Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Davies, a prisoner at HMP Cardiff, on 12 September 2021

A report by the Prisons and Probation Ombudsman

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 Alan Davies died in hospital on 12 September 2021, having been admitted from HMP Cardiff earlier that day. The cause of death was recorded as cardiac arrest in a setting of dehydration and starvation. Mr Davies was 53 years old. I offer my condolences to his family and friends.

Mr Davies was transferred to Cardiff ten days before his death, having spent the previous three years in a medium secure psychiatric hospital. He began to refuse food in his last two weeks in hospital and did not eat anything following his arrival at Cardiff. He stopped drinking on his second day in the prison and rarely engaged with staff, often turning his back on those who tried to speak to him. Mr Davies refused all clinical observations and monitoring.

Managing Mr Davies' needs was challenging for prison and healthcare staff, and many did their best to provide what limited assistance Mr Davies would allow. However, some aspects of his care could have been better. Mr Davies' challenging behaviour and needs should have prompted senior managers to become involved in care planning. Uncertainty about when Mr Davies began refusing food, which could have been resolved with better information sharing, meant that an opportunity to admit him to hospital earlier was missed.

The events of the night of Mr Davies' death are troubling and shocking. He spent over two hours lying naked on the floor of his cell, seemingly unable to get up, and trying to ask for help. Although he was checked several times during this period and was in a camera cell with a monitor in a staff office, the staff on duty did not provide assistance until they recognised that he had stopped breathing.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **March 2023**

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Summary

Events

1. In January 2017, Mr Alan Davies was remanded in custody to HMP Stoke Heath. He was later sentenced to 19 years in prison. In December, shortly after he was transferred to HMP Parc, Mr Davies began to refuse food. In February 2018, Mr Davies was admitted to a medium secure psychiatric hospital under the Mental Health Act.

2. In 2021, hospital staff determined that Mr Davies no longer required detention under the Mental Health Act. On 2 September, he was transferred to HMP Cardiff. On arrival at Cardiff, hospital staff told prison staff that Mr Davies had not eaten for 16 days but had consumed fluids. Mr Davies did not say why he was not eating, other than that he did not want to take his life. Prison staff started suicide and self-harm prevention procedures (known as ACCT) and Mr Davies was allocated a cell in the healthcare inpatient unit.

3. Mr Davies did not appear to eat any food during his time at Cardiff. He had a drink on 3 September but there is no evidence that he had anything to drink after this. He refused all clinical observations and engaged little with prison and healthcare staff, sometimes turning his back on them when they tried to speak to him.

4. On 10 September, a prison doctor and the duty operational manager discussed whether Mr Davies required general hospital admission. The prison doctor said that she decided not to admit Mr Davies because she was told that Mr Davies had been eating shop-bought snacks in the psychiatric hospital. This meant that he had been refusing food for eight days rather than 24 days as she had initially thought.

5. On the night of 11 to 12 September, Mr Davies spent over two and a half hours lying naked on the floor of his cell, seemingly unable to get up. In-cell camera footage shows that he tried to call for help many times. Although the staff on duty looked in his cell several times and could see him on a monitor in the staff office, no one went into the cell to provide assistance. At 2.54am, a healthcare assistant identified that Mr Davies was not breathing. Two minutes later, the healthcare assistant and an officer opened the cell, began cardiopulmonary resuscitation and radioed for emergency assistance. Paramedics took Mr Davies to hospital, where he died later that morning.

Findings

6. Managing Mr Davies' behaviour presented staff at Cardiff with considerable challenges. While some positive actions were taken, and it is apparent that many staff knew and understood the issues surrounding his care, there were some areas where this care could have been better.

Managing the risk of suicide and self-harm

7. There was no consideration given to referring Mr Davies to the Safety Intervention Meeting, where senior managers and other relevant specialists at Cardiff could have considered and discussed his complex and multidisciplinary needs. Support

actions set for Mr Davies were either statements of fact or did not identify how the support needed might be achieved.

Clinical care

8. Some aspects of Mr Davies' clinical care were appropriate and timely. However, the clinical reviewer found that discharge and care planning were unclear and Mr Davies' food and fluid intake should have been better recorded.

9. A lack of clarity and information sharing about the length of time that Mr Davies had not eaten meant that an opportunity to admit him to hospital on 10 September was missed. Following this, healthcare staff could have been better directed about indicators that Mr Davies had deteriorated, and that escalation was required.

Night of 11 to12 September 2021

10. We are very concerned about the actions of staff on the night of Mr Davies' death. It should have been clear that he was in distress and required assistance. It is unacceptable that he was left lying naked on the floor of his cell, unable to get up and trying to ask for help for so long.

