

**Investigation into the circumstances surrounding the
death of a man
at HMP Parc in August 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

May 2009

This is the report of an investigation into the death of a man at HMP Parc. On a morning in August 2008, an officer who was carrying out his morning roll check found the man hanging in his cell. It seems the man had used a canvas strap, which he had taken from his workplace, and tied it around the hinges of his toilet door. The officer and several of his colleagues responded quickly but their attempts at resuscitation were not successful. The man, who had been remanded to HMP Cardiff in February 2008, charged with the murder of one of his sons and the neglect of the other, had transferred to HMP Parc on 13 June. He was 35 years old.

My colleagues and I would like to extend our condolences to the man's family and all those affected by his loss.

The investigation was carried out on my behalf by two of my investigators. A review of the man's clinical care in prison was carried out by a clinical reviewer on behalf of the Healthcare Inspectorate Wales. I am very grateful to the clinical reviewer for her assistance. I also thank the Director of Parc for the co-operation of her staff, several of whom came in on their day off to be interviewed by my investigators.

I make seven recommendations: one each to Parc and Cardiff in relation to transferring medical information, two to Parc regarding healthcare, two in relation to emergency responses, and one regarding security procedures. My own recommendations incorporate two made by the clinical reviewer. I also note one area of good practice.

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

Stephen Shaw
Prisons and Probation Ombudsman

May 2009

CONTENTS

Summary	4
The Investigation Process	5
HMP Parc	6
Key Findings	7
Issues Considered	18
Recommendations	22

SUMMARY

The man had been remanded in custody in February 2008, charged with the murder of one of his sons and neglect of the other. He was held at HMP Cardiff, where after a month he asked to go onto Rule 45.¹ Cardiff does not have a separate unit for vulnerable prisoners so the man was held in the segregation unit. This was clearly not satisfactory and, after some negotiation between the heads of establishment at Cardiff and HMP Parc, the man was transferred to Parc in June 2008.

Throughout the six months he was held in custody, the man maintained he was innocent of the charges against him. He spent considerable amounts of time researching medical information to prove he had not murdered his son, and those who met him at the time have described him as 'obsessed' with the research. As part of his court proceedings, the man had been assessed by a Specialist Registrar in Forensic Psychiatry. The Specialist Registrar wanted the man to be assessed in a secure unit under section 35 of the Mental Health Act 1983 for a more thorough mental health assessment. The man initially co-operated but later refused to communicate with staff from the secure unit. At the time of his death he had not yet received the recommended full assessment.

There was an inadequate handover when the man transferred from Cardiff to Parc, and his records do not appear to have been adequately reviewed at Parc to ensure a follow up of his mental health assessments. Staff from the secure unit had been to see the man two days before his death, but he had apparently refused to speak to them. The visit was not logged in his medical record at the time.

The man's wife was in the process of divorcing him. He was aware of the proceedings but from telephone conversations with his friends he appeared to want to re-establish their relationship. On 15 August 2008, the man received further paperwork regarding his divorce. After he died, this paperwork was found in his cell with the message 'my death sentence' written on it.

Staff to whom my investigators spoke were unaware of the man's marital problems. However, they were aware that he was consumed by his court case and maintained his innocence. He was otherwise described as a private person. Nobody my investigators spoke to had any indication that the man was suicidal, and his death came as a shock to everyone.

The clinical reviewer also found that there should have been a better handover when the man transferred prisons. The clinical reviewer believes that, because the follow up at Parc was inadequate, his mental state might have deteriorated unnoticed. However, she could not judge whether any admission, assessment and treatment, if necessary in a secure unit, would have prevented the man taking his own life when discharged back to prison.

¹ Rule 45 is a means by which vulnerable prisoners may be segregated from the mainstream. Vulnerable prisoners include those at risk of harm from others because of the nature of their offence or for other reasons.

INVESTIGATION PROCESS

1. My investigators requested all the relevant prison documentation including the man's medical and core prison records. My investigators also visited Parc to interview staff and prisoners who had dealings with the man. One member of healthcare who had assisted in attempts to resuscitate the man was on long term sick absence when my investigators visited the prison and he has not therefore been interviewed. The information regarding his involvement has been taken from his 'incident statement' and the statements of other staff.
2. Notices to staff and prisoners were sent to the prison to be displayed. They invited anybody with information to talk to my investigators. In this instance only one person, other than those identified by my investigators, wished to be interviewed. That person was another prisoner on Delta (D) wing who sometimes played chess with the man. He wanted to tell my investigators about the man's research for his court case and the time he spent in the library.
3. A clinical review into the man's clinical care in prison was carried out by the clinical reviewer for the Healthcare Inspectorate Wales. Additionally, my investigator corresponded with the Specialist Registrar in Forensic Psychiatry who carried out and wrote a psychiatric report on the man for his court proceedings.
4. HM Coroner for Bridgend and Glamorgan Valleys was informed of my investigation. The Coroner will receive a copy of this report.
5. My Senior Family Liaison Officer has been in contact with the man's estranged wife and his father to offer them both the opportunity to be involved in this investigation and to raise any concerns they might have. The man's wife has not raised any queries for my investigation. His father has asked why prison staff did not read the letter from his solicitors enclosing paperwork relating to his divorce and take some action to monitor him. I will endeavour to address this question in my report.

