# Investigation into the circumstances surrounding the death of a man at HMP Cardiff

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

**June 2011**

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.

This is the report of an investigation into the death of a prisoner at HMP Cardiff who died on 19 October 2009. The man was 40 years old. He came into prison just over eight weeks before he died. The man had been remanded in custody after being charged with the murder of his partner. The evidence suggests that the man took an overdose of pain relief medication. Letters to his family and friends discovered after his death also suggest that he intended to take his own life. I would like to offer my sincere condolences to the man's family and those affected by his death.

The man passed away in his sleep and was discovered by fellow prisoners after his cell was unlocked during the morning of 19 October. The prisoners raised the alarm and staff discovered that the man had been dead for some time. It appears that, during the evening of 18 October and the morning of 19 October, the man was not observed at the appropriate levels for prisoners who are located in healthcare. Also there was a discrepancy between a statement written by a member of healthcare staff and the closed circuit television (CCTV) record of events. As a result, the former Governor of HMP Cardiff commissioned an internal disciplinary investigation and the staff concerned were officially reprimanded.

The investigation was undertaken by my two of my investigators. I am grateful for the assistance they received from staff at HMP Cardiff, especially the Head of Safer Custody, who has since retired. I would be grateful if the Governor would pass on my thanks. Staff from Healthcare Inspectorate Wales reviewed the man's clinical care and I appreciate their assistance.

After receiving the toxicology report following the man's death, South Wales Police opened an investigation into the circumstances of his suspected overdose. I postponed my investigation until their enquiries were complete. I apologise for the considerable delay issuing this report and any additional distress this may have caused to the man's family and staff at Cardiff. This was caused by the suspension of the Ombudsman's investigation while the police conducted their own investigation, and the late receipt of the clinical review.

The clinical review concludes that the man's clinical care was not comparable to that available in the community. I note the issues highlighted in the clinical review and I endorse the recommendations. These include a review of healthcare systems at Cardiff, carrying out secondary healthcare assessments and ensuring that care plans are put in place. I make recommendations of my own relating to administration of medication, staff being aware of trigger points for prisoners who are subject to self-harm monitoring and the interaction between officers and prisoners when cell doors are unlocked.

**Jane Webb**
**Acting Prisons and Probation Ombudsman** **June 2011**

## SUMMARY

The man was born in 1969 and was 40 years old when he died in the healthcare centre at HMP Cardiff on 19 October 2009.

The man had been remanded into custody by a local Magistrates' Court on 21 August 2009 for the murder of his partner. He arrived at HMP Cardiff the same day. During his first reception health screen interview, it was recorded that the man had previously been treated for deep vein thrombosis and had a history of alcohol dependence. He had also been prescribed medication for acute anxiety and pain relief. Although the man had previously tried to harm himself, the initial reception health screening record did not note that he should be referred for a mental health assessment. Additionally, a secondary health screen assessment did not take place as these are not routinely undertaken at Cardiff.

On 4 September, the man attempted to cut his throat. A self-harm observation and support regime was started but was stopped on 8 October, when the man appeared more accepting of his situation and the risk of self-harm was thought to have reduced.

During the night of 18 October and the early morning of the following day, staff made visual checks of the man. However, they were not at the level of frequency set for prisoners in the healthcare centre and no further checks were made after 6.20am on 19 October. The man's cell was unlocked just after 8.00am, but it was only several minutes later that fellow prisoners raised the alarm after finding him unresponsive. Paramedics attended the prison and confirmed at 8.50am that the man had died.

After the man died, the prison activated its death in custody contingency plan. The police visited the prison and found no suspicious circumstances. A post mortem examination was unable to confirm the cause of death. However, toxicology reports submitted to the Coroner after the post mortem confirmed that the man died as a result of the effects of dihydrocodeine (a prescribed pain relief medication) and tramadol (a pain relief medication that was not prescribed to the man). Letters were also later discovered, addressed to the man's family and friends, which suggested that he intended to take his own life.

The former Governor of Cardiff was concerned about the actions taken by staff on 18 and 19 October. After viewing the closed circuit television (CCTV) footage of events surrounding the man's death, she commissioned an internal disciplinary investigation. Following the investigation, two members of staff were officially reprimanded.

The clinical review carried out by staff from Healthcare Inspectorate Wales (HIW), considered the care provided for the man. In HIW's view, the quality of care given to the man was not equivalent to what he would have received in the community. HIW makes five recommendations for service improvement. I understand that the prison health partnership is considering the findings from the review and is developing an action plan to address them.