Emergency response

11. When staff identified that Mr Davies was not breathing, it took too long to open his cell and request emergency medical assistance.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:
  - case reviews consider all relevant information and address issues through specific and meaningful support actions; and
  - prisoners with challenging needs or significant complexity are referred to the Safety Intervention Meeting.
- The Head of Healthcare should ensure that a range of healthcare staff are involved in discharge planning when a patient is to be transferred from a psychiatric hospital when there are potential issues with physical as well as mental ill health, and that all relevant staff, including prison doctors, receive a formal handover of care.
- The Head of Healthcare should ensure that prisoners who are refusing food or fluid are managed in line with national guidelines, including that:
  - comprehensive care plans are created to identify when further interventions, including hospital admission, are needed; and
  - food and fluid intake and the start date of food and fluid refusal are clearly recorded.
- The Governor and Head of Healthcare should ensure that staff on the healthcare inpatient unit observe prisoners as directed, and that staff satisfy themselves that

the prisoner is alive and well at each observation and provide any assistance required.

- The Governor should conduct a disciplinary investigation into Officer A's actions on the night of 11-12 September 2021.
- The Governor and Head of Healthcare should inform the Ombudsman of the findings of the internal investigations into the events of 11-12 September 2021, and of any action taken as a result.
- The Governor and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and understand their responsibilities during a medical emergency, including that:
  - staff communicate a medical emergency without delay, using the appropriate medical emergency response code; and
  - staff go into cells as quickly as possible in a potentially life-threatening situation.

The Investigation Process

12. 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. He obtained copies of relevant extracts from Mr Davies' prison and medical records.

13. The investigator interviewed nine members of staff at Cardiff in October and November 2021.

14. Healthcare Inspectorate Wales commissioned a clinical reviewer to review Mr Davies' clinical care at the prison. The clinical reviewer joined the investigator for interviews with healthcare staff.

15. We informed HM Coroner for South Wales of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Davies' sister and nephew to explain the investigation and to ask if they had any matters that they wanted us to consider. They asked for information about the cause of death.

17. The family liaison officer also contacted Mr Davies' daughter who asked the following questions:

    - Was appropriate care provided to Mr Davies at HMP Cardiff?
    - Why was Mr Davies not sent to hospital on 10 September 2021?
    - Should more have been done to assist Mr Davies on the night of 11-12 September?
    - Why was she not treated as Mr Davies' next of kin by HMP Cardiff and why was his property not returned to her?

18. We shared the initial report with HM Prison and Probation Service (HMPPS). They did not identify any factual inaccuracies.

19. We also shared the initial report with Mr Davies' family. His daughter raised some issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Cardiff

20. HMP Cardiff holds around 800 remand and sentenced men, many of whom arrive from local courts. Cardiff and Vale University NHS Health Board provides primary and mental health services and healthcare staff are on duty 24 hours a day. There is a 22-bed inpatient unit, including four single cells with in-cell cameras.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Cardiff was in July 2019. Inspectors reported that levels of self-harm were far higher than at similar prisons and over three times higher than at their previous inspection (in 2016). They found that there was no clear strategy for reducing these very high levels. Inspectors also reported that the standard of ACCT records was variable and undermined the care provided. They found that while some prisoners were positive about the support they received, others said that their needs were not being met.

22. Inspectors reported that healthcare inpatients received good, responsive care and the physical environment of the unit had improved. They found that the number of staff on the mental health team had increased but was still not sufficient to meet the high level of need.

Independent Monitoring Board

23. 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 August 2021, the IMB reported that self-harm had reduced by a quarter in the reporting year. The IMB also reported that an increase in staffing in healthcare had led to an improvement in the service provided.

Previous deaths at HMP Cardiff

24. Mr Davies was the ninth prisoner to die at Cardiff since September 2019. Three of the previous deaths were self-inflicted. There are no significant similarities between our investigation findings into the previous deaths and that of Mr Davies.

Assessment, Care in Custody and Teamwork

25. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

26. As part of the process, a caremap (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.

Key Events

27. Mr Alan Davies was admitted to psychiatric hospitals several times from a young age, often following self-harm or threats to take his life. He harmed himself frequently throughout his adult life. Mr Davies was diagnosed with an emotionally unstable personality disorder. Prior to custody, he was prescribed quetiapine (an antipsychotic) and mirtazapine (an antidepressant).

28. On 16 January 2017, Mr Davies was remanded in custody to HMP Stoke Heath. Prison staff noted his history of mental ill-health and self-harm and started ACCT procedures. In February, Mr Davies tried to hang himself and reportedly made another attempt to take his life. For part of the month, he did not eat or drink. On 23 March, prison staff stopped the ACCT procedures.

29. On 25 August, Mr Davies was convicted of grievous bodily harm with intent to endanger life and sentenced to 19 years in prison. After court, he was transferred to HMP Altcourse. Mr Davies chose to stop taking his medication following the transfer.