HMP PARC

6. Opened in 1997, HMP Parc, in Bridgend, is a category B male prison managed by Group 4 Securicor (G4S). It is a modern building, constructed to an American design. Parc holds up to 1,126 remand and convicted juveniles and young offenders and sentenced adult males, and includes a unit for vulnerable adult prisoners.
7. Healthcare services in Parc are provided under contract by Primecare Forensic Medical Services (Primecare). There is 24 hour primary care and an in-patient facility with 24 spaces. Clinical care is provided by doctors, registered general nurses, and registered mental health nurses employed by Primecare. Additionally, there are links with the local NHS Trust and other medical staff who visit the prison to provide services (for example, a psychiatrist, dentist and optician). There is also a mental health in-reach team.
8. The last full inspection by Her Majesty's Chief Inspector of Prisons was in January 2006. Although the Chief Inspector found it to be a disappointing inspection in many respects, she noted that the prison was moving forward under a new Director and a clear management strategy. I do not go into the details of the Chief Inspector's report given the length of time since it was issued. (The full report can be found on the Chief Inspector's website.)
9. Since my own office took over responsibility for investigating all deaths in prison custody in 2004, there have been 14 deaths at Parc. There were seven natural cause deaths and two apparently self-inflicted prior to the man. There have been four apparently natural cause deaths since.
10. In its report for the year 2007-08, the prison's Independent Monitoring Board wrote as follows with regard to safer custody:

"Members of the Board regularly attended Safer Custody meetings during the current reporting period. Staff changes led, regrettably, to the late cancellation of meetings, a cause of concern to the Board in view of the crucial importance to prisoner welfare of these multi-disciplinary meetings ... There were no self-inflicted deaths during the reporting period. There was one near-fatality, following which the Safer Custody team worked successfully to reintegrate the prisoner with his hitherto estranged family. The Samaritan trained Listener scheme continued to be widely used throughout the prison ...

"During the reporting period the ACCT (Assessment, Care in Custody and Teamwork) scheme, fully implemented at Parc in the autumn of 2006, was continuously updated. Staff worked increasingly confidently with what had initially appeared an onerous scheme. ACCT folders were regularly opened as a support mechanism for troubled prisoners; the folders were managed by Wing officers and monitored by the Safer Custody Manager. Board rota members regularly checked on ACCT folders, recoding entries where they had concerns."

KEY FINDINGS

11. The man was remanded to HMP Cardiff in February 2008. He made several court appearances prior to this death. His trial was due to commence in January 2009.
12. On 12 February, the escorting services officer at court completed a suicide/self harm warning form, noting that the man appeared depressed and had taken an overdose two years previously which he had told the officer was "... a cry for help". The officer's observation was that the man appeared "very calm and couldn't care less attitude ...". However, she noted that, if he was convicted, the man might face a life sentence which could possibly lead him to harm himself. It was also recorded that there were "family matters," but there is no further explanation regarding this.
13. A First Reception Health Screen was completed by a nurse. The man was described as physically "fit and well". It was noted that he had taken an overdose of sleeping tablets 18 months previously (this differs slightly from the court form). He had been prescribed anti-depressants (Citalopram) between September 2006 and February 2007, but had stopped taking them as he felt they did not help him. The nurse wrote in the medical record that the man was "very focused on the details of his case [trial] and somewhat detached. Little emotion expressed. Says he has lost everything." The nurse decided that the man needed a further mental health assessment and he was referred to the doctor. A Cell Sharing Risk Assessment (CSRA) was completed to determine the man's suitability to share a cell with another prisoner. He was found to be low risk of harm to others or himself at that time, although his overdose attempt was noted. It was suggested that he be regularly reviewed, particularly in relation to the nature of his alleged offence. The man remained in healthcare to allow for a mental health assessment to be carried out.
14. On 14 February, the man had a formal mental health assessment although the records do not clearly show who undertook it. At the end of the assessment, the assessor described the man as having:

"Bizarre presentation. Detached. Aloof. Intellectual. Attention to detail. Totally preoccupied with finding out case of son's death. A few tears at end of interview. Described hopelessness / helplessness, despair."

The assessor determined however that there was no evidence of a "major affective²/psychotic disorder".
15. The man remained in healthcare and was reviewed on several occasions. On 19 February 2008, he told healthcare staff that he had no suicidal thoughts and had "everything to live for", referring to his son and wife. Later that day he was assessed as fit to be discharged to a residential wing. This did not happen but the reasons are not recorded. Three days later a prison doctor

² Refers to a person's mood.

reviewed the man and noted that he had “an odd affect [mood]” and “seems preoccupied with the detail of case”.