I make three recommendations. HMP Cardiff should review the procedures relating to observation checks of prisoners whilst they are in the healthcare centre. Staff should be aware of trigger points for prisoners who are subject to self-harm and suicide observation procedures. Additionally, when a healthcare cell door is unlocked, the member of staff should interact with the prisoner to ensure that there are no immediate medical issues that may need attention.

## THE INVESTIGATION PROCESS

1. The investigation was opened on 21 October 2009 by one of the Ombudsman's investigators. Notices were subsequently issued to both staff and prisoners at HMP Cardiff, informing them of the investigation process and giving the opportunity to contact my investigator if they felt that they could provide any relevant information. In the event no one came forward.

2. The investigator also studied all the relevant prison records relating to the man. They included his main prison record and his medical records.

3. Staff from Healthcare Inspectorate Wales (HIW) reviewed the man's clinical care. The purpose of this review is to establish whether the care which he received in prison was comparable with what he would have been offered in the community. I am grateful to HIW for undertaking such a thorough review, which was received on 18 November 2010.

4. The investigator and an Assistant Ombudsman visited HMP Cardiff on 10 November, 7 and 8 December and 1 February 2010. They discussed aspects of the man's treatment with staff and interviewed eight members of staff. The investigator returned to Cardiff on 4 March, and met a prisoner who had been in the healthcare centre.

5. After receiving the toxicology report, which suggested that the man died of an overdose, South Wales Police began an enquiry into the care he received. The officer leading the enquiry asked that my investigation be suspended until their investigation, and any subsequent court proceedings, were concluded. In return, the police agreed to share the information they gathered, including the witness statements. The police investigation was closed in July 2010 when the Ombudsman's investigation resumed.

6. The investigator contacted Her Majesty's Coroner to inform her of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist her enquiries into the man's death.

7. One of the Ombudsman's Family Liaison Officers contacted the man's mother who was listed as his next of kin. She discussed the purpose of the investigation and gave the man's mother the opportunity to raise any concerns or questions that the family wanted to be addressed. The investigator and Family Liaison Officer later met the man's mother. She mentioned that her son had been close to three prisoners, one of whom was still in custody at Cardiff. She also raised the following matters:

    - Menacing correspondence received by the man from his dead partner's family.
    - Why prisoners and not officers discovered that the man had died.
    - What medication was being prescribed to the man, how this was administered and what measures are in place to ensure that prisoners are not able to stockpile their medication.

- The man's appearance when he was found.

The investigator has addressed the issues raised by the family within the report. I hope this helps them better understand the events leading up to the man's death. The solicitors representing the man's family received a copy of my draft report. They declined to raise any comments, on behalf of the man's family, in response to the findings, preferring instead to raise matters directly with the Coroner at the inquest.

## HMP CARDIFF

8. Cardiff prison is located very close to the city centre. Originally built in 1827, it has undergone extensive refurbishment. The establishment is what is commonly referred to as a local prison which generally means that it is used to accommodate remand prisoners, although there are also a number of sentenced prisoners.

## Healthcare

9. In May 2008, the healthcare unit at Cardiff moved into a purpose built, 22 bed, two storey building. It provides 24 hour nursing care and is commissioned by Cardiff and Vale University NHS Health Board. All prisoners undergo a health screening during the first night reception process upon arrival at Cardiff.

10. Mental health services are provided by an in-reach team and two registered mental nurses. In addition there is an occupational therapist and a psychiatrist who cover seven sessions each week. Two of the sessions provide tertiary care for those who are assessed as a high risk. There is one full time doctor and one part time doctor who are contracted to provide general practitioner services. The doctors provide 13 sessions each week including Saturday mornings. Out of hours doctor cover is provided by a local surgery.

11. Within Cardiff healthcare, there is a CCTV system with a number of video cameras each capable of recording images on to a computer system. The images can be played back as necessary and provide a detailed account of movement along the majority but not all of the ground floor.

12. Additionally, although not connected to the man's death, there are two specially designed cells which are adjacent to each other. Both cells have a camera which record images on to a video recording system. Whenever a prisoner is deemed to be at high risk of suicide or self-harm, an officer sits outside the cell and observes the prisoner. If there are two prisoners in the adjacent cells, then two officers sit outside, each watching the prisoner who they are responsible for. Unlike the normal cells, the doors are not solid and have vertical bars instead. Covering the bars is a clear perspex sheet allowing observation into the cell. The officers are seated directly opposite the cell door.