30. On 27 November, Mr Davies was transferred to HMP Parc. Staff started ACCT procedures shortly after his arrival, when Mr Davies said that he was thinking of harming himself.

31. In early December, Mr Davies began to refuse food. He reportedly drank irregularly. On 28 December, he said that he was not eating because he believed he was innocent and should not be in prison.

32. On 4 January 2018, a psychiatrist assessed Mr Davies. He concluded that Mr Davies required hospital assessment and treatment under the Mental Health Act. At around the same time, Mr Davies stopped speaking to prison staff, communicating only in gestures.

33. On 25 January, Mr Davies was admitted to a general hospital due to a deterioration in his physical health from not eating. He remained in hospital until 15 February, when he was transferred to Caswell Clinic, a medium secure psychiatric hospital, under the Mental Health Act.

34. After three years at Caswell Clinic, hospital staff concluded that Mr Davies no longer required detention under the Mental Health Act. On 20 August 2021, a member of the mental health team at HMP Cardiff and the Head of the Offender Management Unit attended a discharge planning meeting with staff from Caswell Clinic. The meeting minutes recorded that Mr Davies was refusing medication, with no apparent deterioration in his mental state. They noted that he was reluctant to return to prison and was currently “restricting [his] diet” to purchases and snacks from the hospital shop.

35. A discharge summary, completed shortly before he transferred to Cardiff, identified that Mr Davies just ate soup and snacks in August and did not eat any food provided by the hospital. The discharge summary noted that towards the end of the month (the exact timescale is not identified), Mr Davies’ diet reduced further, and he only drank fluids, which was thought to be in response to realising that he would

return to prison. On 1 September, this information, as well as other documents about Mr Davies' medical history, was emailed to Cardiff healthcare.

HMP Cardiff

36. On 2 September, Mr Davies was transferred to Cardiff. Reception staff started ACCT procedures after staff at Caswell Clinic told them that Mr Davies had not eaten anything for 16 days. Mr Davies confirmed this and said that he had drunk squash and would continue to do so. When asked why he was not eating, Mr Davies said that he did not want to take his own life but that he would not say anything further. It does not appear that Mr Davies ate any food for the remainder of his life.

37. Healthcare staff admitted Mr Davies to the healthcare inpatient unit because of his physical frailty and for observation. He was allocated a camera cell to allow healthcare staff to observe him more easily. (Mr Davies' cell was opposite the staff office, which contains screens showing footage from inside the cell.) Mr Davies refused all clinical observations. There was no formal capacity assessment but the clinical lead recorded that Mr Davies appeared to have the capacity to refuse food and clinical examination.

3 September

38. A nurse recorded that Mr Davies continued to refuse to engage with clinical observations and health screening. Mr Davies refused water but said that he would drink some squash. (Prison staff recorded that he had a drink of squash later in the day.)

39. A senior mental health nurse received email correspondence from Caswell Clinic which stated that Mr Davies had not eaten anything for 16 days. The nurse told us that Caswell Clinic staff suspected that Mr Davies had eaten some snacks during this time, but that this had never been confirmed and that clinic staff were therefore treating him as though he had not eaten.

40. A Custodial Manager (CM), who was the Safer Custody Manager, held the first ACCT case review. A nurse and the mental health team lead also attended. We watched in-cell camera footage of the case review. The mental health team lead established that Mr Davies understood where he was and asked some questions about his mobility, identifying that he had walked with a stick for two months and was able to get on and off the toilet. Mr Davies said that he was "too weak" to use the shower but said that he did not want any help with his mobility.

41. The CM then asked Mr Davies why he was not eating, to which he replied, "I don't want to talk about it". He asked Mr Davies if he intended to take his life, to which Mr Davies answered "no". He then explained the ACCT process to Mr Davies.

42. The CM recorded that Mr Davies had not eaten for 16 days, although there was "some suspicion" that he had consumed food from the shop at Caswell Clinic. He told us a nurse, who had spoken to hospital staff, gave him this information, but he added that it was never confirmed that Mr Davies had eaten anything from the hospital shop. The CM recorded four support actions: for Mr Davies to be

encouraged to engage with the mental health team; that he was physically frail; for him to be given distraction materials; and that he had said he did not want contact with any friends or family. He recorded that Mr Davies was not at high risk of suicide and self-harm and set a minimum of three ACCT observations and two conversations per day.

4-6 September

43. On 4 September, a nurse recorded that Mr Davies refused to engage with him and declined clinical observations. He recorded that Mr Davies had not eaten that day. No one recorded whether Mr Davies had anything to drink.