16. The Specialist Registrar in Forensic Psychiatry employed by the Caswell Clinic, interviewed the man on 6 March (although some paperwork shows this to have been on 5 March) in the court cells. The Specialist Registrar found that the man had no thoughts of self-harm or suicide, but was obsessed by the details of his son’s death and might have been suffering from delusional beliefs. It was the Specialist Registrar’s opinion that the man needed a full and thorough assessment in appropriate conditions. A place at the Caswell Clinic was applied for. The prison doctor reviewed the man again on 10 March, following a court appearance. She noted that she was still waiting for his psychiatric report, and that the man was “emotionally detached”. The prison doctor added in the medical notes that the man had told her he was “coping well with his imprisonment physically and mentally – some low days”. Again, it is documented that the man was preoccupied with proving his innocence and maintaining contact with his surviving son.
17. During March, the man appears to have had problems accessing his telephone credit and numbers. On 11 March, solicitors acting for the man’s wife asked the prison to prevent all correspondence and telephone calls from the man to his wife. The security department at Cardiff actioned this request the following day (12 March). Also that day, the man was allegedly assaulted by a nurse, but he did not report the incident until 14 March.
18. The man’s next court appearance was also on 14 March. On his return to the prison he was interviewed in reception and applied for Rule 45. It is not clear whether the man initially returned to healthcare or if he was seen by the prison doctor in Reception, but when the prison doctor saw him on 14 March he told her about the allegation of assault. He would not allow the prison doctor to give him a full examination, only to observe the bruises on his arm. The prison doctor noted in the medical record that the man would be moved out of healthcare to the segregation unit as a vulnerable prisoner.
19. A governor at Cardiff went to talk to the man about the alleged assault. The man had a bruise (approximately 4cm x 5 cm) on his upper right arm. Photographs were taken to record it and the man was moved from healthcare to the segregation unit under Rule 45. (Cardiff does not have properly designated facilities for prisoners on Rule 45. Vulnerable prisoners are either placed in the healthcare centre or the segregation unit. Neither area, particularly the segregation unit, is suitable for long term residence for someone segregated for their own protection.)
20. In the prison records, there is a partially completed interview log regarding the alleged assault. The man completed the interview section and said that he had been trying to discuss an ongoing query about his telephone credit with the nurse. He alleged that the nurse had pushed him back from the cell entrance and that he fell onto his bed, bruising his right arm. The man was undecided about whether or not to report the incident to police and was going to take advice from his legal team.

21. This appears to be the last action taken by any party in relation to the allegation of assault. There is no recorded follow up and the forms were filed. The forms did not accompany the man's transfer to Parc, where they were unaware of the allegation. My investigators asked the Deputy Governor at Cardiff what the outcome of the allegation was. The Deputy Governor had not been directly involved with the matter but had learnt that, because the man had not pursued the matter within the prison, it was never dealt with. The Deputy Governor also told my investigators that the nurse alleged to have assaulted the man no longer works in the Prison Service.
22. The man remained in the segregation unit over the next three months. It is a mandatory requirement for prisoners in segregation to be seen by a member of healthcare every day. The man was seen by healthcare and was treated for palpitations which were thought to be triggered by anxiety or stress. The man also had three more reviews with the Specialist Registrar, but his interaction appears to have lessened on each visit. The man was still waiting for a place at the Caswell Clinic. Also during this period, although I do not have a specific date, the man received notification that his wife was issuing divorce proceedings.
23. On 1 June, the prison doctor saw the man but noted that he would not communicate with her and appeared detached. She also noted that his personal hygiene was poor and he did not undertake exercise. The segregation daily notes also show little interaction with staff. Three days later (4 June), a charge nurse from the Caswell Clinic visited to assess the man. The nurse noted in the medical record that the man declined to be interviewed until he had consulted his legal team. She also wrote that the man had told her he was already supposed to be in the Caswell Clinic and that the Specialist Registrar had told him "a pack of lies back in March saying he'd be in Caswell by now..." At that point, the interview was terminated.
24. The residential governor in charge of the segregation unit compiled an update for other staff of the situation in the unit and the prisoners on Rule 45. The summary describes efforts being made by the OCA³ department at Cardiff to move the man to HMP Parc. Staff at Cardiff believed, rightly, that it was not appropriate for the man to remain in the segregation unit for a lengthy time. He did not have a full activity regime and slept most of the day. However, whilst Parc has a vulnerable prisoners unit, it is currently only for vulnerable sex offenders. The man was not a sex offender and did not therefore meet Parc's criteria.
25. After some liaison, the Governor and Director⁴ of both prisons became involved. The Director of Parc agreed to take the man until a more suitable alternative could be found, as everyone was in agreement that a segregation unit was not appropriate.

³ OCA – Observation, Classification and Allocation. One of the functions of the department is to arrange prisoner transfers where appropriate.

⁴ In public prisons the head of the establishment is referred to as the Governor. In contracted prisons they are referred to as the Director.

