a genuine attempt to end his life, or was it more a cry for help, and he said it was the latter. Mr Owens said during the review that he had not spoken to his aunt for a while, as he had been isolating himself for safety. He said that he wanted her to be involved in the ACCT process.

55. The SO encouraged Mr Owens to speak to staff if he felt he needed to, and an officer was going to look into the possibility of moving him to another wing. All present agreed to keep the ACCT open and for observations to remain hourly but conversations to be reduced to two a day.

56. The SO completed a care map with one action: a wing move.

57. Immediately after the case review, an officer called Mr Owens' aunt. He noted that she said she was worried about him and did not know what she could do. They agreed that Mr Owens would phone her on a daily basis to keep her updated on his progress. The officer also told her that if she had any queries in the future, she could contact the prison through the concern and safety line. She thanked the staff for the support that they were putting in place.

58. The officer also noted that Mr Owens gave the names of three prisoners who he had issues with that were causing him to self-harm. He passed the names to a colleague from the violence reduction department. He reminded Mr Owens of the avenues of support available to him, and Mr Owens agreed that he would alert wing staff if he felt like harming himself again.

59. An officer from the violence reduction department received the email from his colleague on 6 August, and the same day emailed the residential governor and the Custodial Managers and SOs on Mr Owens' wing telling them about the situation and naming the alleged bullies. He also asked that someone speak to Mr Owens to see how he was and to offer support. He was then off duty until 10 August.

60. The officer told the investigator that when he returned to work on 10 August, he found an email from a SO on the wing saying the matter had been resolved. The email actually says 'Has this been resolved' although there is no question mark. The officer sent a response reiterating his request for someone to speak to Mr Owens.

61. On 12 August, an officer noted on NOMIS that he had met with Mr Owens on A Wing as part of a safer custody check and to offer him a move to D or F Wings. Mr Owens refused to move as he said that he had issues on those wings as well. The officer said he would speak to the custodial manager (CM) of C Wing to see if he could move there. (He emailed C Wing with the details.) Mr Owens said he had no thoughts of suicide or self-harm and that he hoped his cell mate returned from court as he liked to talk to him. The officer reminded Mr Owens of the avenues of support available to him and how he could access them.

62. On 13 August, a SO held the second case review. An officer and wing staff were present. The SO noted that Mr Owens engaged well and seemed to be in a good mood. He said he was feeling much better after being told by the officer that he was moving to another wing. He said he had no intention of ending his life and only said it when he was frustrated and needed to vent his frustration. As the only action

on the care plan was a wing move and this had been secured (and Mr Owens said he had no more issues), the SO stopped ACCT monitoring.

63. Staff moved Mr Owens to a shared cell on C Wing later that day.

64. On 14 August, a Lighthouse mental health nurse saw Mr Owens. He told her he felt settled on the wing after initial concerns about other prisoners bullying him because of his crime. He said he was not allowed to contact his girlfriend or his grandmother, and he wanted to appeal against the restraining order in place for his grandmother. He acknowledged that alcohol was a main trigger for his aggression, and he was keen to start a programme to address his issues in this area. They also discussed his medication and Mr Owens again raised the issue of risperidone. The nurse said this would have to be discussed with a psychiatrist.

65. On 16 August, a SO held a post-closure interview with Mr Owens. He noted that Mr Owens' original issues had been resolved and he had settled well on C Wing.

16 August – 16 September

66. On 16 August, the Head of Safer Custody noted on NOMIS that she had spoken to Mr Owens about self-isolation, but he was participating fully in the regime now that he had moved wings and was fully aware of the support available to him.

67. On 8 September, a psychiatrist saw Mr Owens. Mr Owens said his mood was low and he felt mildly paranoid, although sertraline had helped. He discussed wanting to try Antabuse (an alcohol abuse treatment) but the psychiatrist wanted to wait for a review by the substance misuse team. He increased the sertraline dose to 100mg.

68. On 16 September, an officer noted on NOMIS that Mr Owens had not left his cell to collect his meals that day. He took Mr Owens his food packs and asked him what was wrong. Mr Owens said he was not in the mood to eat but that he would be okay. He said he was enjoying being in the cell on his own.

Third ACCT opened 17 September

69. On 17 September, Mr Owens barricaded himself in his cell. He eventually removed the furniture from the door to allow an officer in. Mr Owens had a bed sheet draped around his neck and tied like a scarf, but it was not attached to anything. Mr Owens told the officer that he 'did not want to be here'. At 5.40pm, the officer started ACCT procedures.