44. On 5 September, a nurse recorded that he spoke to Mr Davies who only engaged by nodding or shaking his head. He recorded that Mr Davies refused food and drink or to have clinical observations taken.

45. On 6 September, Mr Davies again refused food and drink. He said he had not drunk anything for 24 hours but was passing urine. A nurse recorded that Mr Davies said that he "had his own reasons" for this but would not expand further. On the same day, the mental health team lead recorded that she tried to speak to Mr Davies, but he turned away from her to face the wall.

7 September

46. A nurse recorded in the ACCT document that Mr Davies continued to refuse food and fluids.

47. The Head of Safety led an ACCT case review. (The CM who was the case co-ordinator was on a training course that day.) Two nurses (one a senior nurse), a prison GP and a CM from the safety team also attended. In-cell camera footage shows that the Head of Safety asked Mr Davies whether he wanted to be treated were he to become seriously unwell. Mr Davies shook his head in response. He asked Mr Davies if he would be prepared to sign an advance directive, to which Mr Davies also shook his head. He therefore asked Mr Davies if it was correct that he did not want any medical treatment. Mr Davies nodded in response. The Head of Safety told us that it was clear to all present that Mr Davies did not wish to have any medical treatment.

48. The Head of Safety also asked Mr Davies if there was anything they could do to make him more comfortable or to encourage him to eat or drink. Mr Davies shook his head to each question. A nurse asked Mr Davies whether he had eaten or drunk anything since he had been at Cardiff and whether he could remember the last time he had had a drink. Mr Davies shook his head to both questions.

49. The Head of Safety recorded an action point that the senior nurse would contact the regional patient safety team to discuss Mr Davies' refusal of medical treatment and refusal to sign an advance directive. He made no change to the level of risk or observations.

50. The senior nurse told us that she and her colleague contacted patient safety and legal teams at the Cardiff and Vale University Health Board afterwards but neither

of them received a reply. A multi-agency meeting was later arranged for 13 September, with the aim of discussing care planning and when medical staff could intervene to preserve life.

8 September

51. A nurse recorded that Mr Davies refused all fluids.

52. A prison GP reviewed Mr Davies. She recorded that Mr Davies had been refusing food and fluid for six days at Cardiff and that a senior nurse told her that the food refusal started around 16 days before this. The GP noted that Mr Davies did not speak to her and lay on the bed, with his back turned. She recorded that she believed he was choosing not to engage (rather than being unable to) and had capacity to make that decision.

53. Afterwards, the prison GP discussed Mr Davies with the senior nurse and another nurse. She prescribed Fortisip (a nutritional drink supplement) for Mr Davies to be given were he to choose to start eating again.

9 September

54. A nurse recorded that Mr Davies continued to refuse food and drink.

55. A prison psychiatrist reviewed Mr Davies. He recorded that Mr Davies was uncommunicative and shook his head a couple of times before turning to face the wall. He noted that Mr Davies was subsequently unwilling to discuss his food refusal or current wishes. He recorded that it was impossible to assess Mr Davies' mental state adequately as he was unwilling to speak or engage.

56. In the afternoon, the senior nurse assisted Mr Davies when he was on the floor of his cell and unable to get up. During the night, prison and healthcare staff again had to assist Mr Davies from the floor when he was unable to get onto his bed.

10 September

57. Prison staff recorded that Mr Davies continued to refuse all food and drink.

58. At around 9.00am, a CM (the Safer Custody Manager and ACCT case coordinator) and the mental health team lead visited Mr Davies for an ACCT case review. The CM recorded that Mr Davies looked "extremely frail" and that there had been an "obvious deterioration" since he saw him a week earlier. He recorded that Mr Davies had not eaten anything or been seen drinking during that time. In-cell camera footage shows that the CM asked Mr Davies if there was anything they could get him, including different types of drink. Mr Davies shook his head to these questions and repeated this action when asked if he had had anything to drink in the past week. The CM asked Mr Davies whether he intended to die, to which he gave a small shake of the head. (The CM repeated the question to ensure that this was Mr Davies' answer.) The mental health team lead asked Mr Davies if he would allow her to take clinical observations, to which he shook his head.

59. The CM recorded an action point that the multi-agency meeting on 13 September would discuss if and when to intervene medically to preserve Mr Davies' life. He noted that attendees would include a prison GP, the psychiatrist and the Head of Safety. The CM made no change to the frequency of observations.

60. The psychiatrist discussed Mr Davies with a psychiatrist at Caswell Clinic and the mental health team lead. He recorded that Mr Davies' current behaviour appeared to be motivated by protest and engineering a return to hospital. The psychiatrist noted that the other psychiatrist's opinion was that further hospital detention under the Mental Health Act was not currently appropriate. He recorded his view that it was still impossible to assess Mr Davies' capacity to refuse food and fluid given his lack of engagement and that, in the absence of him clearly stating otherwise, he should be actively treated if his physical health deteriorated further, and he needed to be admitted to hospital.