26. The man transferred to Parc on 13 June. Not all of the man's paperwork followed him, and (as noted above) Parc were unaware of the allegation of assault by the nurse. Parc only completed a short medical 'transfer in checklist' and, even though this checklist was completed by a Registered Mental Health Nurse (RMN), the man's history of mental health assessments at Cardiff was not followed up. An entry in the medical notes on 13 June by the RMN records that the man had "no physical or mental health problems". It also noted that the man said he had no substance misuse problems but recorded his previous self-harm attempt. When asked about this attempt, the man told the RMN that he currently felt fine. In interview, the RMN told my investigators that he did not follow up any mental health referrals or information because the man had been deemed 'fit for transfer'. The RMN was of the view that, if there had been any concerns by the previous establishment, it would have been written in the medical record for a follow up. He believed that 'fit for transfer' meant the previous establishment had no concerns.
27. A Prison Custody Officer (PCO) was the man's personal officer. (She has since left G4S and has not been interviewed as part of my investigation.) The PCO introduced herself to the man as his personal officer on 21 June. She wrote in his wing history sheet that he appeared to have settled onto the unit and was mixing well. Three days later, the personal officer made another entry after a conversation with the man. She wrote that he had told her he was coping well with the new routines, and had spoken openly about his offence and the length of time he was facing on remand (his trial was scheduled for January 2009). The personal officer added that the man had told her he had no thoughts of suicide or self harm.
28. The man took employment in the workshop just over a week after arriving at Parc. Shortly afterwards, the prison took on a contract for preparing canvas straps which are used by supermarkets for pulling trolleys. It was the man's job to assemble them.
29. The Industries Instructor, a civilian member of staff, told my investigators that the man was a good worker. He would reach his target for a day and then enjoy some 'down time'. The Industries Instructor explained that prisoners who had completed their allocated work would occasionally do some education homework or sit and speak to him. The Industries Instructor also told my investigators that he sometimes saw the man with his head in his hands, but he was unaware of any reason. The Industries Instructor said that his "door was open" to prisoners if they wanted to talk about anything, and the man was aware that he could do this if he so chose.
30. According to the local security strategy, prisoners should be searched when leaving their place of work. My investigators asked the Industries Instructor about the searching procedure in the workshop. Whilst the Industries Instructor, as a civilian member of staff, is not responsible for carrying out the searches, he said he was aware that the searching procedures in place prior

to the man's death were not followed by officers. I am unable to determine what action any staff or managers took to address this at the time.

31. On 5 July, the personal officer made an entry noting that the man was working in the industries workshop and that he had told her he was "enjoying the distraction from constantly being in his cell". It was also noted that he "continues to work hard gathering information for his court case in his spare time". Just over a week later, on 16 July, the personal officer recorded that the man was receiving numerous legal visits and was to attend court the next day. She wrote that the man had told her he was feeling confident that the case would go in his favour and prove that he was not guilty of the shaken baby syndrome or the neglect of his other son. The personal officer and the man had two more similar conversations over the next three weeks. The entries in the wing history sheet show that the man was spending a lot of time preparing for his impending court case and that he now had medical information which he believed would prove his innocence.
32. The last entry made by the personal officer in the man's wing history sheet was on 11 August. She wrote that there were no changes to note and no concerns. The man had told his personal officer that he had no issues to raise with her.
33. The telephone records show that the man telephoned a friend on 11 August.⁵ The conversation started by the man telling his friend that he was doing "not too bad" and was keeping his strength up. He said he was having problems with the Pinphones,⁶ and then went on to talk about wanting to fire his legal team. Later in the call the records show that he was upset about not knowing how his wife felt about him, and he wanted to "try and pick up his marriage next year". He then said that he had lost everything including his son, and would probably emigrate and start a new life with a new family, but then spoke about how he loved and missed his wife and would cry at night thinking about her. His friend told him to remain positive and think of winning his court case. She also tried to dissuade him from firing his legal team.
34. The following day (12 August), the man telephoned another friend. They talked about the man's upcoming trial in January 2009 and how he hoped to get justice, presumably relating to some new evidence he had come across. They also talked about the man's son being returned to his wife (it appears that there had been Social Services involvement between the man and his wife and their surviving son), and how he took comfort in one of them getting justice. His friend said he was waiting to find out when he could visit, and the man replied that he could come whenever he wanted. He added that he would get his friend's address when they spoke again as he did not have a pen with him. The man told his friend that he would write with dates and times for a visit.

⁵ Telephone conversations are digitally recorded and listened to either randomly or if intelligence suggests they should be. There was no specific reason to monitor the man's calls. After his death the prison retrieved the digital recording and provided my investigator with a written summary.

⁶ The telephone system used by prisoners.