70. A SO completed the Immediate Action Plan. Staff moved Mr Owens to a safer cell (a cell designed to minimise ligature points) on his own, as no suitable cell shares were available, and put him on two observations an hour with three quality interactions a day.

71. At 8.00am on 18 September, an officer carried out the ACCT assessment interview. Mr Owens said he was feeling stressed and paranoid. He said he was on medication for mental health issues but was unsure if it was doing him any good. He said he did not have suicidal thoughts at that time, but they did come over him in waves. He was aware of the support available and said he was willing to ask for it. He said he had self-harmed in the past, but it had not solved anything for him. Mr

Owens told her that although he had support from his aunt, he felt too paranoid to make calls, so staff had offered to help him do so at quieter times and he intended to take them up on this. He was happy to attend another Lighthouse appointment and participate in counselling again. The officer noted she would refer Mr Owens for another Lighthouse appointment. Distraction packs were in the cell and Mr Owens talked about the future in terms of an upcoming sports match the next day. He declined to complete a safety support plan at that time.

72. At 8.30am, SO A chaired the first ACCT review. He noted that he received verbal contributions from an officer, another SO and a nurse. The officer told the investigator that he had discussed Mr Owens with SO A following the ACCT assessment interview. Another SO said that he spoke to SO A about Mr Owens after the morning meeting. The nurse said that SO A had not spoken to her at all about Mr Owens. SO A has since accepted that he did not speak to the nurse, but said that he called the healthcare treatment room and got a contribution from someone who said there were no concerns about Mr Owens. We have been unable to verify this and none of the nurses on duty that morning recall speaking to him.

73. SO A noted that Mr Owens engaged well during the review and was polite and respectful throughout. Mr Owens said he was stressed because he was struggling to sleep at night. He said he was very bored in his cell but at the same time liked being on his own. The other SO had requested that Mr Owens move cells that day and Mr Owens said he was happy with that plan. He was aware he would not have a new cellmate for a few days as wing staff had said they would give him a few days to himself, which he was happy about. He said he had no thoughts of suicide or self-harm and knew how to access support.

74. SO A noted that he and the officer thought Mr Owens would benefit from an appointment with Lighthouse but that observations could be reduced to one an hour (the three quality conversations a day were maintained). He assessed Mr Owens' risk as low and set the next review for 22 September.

75. SO A completed a caremap with the following actions: a referral to Lighthouse, to issue a distraction pack and for wing staff to facilitate Mr Owens being on his own in a cell for a few days to 'sort his head out'. He marked all these actions as completed on 18 September.

76. The observation sheets show that observations were carried out as set and meaningful conversations were held. The last conversation recorded in the ACCT document was noted by an officer at 4.25pm on 18 September. He recorded that Mr Owens had declined food over the preceding 24 hours and that he and a SO spoke to Mr Owens at length. Mr Owens was emotional and seemed a bit fearful. Although he agreed to collect his food, the officer ended up carrying it back to the cell for him.

77. At 4.20pm a SO made his own note on NOMIS. It said that Mr Owens had come out to collect his evening meal and his breakfast pack for the next day. Mr Owens had seemed very upset over the preceding few days but was reluctant to tell staff why. After a lot of persuasion, he eventually told the SO and an officer that he was struggling to come to terms with a friend's death and his own alcohol issues. He said he was engaging with Dyfodol (drug and alcohol support) and did not want to

speak any further. He was grateful for their help and said he felt more positive after speaking to them.

78. The ACCT ongoing record shows that Mr Owens was checked once an hour during the night with the last check at 8.05am.

19 September

79. On 19 September, at approximately 8.40am, Officer A went to see how Mr Owens was (having spoken to him at length the day before). A colleague was unlocking prisoners who needed medication, but Mr Owens had not yet been unlocked. He opened Mr Owens' door and found him hanging from a bed sheet attached to the bars of the cell window. He shouted for staff assistance while trying to lift Mr Owens' body.

80. Officer B was first to respond and helped to hold Mr Owens up. Another officer then arrived, and the other officers shouted for him to cut the ligature. He used his fish knife out and started to cut through the bed sheet. When this was released, he noticed a second ligature attached to the window bars and he cut through this as well.

81. A SO arrived and Officer A asked him to call a medical emergency code urgently. The SO called a medical emergency code and the control room officer called an ambulance.

82. The control room log shows the medical emergency code was called at 8.43am and the ambulance requested at 8.48am. The control room officer told us that his colleague was completing the log (for the first time) and there are various time pieces in the control room which are not all synchronised (a matter which he says he raised in the hot debrief).