61. At 1.50pm, a prison GP visited Mr Davies. In-cell camera shows that three members of staff helped Mr Davies onto his bed, after which he turned his back to the GP. She told Mr Davies that it was difficult to assess his capacity if he did not speak to her and he could not be treated properly if he would not tell her his wishes. Mr Davies did not appear to respond.

62. The prison GP recorded that she was not satisfied that Mr Davies had the capacity to make decisions about his treatment. She recorded that he had been accepted for admission to the University Hospital of Wales that day but that this would expire if he was not in hospital by midnight and a new referral would therefore be needed.

63. The prison GP recorded that she had discussed Mr Davies' potential admission with the duty operational manager. She noted that the discussion highlighted "a number of contextual issues", including that there were three prisoners on bedwatch (hospital inpatients) and that Mr Davies might be recategorized as a Category B, rather than Category C, prisoner. She noted that she would see Mr Davies with the duty operational manager and reassess him. (The duty operational manager did not make any record of the events of 10 September.)

64. At 2.55pm, the prison GP and the duty operational manager visited Mr Davies. The manager asked Mr Davies if he wanted to have a conversation, to which Mr Davies responded by shaking his head. He told Mr Davies that his future prison location would depend on whether he was classified as a Category B or Category C prisoner. Mr Davies did not respond. The GP told Mr Davies that a return to Caswell Clinic was not an option being considered but that they could arrange any medical treatment he wanted. The manager asked Mr Davies if he would let them take him to hospital for treatment, to which Mr Davies nodded. He did not answer any follow-up questions.

65. Following the assessment, the prison GP recorded that she had now been told that Mr Davies had been buying food from the hospital shop at Caswell Clinic, meaning that he was on day eight of food refusal rather than day 24. She recorded that this meant that his level of risk was lower than previously thought and that he no longer needed immediate hospital admission. She noted that this should be revisited over the weekend (10 September was a Friday) or early the following week.

66. The prison GP told us that she did not know whether Mr Davies had eaten in his last 16 days at Caswell Clinic. She said that the prison GPs did not receive a handover from Caswell Clinic staff, and she therefore relied on what prison and healthcare staff told her about Mr Davies' history. She said that she initially thought that Mr Davies should be admitted to hospital because his level of risk, having not eaten for three weeks and not drunk anything for some time, had increased to the point that he needed hospital treatment. The GP said that the duty operational manager subsequently told her that he was informed at the discharge planning meeting (on 20 August) that Mr Davies had been buying food from the hospital shop, which she concluded meant that he had not been fasting for as long as she had initially thought. She said that this meant that Mr Davies was now in a lower category of risk and that this was the reason that she chose not to admit him to hospital. She added that operational issues were not a factor in this decision.

67. The duty operational manager told us that if the GP had wanted Mr Davies to be admitted to hospital, this would have gone ahead, regardless of any operational issues. He said that he discussed the findings of the discharge planning meeting with the GP and that she concluded that he should remain at the prison rather than go to hospital.

68. During the night, prison and healthcare staff observed Mr Davies lying on the floor of his cell unable to get up. They went into the cell and helped him onto his bed.

11-12 September

69. Prison and healthcare staff recorded that Mr Davies refused all food and drink offered to him. They recorded that he remained in bed all day and did not communicate, other than sometimes nodding or shaking his head. At around 6.00pm, prison staff helped Mr Davies from the floor of the cell onto his bed.

70. A nurse and a Healthcare Assistant (HCA) were on duty in the healthcare inpatient unit on the night of 11-12 September. Officer A was also in the unit, constantly supervising a prisoner in a neighbouring cell to Mr Davies' cell.

71. The nurse told us that, at around 10.00pm, she called the duty manager to the healthcare unit to help Mr Davies from the floor of his cell back onto bed. Officer A said that he helped with this too. There was no record of this in the medical record or ACCT document.

72. We viewed in-cell camera footage of the events of 11-12 September. At 10.38pm, Mr Davies rolled off his bed onto the floor. He remained on the floor for over an hour, occasionally wriggling.

73. The nurse recorded that she completed an ACCT observation at 11.00pm. (Although Mr Davies' ACCT observations were set less frequently than this, the nurse told us that all healthcare inpatients are observed hourly during the night.) She told us that she could not remember what Mr Davies was doing at this time.

74. At 11.45pm, Mr Davies climbed back onto his bed. The HCA recorded that she completed an ACCT observation at 12.00am. She told us that Mr Davies was "[lying] on the bed breathing".