## Care Team

13. Each prison has its own care team. Care team staff are drawn from all areas of the prison and trained specifically to help and support prison staff. Following any serious incident, they provide an invaluable role to any member of staff who requires support.

## Assessment, Care in Custody and Teamwork (ACCT) procedures

14. ACCT procedures are pivotal in the management of any prisoner thought to be at risk of suicide or self-harm. The ACCT document is the principal tool for assessing, monitoring and managing any prisoner through a period of crisis.

ACCT procedures can be initiated by any member of staff, irrespective of grade or discipline. The ACCT form itself contains instructions and guidance for its use.

15. If a member of staff has reason to believe that a prisoner is at risk of self-harm or suicide, he or she must open an ACCT form immediately. The following further actions must also be completed:

    - A 'Concern and Keep Safe' form must be opened immediately. The purpose of this form is to determine the main issues causing the prisoner to be at risk of self-harm or suicide.

    - An immediate action plan must be compiled within one hour of the ACCT form being opened. The purpose of the immediate action plan is to consider and record the most appropriate environment and regime required to support the at-risk prisoner prior to the first case review. The plan should be drawn up within an hour of the ACCT form being opened.

    - An assessment interview must be conducted with the at-risk prisoner by a trained assessor within 24 hours of the ACCT form being opened. The purpose of this interview is to examine in depth the reasons behind the risk posed by the prisoner. The details of the assessment then inform the initial case review.

    - An initial case review must be conducted within 24 hours of the ACCT form being opened. The review panel must, in conjunction with the at-risk prisoner, agree a care and management plan - or 'caremap' - setting out goals or the prisoner to achieve, with the help of staff, in order to reduce his risk.

    - Thereafter, regular multi-disciplinary case reviews must be convened, each involving the at-risk prisoner, so that his risk can be monitored and his caremap updated.

16. The ACCT form can be closed once those involved in the prisoner's care, as well as the prisoner himself, are content that the risk has reduced to the point where formal monitoring is no longer necessary. A post-closure review, once again involving the prisoner and a multi-disciplinary panel, must be convened within an appropriate interval.

**Performance Rating**

17. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS use a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four (one being "serious concerns" and four "exceptional performance"). For the last four quarters, HMP Cardiff has been given a rating of three (or "good performance").

## Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. In the most recent published annual report, covering the period from September 2008 to August 2009, the IMB said they found Cardiff to be a well run establishment, with good relationships between staff and prisoners. They also considered that ACCT documents were being used appropriately to help prisoners who were thought to be at risk of harming themselves.

19. The IMB report states that there: "are still concerns about prisoners with mental health issues being held in the mainstream prison which is not designed to meet their need". The report added that the Board were aware of the financial constraints which had affected both uniformed and administrative staff and hoped that the effects would not be detrimental to the positive work being carried out.

## Her Majesty's Chief Inspector of Prisons

20. In January 2008, Dame Anne Owers, the former Chief Inspector, carried out an announced inspection of the prison. There was an unannounced short follow-up inspection in July 2010, but the report of that inspection has not yet been published. In the introduction to her 2008 report, Dame Anne said the prison suffered from all the difficulties of an overcrowded and pressurised prison system. She went on to say the prison was essentially safe and that prisoners were more likely to report feeling safe than at other local prisons.

21. Of particular note, Dame Anne commented that:

> "Anti-bullying procedures had improved since the last inspection, but it was disappointing that the enthusiasm of the safer custody manager had not communicated itself to those staff responsible on a day-to-day basis for supporting those at risk of self-harm."

22. Dame Anne found that not all staff had been trained in the use of the ACCT procedures, and she recommended that training should be fully implemented. Similarly, she recommended that all staff receive anti-bullying training. In general, the quality of completed ACCT documents was good.

23. Dame Anne said that, overall, her report reflected the positive work being done at Cardiff, in spite of the pressures and difficulties within the prison system. She added that the prison's strengths were its local links and ethos along with the support it has been able to obtain from the Welsh statutory, private and volunteer organisations.

## Police investigations of deaths in custody

24. With all deaths in prison custody, the police are notified by the prison as soon as the death is discovered. In the first instance, the police treat the area as a

potential crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that the Ombudsman's investigators are allowed to begin their own investigation.

**Previous investigations of deaths in custody**

25. The investigator reviewed the Ombudsman's reports for deaths at Cardiff. While none of the circumstances of those investigations are similar to this, previous recommendations have also mentioned that improvements should be made to record keeping.