35. Two staff from the Caswell Clinic visited the prison on 14 August to interview the man. (The clinical reviewer has noted that the visit was not logged in the medical record at the time). On the day that the man died, the RMN wrote a retrospective entry to say that the nurses had attended but that he did not know, at the time, if the man was actually seen. The clinical reviewer has noted that, from information received from the Caswell Clinic, the man refused to be interviewed by the nurses. The reason he gave was that he had been told not to by his legal team.
36. A PCO on D wing remembers speaking to the man on Thursday 14 August about access on his telephone account. He was unhappy because he had been trying to get two friends' numbers on his list since he was at Cardiff. The PCO took the numbers to the security department to be checked, and then to the Pinphone department to add them to the man's Pinphone list. The security form only shows one number but the man never used it. It might have been that the man did not have sufficient credit on the Pinphone system at the time he tried to make the calls.
37. The man did, however, manage to make a telephone call to his legal team on the Thursday and Friday before his death (14 and 15 August). Legal calls are not monitored, but my investigator spoke to the solicitor acting in the man's criminal case. She remembers that they spoke about an expert evidence report from Australia in relation to immunisation jabs, which the solicitor expected to receive the following week. The man asked his solicitor about arranging a visit with him when she received the report.
38. Also on the Friday before his death, the man received a letter dated 13 August from the solicitor dealing with his family care proceedings. (This was a solicitor from the same company as his criminal case solicitor.) Enclosed with the letter was some court paperwork which his solicitor had received in relation to the man's divorce case. Although the family care proceedings solicitor was not acting for him with regard to his divorce proceedings, he thought it appropriate to enclose a court order which had been forwarded to their office. The letter explained what the order meant, and that the solicitor would be happy to discuss this issue with the man at their forthcoming meeting (scheduled for 26 August).
39. Although the solicitor to whom my investigator spoke was not the one dealing with his family care proceedings case, she was able to provide information. The letter was not from her, but she said that the man's divorce proceedings were not a surprise to him, and he had been aware of them since earlier in the year. The firm of solicitors did not therefore feel the need to raise any concerns when forwarding to him the information that had been sent to them. (Prison staff do not monitor any mail that arrives under legal privilege (Rule 43) and therefore they would not have read the solicitor's letter.)
40. A menu choice was delivered to all prisoners that Friday (15 August) as usual. The man completed his choice of meals for two weeks commencing 18 August. The menu list was found in his cell after his death.

41. That evening, the man declined to come out for association. The PCO, who was on duty that evening, said at interview that prisoners are unlocked for association at about 6.00pm when they can play cards or chess together or just talk to one another or to staff. The PCO had unlocked the man for association, but he said he did not want to come out and so his door was locked again. She did not think that there was anything untoward when the man did not want to come out because prisoners can choose whether or not they want to be out for association. The PCO added that the man did not give a reason why he did not want to come out. She said that, in hindsight and following a conversation with other prisoners after the man's death, he did usually come out for association to play cards and chess and so it was out of the ordinary that he chose to stay in his cell. Since the man's death, my investigators have had sight of a letter he left for his son. He wrote that he was starting the letter at 6.30pm that night.
42. At approximately 7.45pm, prisoners on the wing were allowed showers or a last game of pool etc before being locked up for the night. The prisoner in the cell next to the man remembers speaking to him approximately ten minutes before being locked up. They spoke about a television programme which was on later that night. Everybody was then locked in their cells shortly after 8.00pm, and staff carried out a roll check. The PCO carried out the check for the man's landing. She remembers that his cell door was open and that he was looking out of the window. The PCO thinks that she just said "Good night", but remembers that there was nothing that gave her any concern. That was the last time she saw the man.
43. Two different PCOs came on duty at approximately 8.00pm. They were detailed to work on D wing and C wing respectively. The two wings are connected by interlocking doors. As part of their duties the officers would check any prisoners on an ACCT⁷ form at the given intervals through the night. There are no other mandatory requirements to check prisoners through the night, but officers can use their discretion. For instance, if during the shift handover the night officer is told that somebody has had an upsetting telephone call they might check periodically through the night. My investigators asked the D Wing PCO if he had any reason to check on the man during his shift. The D Wing PCO could not recall any concerns being reported to him that night.
44. Parc has an electronic printout of ACCT visit checks as well as a pegging report.⁸ The printouts show that the D Wing PCO checked the six prisoners who were on ACCT at the time, and pegged regularly throughout the night. The records show that the PCO completed ACCT checks between 5.35am and 5.42am as he started carrying out the morning roll check.

⁷ Assessment, Care in Custody and Teamwork (ACCT). The Prison Service's monitoring form and process for supporting prisoners at risk of harming themselves.

⁸ Pegging is an expression used by the Prison Service to describe a security procedure for accounting that an area has been visited by an officer. The system records the date and time, and can be monitored as necessary.

45. At 5.43am, the PCO arrived at the man's cell. At interview, the PCO said that he opened the cell observation panel and saw the man. At first he thought the man was standing or going to the toilet or basin. The PCO said that some prisoners are awake at that time of the morning, getting washed or dressed. As he was closing the panel he felt that something was not right. He looked back into the cell and saw that the man was hanging from his toilet door. The PCO pressed the personal alarm button on his prison radio. He also asked the control room to open the cell door electronically.⁹
46. At the same time, the C Wing PCO had returned to C Wing to start his own roll count. He had just entered the wing when he heard the personal alarm call. He responded straightaway and asked the control room to open the interlocking door for him (electronically).
47. A member of staff was designated Oscar 1 (the senior member of staff in charge at night), and was in the healthcare centre as part of his rounds when he heard the alarm. The centre is only a few yards from D Wing. A Healthcare Nurse (HCN) and a Healthcare Assistant (HCA) were also on duty in the centre. An additional PCO was working an extra shift, carrying out constant observations on a prisoner on ACCT in the healthcare centre.
48. When the D Wing PCO pressed his personal alarm, Oscar 1, the additional PCO and the HCN responded, the HCN taking an emergency equipment bag (excluding the defibrillator) with him. The HCA had to remain in the healthcare centre on standby because they could not leave healthcare unstaffed especially with prisoners on ACCT. The staff then ran to D Wing, asking the control room to electronically unlock the doors for quicker access.
49. As they entered the wing, the D and C Wing PCOs were already in the man's cell. They had lifted the man to take his weight off the ligature. The additional PCO entered shortly behind them and cut the ligature, which was attached to a hinge on the toilet door, with his fishknife.¹⁰ The ligature was one of the canvas straps prepared in the workshops. The officers then lay the man on the floor. The staff could not detect a pulse and so the HCN and the D Wing PCO began cardiopulmonary resuscitation (CPR). The additional PCO was sent back to healthcare so that the HCA could collect the defibrillator. He arrived and took over the D Wing PCO's role in the resuscitation attempts. Whilst all this was happening, Oscar 1 asked the control room to call an ambulance. The defibrillator, which can restart the heart if it detects a shockable rhythm, was applied. It did not advise any shocks and so CPR was continued.
50. The ambulance arrived at 6.00am (although this entry is written retrospectively in the control room ledger). Paramedics attempted resuscitation but were unsuccessful. The prison doctor arrived and pronounced the man dead at 7.15am. A member of the chaplaincy team went to the man's cell and said prayers for him. Oscar 1 arranged for the prisoner