75. At 12.08am, Mr Davies rolled from his bed and onto the floor. He was not wearing a top and his trousers and underpants were below the groin and halfway to his knees. By 12.17am, Mr Davies' trousers and underpants were down to his ankles, meaning that he was effectively naked. (Mr Davies remained on the floor with his clothing in this position for the rest of the night.)

76. From 12.19am, Mr Davies began to repeatedly say, "Help me". He appeared to be trying to shout but the words came out in a loud whisper. From 12.26am, Mr Davies began to bang the chair in his cell while still saying, "Help me".

77. At 12.37am, the HCA shouted from outside the cell, "Alan, cover yourself up or get back into bed". Mr Davies continued to bang the chair and say "help" afterwards. The HCA told us that this is something she had also said to Mr Davies earlier in the week when he had been on the floor, and that he would previously comply with the instruction. She said that Mr Davies did not get back onto the bed on the night of 11-12 September and so she "just left him there". She told us that she did not hear Mr Davies asking for help, but could see him banging the chair on a monitor in the staff office.

78. From 12.48am, Mr Davies began to bang the chair and say "help" less frequently than previously. He often wriggled on the floor and looked like he was trying to get up.

79. The HCA recorded an ACCT observation at 1.00am. She told us that she did not consider asking for someone to open Mr Davies' cell door so they could help him as this was "the norm" for him and "[not] out of the ordinary".

80. From 1.20am, Mr Davies began to lie still. He was no longer wriggling although moved his arms a little.

81. At 2.00am, the HCA recorded that she had completed an ACCT observation.

82. From 2.23am, Mr Davies was lying still, with no movement. This did not change for the rest of the night.

83. At 2.27am, Officer A shouted outside the cell, "All right. What's his name? What's his name? Oi." He told us that he did not hear Mr Davies speaking or banging his chair earlier in the night. Officer A said that, at 2.27am, he looked through the observation panel and could see Mr Davies lying on the floor. No one took any further action.

84. At 2.54am, the HCA said outside the cell, "Alan … Alan … Alan … he's not breathing, is he?". The HCA and Officer A are then heard speaking further away from the door, so their conversation is unclear. Around 30 seconds later, Officer A shouted into the cell, "Oi, oi … Alan". A minute later, he shouted, "Oi" again. Officer A and the HCA then have a conversation away from the door. The majority of this conversation is unclear on the recording, although the HCA can be heard using the words "code blue" (as part of the conversation rather than an emergency radio message).

85. The HCA told us that she went to Mr Davies' cell at 2.54am because from the monitor in the office, "he look[ed] dead". She said that when she looked into the

cell, she “knew he wasn’t breathing”. She said that she therefore went to fetch the nurse.

86. At 2.56am, Officer A radioed a code blue medical emergency, indicating a life-threatening situation. The control room operator telephoned for an ambulance immediately.

87. After Officer A radioed the medical emergency, he opened the cell, and the HCA began chest compressions. At 2.57am, the nurse applied a defibrillator, which advised no shock and to continue cardiopulmonary resuscitation. The three staff rotated chest compressions until paramedics arrived at 3.23am.

88. At 4.20am, paramedics took Mr Davies to the University Hospital of Wales. At 9.07am, hospital staff confirmed that he had died.

Contact with Mr Davies’ family

89. Mr Davies did not name a next of kin when he arrived at Cardiff. On the morning of 12 September, prison staff contacted Caswell Clinic and obtained contact details of Mr Davies’ sister (who he had nominated as his next of kin on 12 August). At 9.20am, a prison family liaison officer (FLO), contacted Mr Davies’ sister and told her of his death. Mr Davies’ sister later received his property from Cardiff.

90. On 14 September, Mr Davies’ daughter telephoned the FLO, having been informed of his death by Mr Davies’ aunt. The FLO explained the circumstances of the death. On 15 September, Mr Davies’ daughter contacted the FLO and requested no further contact or involvement.

Support for prisoners and staff

91. After Mr Davies was taken to hospital, the duty operational 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.

Post-mortem report

92. The post-mortem examination gave the cause of death as cardiac arrest in a setting of starvation and dehydration.

Findings

Managing the risk of suicide and self-harm

93. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It identifies that the decision to refuse food and/or fluid is not considered in law to be a form of self-harm. However, PSI 64/2011 says that the ACCT process may provide a useful way of recording the care offered to such a prisoner and facilitate the sharing of information. It instructs that every effort must be made to try and find out why the prisoner is refusing food and/or fluids and address the reasons for their refusal.

94. Managing Mr Davies was challenging for prison staff. Although he indicated several times that he did not wish to die as a result of his actions, Mr Davies communicated little with staff and largely refused to participate in any clinical assessment or discussion about his intentions or motivation. Some positive, supportive actions were taken, and prison staff appropriately started ACCT procedures when Mr Davies was transferred to Cardiff. The ACCT case reviews were multidisciplinary, and it was apparent from our interviews that staff were aware of the issues surrounding Mr Davies' care.