## KEY EVENTS

26. The man was in 1969 in South Wales. On 21 August 2009, he was remanded into custody by a local Magistrates' Court for the murder of his partner. The man arrived at HMP Cardiff on the same day. It was not the man's first experience of being in custody, but his previous convictions had only led to short custodial sentences. Prior to coming into custody the man received state benefits as he was unable to work due to ill health.

27. At the man's first reception health screen interview, it was recorded that he had a history of alcohol dependence and had been prescribed medication for acute anxiety and pain relief. It was also recorded that he had been treated for deep vein thrombosis and had used illicit drugs. The man was also a smoker. On his arrival at Cardiff, the man provided details of his doctor and mentioned his on-going health problems. Neither the HIW nor my investigator could find any evidence of his medical records being requested or followed up.

28. During his first reception health screen, the man admitted that he had attempted to harm himself in the past, although he said he had "no thoughts of self-harm at present". There was no record of the man being referred for a mental health assessment despite being charged with murder[1] and him reporting that he had tried to previously harm himself.

29. Unlike most other prisons, Cardiff does not routinely undertake a secondary health assessment within 72 hours of admission. This meant that further opportunities for care planning and investigation of healthcare issues were missed. (The secondary health screening is a general health assessment and should be offered to every prisoner in the week following arrival in custody. This assessment is equivalent to a primary care assessment when registering with a doctor in the community. It provides an opportunity for gathering further health information, health education and promotion and, importantly, checking how a prisoner is settling in.)

30. Due to the nature of his offence, the man was initially admitted to the healthcare centre for observation. On 26 August, the man moved to the induction wing where he underwent a short alcohol detoxification programme.

31. The man was prescribed the following medication: propranol (for anxiety), amytriptyline, mirtzapine and trazodone (for depression), carbamazepine (for alcohol withdrawal), flucloxacillin (an antibiotic), zopiclone (for insomnia), and gabapentin and dihydrocodeine (for pain relief). The medication was dispensed to the man every day. My investigator was told by healthcare staff how medication is administered. A prisoner is asked to get a drink and is then given their medication which is taken in front of the member of staff.

[1] Part 2 of the First Reception Health Screen form clearly states in bold capital letters: "If charged with murder or manslaughter, refer for mental health assessment".

32. During the period from 26 August until 4 September, the man complained to staff of feeling nauseous and sweating. There was no evidence in the records of medical observations being undertaken during this period.

33. The man was taken to Crown Court on 27 August and was due to return to court on 6 November.

34. Around 6.00pm on 4 September, staff discovered the man lying on his bed having cut both his wrists and his throat. The following entry was made by a nurse at the prison in the man's medical record:

> "He told me that he was missing his partner (he is accused of her murder), and that he hadn't done a good enough job of killing himself and that he would try again when he had the chance."

35. A letter from the man to his mother was also found by staff. He wrote:

> "Just a few lines to say I'm very sorry for what I've done. I can't go on without … [the man's partner] mum I loved her more that I can imagine. I don't want to go on without her any more."

36. The man was taken to the Accident and Emergency (A&E) department at a local hospital. After his injuries were treated, the man was seen by a Specialist Psychiatric Registrar. She wrote that in her view: "Incident of self-harm as a reaction to the circumstances and consequences of the index offence. Risk of further harm is high in view of this".

37. The Specialist Psychiatric Registrar suggested that the man's amytriptyline be stopped, as it "can be serious in overdose if he secretes it". The doctor agreed the proposed plan with a consultant psychiatrist and that "meds [medicines] can be continued if they can observe him/supervise meds". The man returned to the prison later that same night and was admitted to the healthcare centre.

38. As the man was identified as an ongoing suicide risk, an Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support regime was started at 6.35pm on 4 September.

39. As part of the ACCT process, an assessment interview was undertaken, on 5 September, by a member of the Safer Custody team at Cardiff. At section 3 of the Record of Interview he noted that: "The man stated that he had no previous incidents of self-harm in his life. The man had always been able to cope without the use of self-harm". At section 4 it was recorded that the man had "no history of anxiety attacks, and no history of auditory or visual hallucinations. States no problem with sleeping and eating a full diet".

40. Following the interview it was recorded that the man was to "remain on continuous observation level in healthcare, and to be further assessed by a Safer Custody Manager and psychiatric services. Locate in camera/gated cell". The Action Following Assessment Form was completed at 9.50am on 5 September and noted that "the man is assessed high risk due to sentence".