⁹ In Parc, the cell doors and wing gates can be operated electronically.

¹⁰ Also referred to as a 'cut down' or 'anti-ligature' knife. It is a knife designed make the cutting of a ligature easier.

in the cell next door to be moved and for the area to be sealed off to provide privacy and decency.

Events after the man's death

51. The staff involved in responding to the man's cell, with the exception of Oscar 1 who remained on the wing, attended a debrief. (A debrief gives staff the opportunity to talk through an incident or traumatic event.) All staff were offered support by the care and welfare team should they wish.
52. The Houseblock Manager had arrived at the prison soon after the man was found. She unlocked some Listeners¹¹ and went round to all prisoners to explain what had happened. A death in custody can be a vulnerable time for other prisoners. I acknowledge the efforts of the Houseblock Manager who ensured that all prisoners were informed of the man's death and were given the opportunity to speak to a Listener.
53. The PCO who had been on duty during association the previous evening, came on duty later that morning and was told that there had been a death in custody. She initially assumed it was one of the older prisoners. She said in interview that, when she discovered it was the man, she was shocked and frustrated that she had not asked him if everything was alright the night before. However, there had been no indication that anything was wrong.
54. A prisoner on D Wing, asked to speak to my investigators. The prisoner sometimes played chess with the man and also used to see him in the library. The prisoner wanted to give my investigators some background information about the man. He said that the man would regularly play cards and chess and that he was very good with numbers (in relation to the games). The prisoner said that the man would also regularly visit the library, and it would sometimes be difficult to persuade him to leave when the allocated time of 45 minutes was over.
55. The man was researching prescription drug compositions and spoke about 'medical negligence'. The prisoner said that the man was a very secretive person but that it was known he was carrying out research with regard to his court case. The prisoner said that, approximately a fortnight before his death, it had been a particular struggle to get the man out of the library. One of the books he was looking at was a reference book so he could not remove it and the photocopier was not working. The man had also told the prisoner that "it was all over" and that he was going to sack his legal team and represent himself. He had apparently had an argument with his legal team.
56. According to the prisoner, approximately a week before his death the man was not concentrating on his card games. The prisoner said that other prisoners also noticed that he was not playing cards as well as usual. The prisoner told my investigators that this was the only noticeable change. He

¹¹ Like most jails, Parc has a Listener Scheme under which the Samaritans train selected prisoners to be the first contact for any prisoner who is feeling vulnerable and at risk.

did not think that the man looked depressed or different in any way. When my investigators asked the prisoner how he felt about the man's death he said:

“He gave no indication, he didn't look depressed or in need. You do find on this wing a lot of the guys look out for each other, if somebody starts sitting on their own we'd go up and have a talk with them and find out you know what's, you know what's going on or are you okay? We've got the Listeners, they are pretty keen as well and the staff. The staff are pretty good at noticing somebody going off on their own or they start getting depressed, you know they jump on that straightaway. When I did find out in the morning there was an incident I was guessing about other people ...”

57. My investigators asked to speak to other prisoners who knew the man and those who had cells close by. Only one other prisoner agreed to give information. The second prisoner was in the cell next to the man. The second prisoner remembered seeing the man earlier in the day on Friday 15 August. He said that the man was “down” because of his Pinphone problems. The second prisoner then spoke about seeing the man about ten minutes before the night lock up. He said that they had spoken about the television programme, *Big Brother*, which was on that evening. The second prisoner said that the man was generally not a happy person, but he did not notice anything different that night.
58. The second prisoner said that he was aware that the man had marital problems and knew that he had received a letter. He did not see the letter, but the man had shown him the envelope. The second prisoner told my investigators that, if he had thought the man was depressed, he would have alerted staff. He added that when staff found the man they tried hard to revive him. He had heard the paramedics through the door asking how long staff had been attempting resuscitation. He had heard them say “16 minutes”. He also told how the Houseblock Manager had informed everybody what had happened and why there were delays unlocking the other prisoners out for breakfast.
59. After the man's death, the court paperwork regarding his divorce was found with the words “my death sentence” written across it. Also found was the letter the man had written to his second child. The police took possession of the documents when they attended the prison following the man's death. In the letter, the man asked for forgiveness if he was emotional because “these are the last moments of my life as I have gone through so much pain, heartache and persecution over the last 3½ years since the loss of your brother...” He told his son why he was in prison but that it was all a “lie” and he had proof of his innocence, going on to explain the medical evidence he felt he had. He added:

“I know that if and when I die I know how my son and your brother died and I can have a clear conscience because after all this time I finally have the truth ... unfortunately the truth has come too late for me as I am in too much pain to go on with this harrowing nightmare as today I received the

divorce papers by letter from my solicitor who in turn got them from your mother so today is judgement day for me by my hand..."

The rest of the letter talks about his son's future, with the man wondering what he will do with his life. He told his son that he and his brother were the most special gifts in his life, but that he did not have the mental strength to go on.

60. The man's father has expressed concern that nobody read the solicitor's letter and thus was unable to ensure his son was monitored. As I have explained in my report, any legal mail that is marked as Rule 43 and any legal telephone calls are not permitted to be monitored by prison staff. This is an essential safeguard that guarantees prisoners' access to legal advice and support. However, it may mean that information relevant to risk of suicide or self-harm is not known. The man's solicitors said that he was aware of the divorce proceedings, and that they did not consider there was any need to alert the prison of the documentation being sent to him.

ISSUES CONSIDERED

Clinical Care

61. The prison doctor reviewed the man in HMP Cardiff on 1 June. She noted that he appeared detached and would not interact with her or other staff. The prison doctor wrote that the man had poor personal hygiene and was declining exercise. The clinical reviewer has commented that, with hindsight, the man might have been suffering from a depressive illness. However, the man had been seen by the Specialist Registrar on a number of occasions and the clinical reviewer has concluded that the man might not have been suffering from a treatable psychiatric illness. The full assessment had not been carried out as recommended by the Specialist Registrar in March 2008, so a firm diagnosis cannot be made.
62. The clinical reviewer says it is surprising that a prisoner who was regularly seen by psychiatric staff at Cardiff was assessed as having “no physical or mental health problems” on transfer to Parc on 13 June 2008. She believes that there should have been a more comprehensive handover from Cardiff to Parc. Once the man transferred to Parc, he was not seen by the Specialist Registrar again. When staff from the Caswell Clinic came to see him two days before his death, he is reported to have declined to speak to them. The clinical reviewer has noted that any deterioration in the man’s mood might have gone unnoticed in the two months he was at Parc. The medical record only shows two occasions when the man was seen by the healthcare team at Parc. These were on 16 and 17 July and were in relation to his fitness for a court appearance and return from court.
63. I have already commented that the RMN did not believe there were any concerns regarding the man’s health because he had been assessed as “fit for transfer”. The RMN believed that, if the Caswell Clinic were working with the man, they would be in touch with staff at Parc. It is of concern that healthcare staff accepts ‘fit for transfer’ as meaning there are no medical issues. ‘Fit for transfer’ simply means that a prisoner is able to undertake a move to another prison and the journey, in the same way s/he might be fit to attend court.

The Head of Healthcare at Parc should ensure that healthcare staff are aware of the meaning of ‘fit to transfer’ and that staff do not use this as a reason not to check historical entries.

64. Reviewing the man’s medical record and noting the comments of the clinical reviewer, I am concerned that full information was not clearly handed over to Parc. However, I am also concerned that the man’s medical notes were not fully reviewed by healthcare staff at Parc. If they had been, it would have been clear that there were ongoing assessments, and outstanding appointments, to determine the man’s mental health state. Additionally, had wing staff been made aware of this, they might have monitored the man more closely.

The Head of Healthcare at Cardiff should ensure that proper written handovers are given to any receiving prison especially when a prisoner has ongoing medical issues.

The Head of Healthcare at Parc should remind staff to review a prisoner's medical record on reception or within 24 hours if no handover is given from the sending prison.

65. At the time of his death, the man was still waiting for admission to a medium secure unit for an assessment of his mental health. The Caswell Clinic is the only NHS medium secure unit in South Wales. The man was on a waiting list but a space had not become available. The services provided by the Caswell Clinic are for tertiary assessments for those who are likely to transfer to a secure unit, and the clinic is not contracted to provide day-to-day psychiatric care to prisoners. That said, the staff at the Caswell Clinic made efforts to support the man when he was at Cardiff but he would not co-operate fully with them. The clinical reviewer is unable to judge whether or not the man would still have taken his life had he been admitted, assessed, and treated if necessary.
66. There were no records made when staff from the Caswell Clinic visited the man on 14 August. After the man's death, the RMN was asked to make a note of the visit. This was inappropriate and an entry should have been made either by the Caswell Clinic staff or by a member of healthcare on the day.

The Head of Healthcare at Parc should ensure that any medical contact made with a prisoner, either by internal or external staff, is recorded in his medical notes according to best practice guidelines. This should be audited regularly.