95. However, there were some aspects of ACCT procedures that might have been improved. PSI 64/2011 says that the case review team must set and review support actions to mitigate and lower risk. Setting support actions for Mr Davies was difficult given his lack of engagement but those set were either statements of fact and/or did not identify how the support needed might be achieved.

96. PSI 64/2011 also identifies that some prisoners supported through ACCT may have particularly challenging needs or a significant level of complexity. It says that such prisoners should be referred to a Safety Intervention Meeting (SIM, a multidisciplinary safety risk management meeting, chaired by the Senior Management Team). PSI 64/2011 gives two specific instances where prisoners must be referred to the SIM (neither of which applied to Mr Davies) but says that it is largely up to ACCT case review teams to decide whether a case requires a referral for discussion at a SIM.

97. None of the case review teams identified that Mr Davies might require referral to and discussion at a SIM. We consider that Mr Davies' complex needs, and behaviour meant that he met the requirement for referral to a SIM. This would have ensured that senior managers at Cardiff and other relevant specialists took an active and collaborative part in Mr Davies' care planning and might have helped ensure better information sharing. We make the following recommendation:

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

- **case reviews consider all relevant information and address issues through specific and meaningful support actions; and**
- **prisoners with challenging needs or significant complexity are referred to the Safety Intervention Meeting.**

Clinical care

98. The clinical reviewer found that some elements of Mr Davies' clinical care were appropriate and timely. He was promptly assessed on arrival at Cardiff and appropriately admitted to the healthcare inpatient unit. The clinical reviewer highlighted that Mr Davies was seen by healthcare staff at least twice a day and encouraged to eat and drink. He also highlighted that staff consulted Department of Health guidelines on the clinical management of people refusing food in prisons to minimise the risk of refeeding syndrome, were Mr Davies to choose to recommence eating.

99. However, the clinical reviewer found that there were some instances where the level of care was not appropriate. He found that there was insufficient healthcare involvement in discharge planning from the Caswell Clinic, including no involvement from the primary care team or prison doctors. This might have contributed to the uncertainty about how long Mr Davies had not been eating.

100. There was no clear plan documented for clinical monitoring of Mr Davies' food and fluid refusal and intake. We were told that prison and healthcare staff used the ACCT document to document food and fluid intake, but this was not recorded every day. In addition, a healthcare professional would have to look through several pages of daily ACCT entries to identify the information about food and fluid intake, which would be better recorded in a separate document.

Potential hospital admission

101. On 10 September, a prison GP arranged for Mr Davies to be admitted to hospital. She told us that this was because she understood that Mr Davies had not eaten for 24 days, which meant that he was at high risk of serious illness from his fast. Following discussion with the duty operational manager, she said that she now understood that Mr Davies had eaten snacks at Caswell Clinic and that he had therefore not eaten for eight days (since arriving at Cardiff) rather than 24 days. She said that his risk of serious illness was not therefore as high as previously thought and he did not require hospital admission at that time. She added that Mr Davies would have become at high risk had he gone 10 days without eating, which she thought at the time would have been on 12 September.

102. We note that the information provided by the duty operational manager was based on what he was told at the discharge planning meeting on 20 August, nearly two weeks before Mr Davies was transferred. Information later emailed to the prison, and handed over on his arrival, was that Mr Davies had not eaten anything for up to 16 days before the transfer. Although this was recorded in the medical record, many prison and healthcare staff we spoke to were uncertain about how long Mr Davies had not eaten and whether he had consumed snacks in his last two weeks at Caswell Clinic. The prison GP told us that the duty operational manager's information was new to her, and she therefore had contradictory information to consider. She said that, following Mr Davies' death, she learnt that the operational manager's information was not correct. She told us that the prison doctors did not receive a formal handover about Mr Davies' care, which might have provided clarity about his medical history.

103. The clinical reviewer noted that Department of Health guidelines state that a prisoner refusing food or fluids should be assessed in hospital once they become weak, dehydrated, oedematous or develop significant biochemical abnormalities. He found that Mr Davies could have been admitted to hospital on 10 September but his refusal of all clinical observation and tests made this decision more complex. However, he added that this refusal might have lowered the clinical threshold for hospital admission. The clinical reviewer also found that no one provided clear guidance for healthcare staff on signs to look for to determine when Mr Davies' condition had deteriorated and when to escalate concerns. We make the following recommendations:

The Head of Healthcare should ensure that a range of healthcare staff are involved in discharge planning when a patient is to be transferred from a psychiatric hospital when there are potential issues with physical as well as mental ill health, and that all relevant staff, including prison doctors, receive a formal handover of care.