83. The officers managed to get Mr Owens to the floor and other staff attended. Officer B began cardiopulmonary resuscitation (CPR). Two nurses arrived quickly and assessed he was warm to the touch and no mottling was present. The nurses inserted an airway and gave Mr Owens oxygen. The defibrillator advised 'no shock' and the nurses continued with CPR.

84. At 8.55am the ambulance arrived, and paramedics continued CPR for a further half an hour (resuscitation attempts went on for approximately an hour in total). However, they were unsuccessful and declared Mr Owens dead at 9.30am.

85. The post-mortem report states that a letter from Mr Owens to his aunt was recovered from Mr Owens' cell. The coroner would not release a copy to the investigator or provide a written summary of the contents.

Contact with Mr Owens' family

86. On 19 September, the prison appointed two family liaison officers. They visited Mr Owens' family that morning to break the news.

87. Mr Owens' funeral was on 9 October and the Governor and one family liaison officer attended. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

88. After Mr Owens' death, a prison manager 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. However, staff told us that they did not consider the hot debrief to be a 'structured' debrief and some considered there was a lack of support.

89. The prison posted notices informing other prisoners of Mr Owens' 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 Owens' death.

Post-mortem report

90. The post-mortem report concluded that the cause of Mr Owens' death was 'consistent with hanging'. The toxicology report said only therapeutic levels of sertraline had been detected.

Findings

Management of Mr Owens' risk of suicide and self-harm

91. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as being at risk of suicide and self-harm.

92. Mr Owens was monitored under ACCT procedures on three separate occasions at Swansea and was being monitored when he was found hanging on 19 September. Staff started the last period of ACCT monitoring on 17 September after Mr Owens barricaded himself in his room, tied bedsheets around his neck and told staff he 'did not want to be here'. We have concerns about how the last period of ACCT monitoring was managed.

Attendance at first case review

93. SO A chaired the first case review at 8.30am on 18 September. PSI 64/2011 says that the first case review should be attended by the ACCT assessor whenever possible, a member of staff who knows the prisoner (for example, a wing officer) and a member of healthcare staff. It says that if invited participants cannot attend in person, exceptionally, they can provide a written account of their input.

94. SO A was the only person to attend the first case review with Mr Owens. He noted that an officer (the ACCT assessor), another SO (the wing SO) and a nurse gave verbal handovers. The officer said she spoke to SO A after the ACCT assessment interview and the other SO said he spoke to SO A after the morning meeting, but it appears neither were invited to take part in the case review as they should have been. More worryingly, the nurse disputes that SO A ever spoke to her about Mr Owens and was very surprised to learn that the case review record shows that she provided a verbal handover.

95. SO A noted on the case review record that healthcare staff were unable to attend due to dealing with the morning medications, but that he had managed to speak to the nurse, who had provided a full handover and said there were no concerns about Mr Owens. However, the nurse said that she had not provided a contribution to the ACCT review and had not even spoken to the SO about Mr Owens.

96. When this was put to SO A, he said that he had called the healthcare treatment room and had spoken to someone who he thought was the nurse, but it must have been someone else. Neither of the other two nurses who were on duty at the time could recall speaking to him. All the nurses said that, in any case, an ACCT contribution would be a matter for the Crisis team, so they would have passed any such call on.

97. The Governor checked the telephone records for that day and told us that a call was made from the wing office to the healthcare treatment room at approximately 8.00am, which lasted 11 seconds. It is probable that this was SO A, but we consider that 11 seconds would have been insufficient time for him to explain who he was calling about and why, let alone receive a quality contribution to an ACCT review.

98. In addition, it appears that the Crisis team were expecting to be invited to the first case review but were not told about it. At 3.05am on 19 September, a member of the Crisis team noted on Mr Owens' medical record that he had not attended a Crisis session which should have taken place on 18 September. The Head of Healthcare told the investigator that this referred to the ACCT review that Crisis expected to be invited to but were not.

Assessment of risk

99. At the first case review, SO A reduced the observations from two to one an hour and also noted that he was content for Mr Owens to be moved from a safer cell into a standard cell on his own. We are very concerned that there was no healthcare input to these decisions, not only because a member of healthcare staff should have been at the first case review, but also because of the concerning behaviour that Mr Owens had displayed the day before, when he was found with a bed sheet tied around his neck and said he wanted to die. We consider that it was important for mental health staff to have input into the case review and into the decisions on reducing observations and moving Mr Owens from a safer cell.