Searching prisoners as they leave work areas

67. When leaving their place of work, prisoners should be searched according to the local security strategy. The risk assessment for the workshop which was in place at the time of the man's death instructed that all prisoners leaving the workshop should have a hand held metal detector search and a rub down search. (This is carried out by placing hands on the prisoners' clothing and then moving the hands across the material to check for concealed items). My investigators were told that the searching policy was not being carried out properly in the workshop prior to the man's death. This meant that he was easily able to take the canvas strap from the workshop back to his cell.
68. Given the type of strap, I am aware that, even if searching had taken place properly, there is the possibility it could still have been removed from the workshop. I am also mindful that there are other materials which could be used as ligatures which are readily available in cells (for example, bedsheets, clothing or shoelaces).
69. However, my investigators found that the risk assessment for materials in the workshop was out of date and inadequate. I have been pleased to learn that,

since the man's death, searching procedures in the workshop are being implemented properly. However, I highlight the point to the Director so that she can satisfy herself that the searching and risk assessments across the prison are adequate.

The Director should satisfy herself that the establishment complies with its local security strategy in relation to activity exit searching and that all activity risk assessments are updated when the operation of an activity area changes.

Emergency Response

70. Director's order 1.196.2006 outlines the codewords for events requiring emergency response from healthcare. It states, "... it is the responsibility of the officer at the scene to decide which code the medical assistance is and to inform the Control Room accordingly." The order goes on to describe the codes as:

- **"Code red"**

This is a major event, which requires IMMEDIATE nurse response and the examples of this could be: -

- A loss of consciousness (by any means)
- Hanging
- Collapse
- Serious self harm

- **Code blue**

A nurse is required urgently and the prisoner is too ill to walk to Healthcare".

71. The prison's death in custody contingency plan slightly contradicts the order and states that the personal alarm could be used. The code system requires the member of staff to talk over the radio to raise the alarm, hence being able to say what is required. The personal alarm is a button which is pressed on the radio to alert other staff that there is a problem, but which gives no indication of what it is for - a fight between prisoners or with staff or a medical emergency, for example.

72. The second PCO pressed his personal alarm when he discovered the man hanging. By doing so, other staff knew to respond quickly but did not know what they were responding to (although, due to the time, several staff had guessed). However, the proximity of staff when help was summoned on this occasion was largely down to chance. In the event of a similar situation, staff might not be as nearby and would take longer to respond, losing precious minutes trying to obtain the right equipment.

73. Although the code system was not applied, I make no criticism of the second PCO who responded quickly and helped with resuscitation attempts. Indeed, the efforts by staff responding to the man should be commended.

The Director should ensure that the instructions in all emergency response documents and control room procedures are consistent, and that staff are aware of the correct procedures.

74. During interviews it became clear that not all staff were aware of the requirement to replace the blade in the fishknife if it has been used. Staff on night duties also have difficulty replenishing their first aid kit because the supplies are kept by staff working on day shifts.

The Director should ensure that all staff are aware of the need to replace emergency equipment and that there is an easy way to do this.

Conclusion

75. Whenever a person takes his or her own life in prison, my investigators will check if they were on an ACCT and if not what the reasons were. From the documentation and interviews, it is clear that nobody was aware of the man's thoughts and feelings and more specifically that he was intending to take his own life. My investigators found that there were six prisoners on open ACCTs on D Wing the night the man died. I believe that had the man approached staff, or if staff had had concerns over his welfare, he would also have been placed on an ACCT.
76. Intra-familial violence is an acknowledged risk factor for suicide. Family breakdown is another. Previous self-harm is another. However, given that the man had been in custody for six months and that he had given neither staff nor fellow prisoners any particular reason for concern, I do not believe his death could reasonably have been predicted.

RECOMMENDATIONS

HMP Cardiff

1. The Head of Healthcare at Cardiff should ensure that proper written handovers are given to any receiving prison especially when a prisoner has ongoing medical issues.

A response to this recommendation is still to follow.

HMP Parc

2. The Head of Healthcare at Parc should ensure that healthcare staff are aware of the meaning of 'fit to transfer' and that staff do not use this as a reason not to check historical entries.

This recommendation has been accepted.

3. The Head of Healthcare at Parc should remind staff to review a prisoner's medical record on reception or within 24 hours if no handover is given from the sending prison.

This recommendation has been accepted.

4. The Head of Healthcare at Parc should ensure that any medical contact made with a prisoner, either by internal or external staff, is recorded in his medical notes according to best practice guidelines. This should be audited regularly.

This recommendation has been accepted.

5. The Director should satisfy herself that the establishment complies with its local security strategy in relation to activity exit searching and that all activity risk assessments are updated when the operation of an activity area changes.

This recommendation has been accepted.

6. The Director should ensure that the instructions in all emergency response documents and control room procedures are consistent and that staff are aware of the correct procedures.

This recommendation has been accepted.

7. The Director should ensure that all staff are aware of the need to replace emergency equipment and that there is an easy way to do this.

This recommendation has been accepted.

Good Practice

The third PCO said that, when patrolling the landings, he checks anything which may be out of the ordinary, for example lights on after a certain hour. Although it is not a mandatory requirement, it is good practice which should be shared with other staff.

This has been noted and the good practice shared.