The Head of Healthcare should ensure that prisoners who are refusing food or fluid are managed in line with national guidelines, including that:

- **comprehensive care plans are created to identify when further interventions, including hospital admission, are needed; and**
- **food and fluid intake and the start date of food and fluid refusal are clearly recorded.**

Night of 11-12 September 2021

104. From 10.38pm on the night that he died, Mr Davies spent most of the time lying on the floor of his cell. For the last two and a half hours before the emergency response, he laid on the floor naked. Mr Davies spent some of this time trying to summon assistance by repeatedly saying, "help me", and banging his chair. As the night wore on, he began to move less and spent the last half an hour lying still.

105. During this time, the nurse visited the cell at least once (at 11.00pm), the HCA at least four times (at 12.00am, 12.37am, 1.00am and 2.00am) and Officer A at least once (at 2.27am). The inside of Mr Davies' cell was also visible on a monitor in the staff office.

106. No one took any action to assist Mr Davies during this time. The HCA told us that she considered this "normal" behaviour for Mr Davies. Having viewed the in-cell camera footage, our view is that it is clear that Mr Davies was in distress and required assistance. We consider that to leave him on the floor, naked, in these circumstances was inhuman and degrading. While we cannot be certain whether more thorough checks on Mr Davies' wellbeing earlier in the night would have affected the eventual outcome, it is possible that they may have done.

107. Since Mr Davies' death, the nurse and HCA have been subject to an ongoing disciplinary investigation. They were both subsequently dismissed from the employment of Cardiff and Vale University Health Board.

108. While we appreciate that Officer A's role on the night was to supervise constantly a prisoner in the neighbouring cell, we consider that he should also have taken action to assist Mr Davies when he looked in the cell. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff in the healthcare inpatient unit observe prisoners as directed, and that staff satisfy themselves that the prisoner is alive and well at each observation and provide any assistance required.

The Governor should conduct a disciplinary investigation into Officer A's actions on the night of 11-12 September 2021.

The Governor and Head of Healthcare should inform the Ombudsman of the findings of the internal investigations into the events of 11-12 September 2021, and of any action taken as a result.

Emergency response

109. PSI 03/2013 on medical emergency response codes sets out the actions that staff should take in a medical emergency. It contains mandatory instructions for Governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Cardiff uses the emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which staff should use code blue are when a prisoner has difficulty breathing or is unconscious.

110. PSI 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer manager and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

111. When she went to his cell at 2.54am, the HCA identified that Mr Davies was not breathing. She told us that she thought that he "look[ed] dead". She said that she did not open Mr Davies' cell immediately because she understood that during a night shift, you do not go into a cell without first obtaining the permission of the night manager.

112. There was a delay of over two minutes from when the HCA identified that Mr Davies' was not breathing until the cell was opened to provide emergency medical assistance and before an emergency radio message was transmitted. We recognise that it can be difficult for staff in such situations to make instant decisions but when there is a potentially life-threatening situation, it is essential to act quickly. She identified that Mr Davies was not breathing and, in these circumstances, we would normally expect prison and healthcare staff to go into a cell and communicate

an emergency as soon as possible in case there is a chance of saving someone's life. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and understand their responsibilities during a medical emergency, including that:

- **staff communicate a medical emergency without delay, using the appropriate medical emergency response code; and**
- **staff go into cells as quickly as possible in a potentially life-threatening situation.**

Family liaison

113. Mr Davies' daughter told us that she was concerned that prison staff at Cardiff did not consider her to be Mr Davies' next of kin and they did not return his property to her.

114. PSI 64/2011 instructs that, following a death in custody, prisons "must promptly notify the next of kin and any other person the prisoner has reasonably nominated to be informed". It instructs that prisons must record a next of kin for each prisoner and that prisoners may identify more than one next of kin or family member whom they wish to be contacted. PSI 64/2011 also instructs that prisons must return the property of the deceased to the family.

115. When he arrived at Cardiff, Mr Davies did not nominate a next of kin or anyone else to be contacted in an emergency. After he was admitted to hospital, prison staff contacted Caswell Clinic and established that he had recently asked for his sister to be recorded as his next of kin. As a result, they contacted her about his death. This was appropriate and in line with national instructions.

116. While we understand Mr Davies' daughter's concerns, prison staff are required to comply with the wishes of the deceased in terms of their next of kin. We note that Mr Davies did not provide contact details for his daughter and that, three days after his death, she asked to have no further contact from staff at Cardiff. In the circumstances, we consider that it was reasonable that Mr Davies' sister was treated as his next of kin and his property returned to her.

Inquest

117. The inquest into Mr Davies' death concluded on 15 March 2024. The jury found that Mr Davies died from an equal combination of misadventure, self-neglect and neglect.

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