100. We consider that the decision on 18 September to reduce observations was poorly judged. SO A told the investigator that he reduced the observations because Mr Owens told him he had no current thoughts of suicide or self-harm and had not self-harmed in a while. Given that less than 24 hours before Mr Owens had been found with a bed sheet tied around his neck and told staff he wanted to die, we consider that it was naïve of him to accept Mr Owens' assertions that he no longer had thoughts of suicide and self-harm. He had also told an officer less than 30 minutes earlier that he experienced suicidal thoughts in waves. We therefore consider that there was little evidence that Mr Owens' risk had reduced and that the decision to reduce observations was premature.

101. As for the decision to move Mr Owens from the safer cell, a SO told the investigator that he had spoken to SO A about concerns he had with Mr Owens' location. He said that the safer cell was dark and gloomy and had no wiring for a television, which Mr Owens was entitled to. It was also close to the Segregation Unit, which could be noisy. He thought that Mr Owens would be better off in a standard cell, which was more comfortable and had more to occupy him.

102. On 18 September, Mr Owens was moved to a standard double cell but remained on his own. When interviewed, SO A acknowledged that a cellmate was a protective factor and said that he discussed the option of cell sharing with Mr Owens, but he said he had issues with the possible sharers. The SO said he left the matter with the wing staff and specifically another SO to sort out a suitable cell share for Mr Owens. However, his entry in the ACCT document says Mr Owens would not have a cellmate for a few days because wing staff had said they would let him have a few days to himself. We consider that while there were sound reasons for moving Mr Owens out of the safer cell, he should not have been moved to a standard cell on his own.

Access to previous ACCT documentation

103. SO A noted on NOMIS that one of the reasons for reducing observations was because Mr Owens had not self-harmed for a year – this was not correct and would

have been obvious from previous ACCT documents. He told the investigator that previous ACCT documentation was kept in the Safer Custody department and was not available. If he had had access to the previous documents, not only would he have seen that Mr Owens had taken an overdose in August, but also that actions to re-engage him with his family had had very positive results.

Caremap

104. SO A completed a caremap for Mr Owens at the first case review. He signed off that he had made a referral to Lighthouse and the investigator has seen evidence of this. However, we consider a more effective action would have been to ensure an appointment for a mental health assessment was, at least, in place before signing off the action.

105. In light of the false record made by SO A about healthcare staff's input into the ACCT case review on 18 September and the multiple failings with the management of the ACCT procedures, we make the following recommendations:

The Governor should initiate an investigation into SO A's actions in relation to the ACCT case review on 18 September with a view to considering whether disciplinary action is appropriate.

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national policy, in particular staff should:

- **keep accurate records of case reviews and who attended or contributed;**
- **assess risk based on the prisoner's known risk factors, including any recent suicide attempts and incidents of self-harm, and not solely on what the prisoner tells them;**
- **be mindful of the protective element provided by a cellmate and ensure that when a prisoner being monitored under ACCT is moved into a cell on their own, the reasons are fully documented;**
- **set appropriate, meaningful caremap actions and mark them as complete only once they are actioned fully;**
- **consult previous recent ACCT documentation.**

Lack of involvement by the Crisis team

106. On 18 September, the Crisis team clearly missed an opportunity to contribute to the ACCT case review. The Head of Healthcare told the clinical reviewer that the Crisis team were aware that a case review was going to be held on 18 September as they had been given the list in advance from Safer Custody and entered it onto their ledger (specific times are not given for the reviews). However, when they did not receive a call summoning them to the review, they did not check at the end of the day what had happened.

107. It appears that the Crisis team did not have a policy in place clarifying that staff should check 'missed' ACCT reviews, although the Head of Healthcare told us that she has since spoken to staff about the matter. She has provided a copy of a new draft policy, but we do not feel it addresses this particular issue. We make the following recommendation:

The Head of Healthcare should ensure a policy is in place to ensure members of the Crisis team query any ACCT reviews that they have been booked for but not subsequently asked to attend.

Emergency response

108. PSI 03/2013, Medical Emergency Response Codes, requires prisons to have a medical emergency response code protocol, which should ensure that staff call an appropriate code to summon help immediately and to ensure an ambulance is also requested at once Swansea has such a protocol.

109. At approximately 8.40am on 19 September, Officer A entered Mr Owens' cell and found him hanging. He shouted for assistance whilst trying to lift Mr Owens up in order to relieve the pressure on his neck from the ligature. Officer B entered the cell and immediately helped Officer A shoulder the weight, followed by another officer, who started to cut the ligature. A SO entered the cell swiftly after the third officer and called a medical emergency code over his radio before assisting the officers.

110. When interviewed and asked why they had not called an emergency code straightaway, neither Officer A nor the third officer could recall if they were carrying a radio; Officer B was unavailable for comment. The SO said there were only three radios per five staff on that wing, and he definitely had one of them.

111. Although staff demonstrated at interview that they understood when and how to use the emergency codes, they found it difficult to express what they would do when faced with the choice of calling a code first or dealing with a ligature. We understand the dilemma staff face in this situation but do not think it was acceptable that it took a fourth person to arrive at the scene before an emergency code was called. We make the following recommendation:

The Governor should remind staff of the medical emergency response protocol and ensure they are clear that where codes are appropriate, they should be used immediately.

Timings

112. The investigator noticed that the records indicate a delay between the time the control room recorded hearing the medical emergency code (8.43am) and when they called an ambulance (8.48am). Ambulance records show that the call was made at 8.48am.

113. The control room officer who made the call to the emergency services, told the investigator that there were three clocks in the control room all showing different times. He said it was also the first time his co-worker had completed the log and he believes she was possibly looking at different clocks when doing so. He said there had been no delay between hearing the emergency code and calling the ambulance. If that is so, it seems likely that the medical emergency code was actually called nearer to 8.48am, which would mean there was around an eight-minute delay between staff finding Mr Owens hanging and calling the emergency code.

114. We have no way of knowing when the emergency code was called, and we recommend:

The Governor should ensure that key establishment clocks are accurate.

Key workers

115. All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them. Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

116. However, key work was suspended in prisons on 24 March 2020 due to the COVID-19 pandemic. On 12 May 2020, HMPPS introduced an Exceptional Delivery Model which sets out how some elements of key work should be delivered. It identifies several priority groups and says that prisons should identify prisoners in those groups and seek to deliver the exceptional delivery model of key work to them. It lists prisoners at risk of suicide or self-harm as a priority group and says prisons should maintain the delivery of key work to prisoners on open ACCTs and consider retaining it for those in the post-closure phase.

117. Mr Owens was managed under ACCT from 28 to 29 July, from 5 to 13 August and from 17 September. We were told that Mr Owens was allocated a key worker as soon as he appeared on the Safer Custody log. However, there is record of only one key worker session - on 28 July 2020 – which his allocated key worker did not carry out anyway. An officer confirmed whom Mr Owens' allocated keyworker was, but that during the rest of Mr Owens' period in custody she was either on nights or rest days, and then was in COVID-19 isolation. No plans were made to replace the officer as Mr Owens' key worker.

118. Although Mr Owens was on three ACCTs in two months, and records indicate staff were good at having meaningful conversations with him, it would have been beneficial for Mr Owens to have had a consistent member of staff to build a rapport with and hold frequent conversations. We make the following recommendation:

The Governor should ensure that during a restricted regime, key work is delivered in line with the Exceptional Delivery Model.

Clinical care

119. The clinical reviewer concluded that overall, the clinical care Mr Owens received was of a high standard. Staff carried out comprehensive reception screens covering both physical and mental health and made appropriate referrals. Mr Owens received appropriate detoxification medication.

Support

120. Support for staff after a self-inflicted death is essential for ensuring their personal wellbeing and preserving their ability to do their job effectively.

121. A prison manager told the investigator she had carried out a hot debrief after the incident where staff were signposted to the support available to them. A SO told

the investigator that the debrief was not particularly structured (although he felt that subsequent support was good).

122. The officer who had opened the last ACCT just two days before Mr Owens' death, was told what had happened by a colleague. He then received a general email to staff but was not signposted to support specifically. He felt it would have been helpful to have had support from the start.

123. SO A said he was relieved of ACCT duties for a couple of weeks after the incident in order to 'clear his head', but he did not receive any support as such.

124. We make the following recommendation:

The Governor should remind managers of the importance of offering support to all staff involved following a death in custody.

Inquest

125. At the inquest, held from 11 to 22 September 2023, the jury concluded that Mr Owens died by suicide contributed to by neglect. The jury considered that Mr Owens' risk of suicide was not adequately assessed on 18 September 2020 and as a result, appropriate action was not taken to safeguard him. In particular, the ACCT review undertaken on 18 September failed to sufficiently evaluate and reduce his risk.

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