The need for an urgent referral to psychiatric services was also noted and the date and time for the next review was set for 9.00am on 7 September. A care and management plan (Caremap) was drawn up and four goals and related actions were established. Each of the goals related to keeping The man safe and the related actions were:

- Locate in a safe camera cell continuous watch in healthcare.
- Ensure cell staff are aware of the observation and interaction level and the recording of these levels.
- Supervise shaving at all times. Remove all sharp objects including cutlery when not in use.
- To be assessed by psychiatric services.

The Caremap makes no reference to the recommendation made by the Specialist Psychiatric Registrar in respect of medication being continued under supervision.

41. A care plan was also drawn up healthcare staff on 5 September and this recorded the nursing action as follows:

- One to one over weekend.
- No sharp objects or in possession medication.
- Contact on call psychiatrist at the local hospital to come and assess the man.
- Review safer custody.
- Establish therapeutic relationship.
- Allow time to ventilate feelings.
- Ensure any medications are given.
- Review with GP as soon as possible.

No reference is made in the care plan to cleaning or checking the man's wounds. The care plan was to be reviewed on 7 September but this did not take place. There were no further reviews of the care plan or any additions or amendments after 5 September.

42. At the first ACCT case review held on 7 September, it was recorded that the man was still located in the healthcare centre under continuous observation[2]. The following was written in the record of the case review:

> "The man describes feeling more settled this morning, with mood being stable, looking towards the future. The man has been in contact with his mother by telephone over the past few days, which has made him realise the effects this incident would have on family members. The man now feels the self-harm was a silly act, which he now regrets. The

[2] Whenever a prisoner is deemed to be at high risk of suicide or self-harm, an officer sits outside the cell and continually observes the prisoner. Unlike the normal cells, the doors are not solid and have vertical bars instead. Covering the bars is a clear perspex sheet allowing observation into the cell. The officers are seated directly opposite the cell door.

man continues to state the self-harm was offence related, and now has to come to terms with this issue."

43. During the review it was decided that as the man's mood had improved, the level of observations was to be reduced from continuous to intermittent (up to four times an hour) level and that he was to stay in the healthcare centre for further assessment.

44. At the second ACCT case review it was recorded that the man was in "good spirits" and was coming to terms with what had happened to him. It was recorded that:

> "The man stated that it had all come on top at one time and it would never happen again. The man expressed no thoughts, plans or intent to perform any other acts of self-harm now or in the future."

45. During the morning of 11 September, The man was taken back to hospital for an outpatient appointment with a Consultant Oral and Maxillofacial Surgeon. This was to review the wound to his neck. He returned to prison the same day. In his letter dated 22 September, the consultant wrote:

> "Sutures have now been removed and the wound is clean and healing well. He has some loss of sensation in the region of the wound and in light of this a review appointment in three months time has been arranged."

46. Around 9.15pm on 11 September, the following entry was made in the man's medical record: "requesting further medication states staff are ignoring him because of his charge". On the following day, 13 September, it was recorded that the man was: "still complaining about his medication and that we [a]re not taking him seriously". HIW is not clear from the records what the man's exact concerns were about his medication.

47. The man's partner's funeral took place on 15 September. He received bereavement support from staff and a visit from the chaplain. The man was also visited by his mother and brother. At his ACCT review the following day, 16 September, it was noted that the man was having a difficult day after the funeral of his partner. A psychiatrist was not at the meeting and there was no evidence that a psychiatric report was prepared or considered at the ACCT review. The following was written in the record of case review:

> "The man was tearful and remorseful at what he had done … the man is now coming to terms with his situation and he has no further thoughts of self-harm and his risk level has been reduced to low."

48. During the evening of 16 September, it was recorded in the medical record that the man had asked for medication to help him sleep. He was prescribed zopiclone (a medication for insomnia) despite having slept well the night before.

49. The following entry was made in the medical record on 17 September: "Demanding sleepers [sleeping tablets] again … Says he needs them due to him feeling anxious. Advised to discuss with psychiatrist". On the following day, 18 September, it was recorded that the man was: "still demanding sleepers and something to make me less anxious … Remains somewhat belligerent but has not been aggressive".

50. On 21 September, the man was seen by a consultant psychiatrist. However, they did not seem to be made aware of his repeated requests for medication to help him sleep. The following entry was also made in his medical record:

> "Stating that was fine until approached by staff re[garding] possible move back to F wing … received letter which he perceived to be threatening (from family of wife) and this has worried him."

51. During the afternoon of the following day, 22 September, the fourth ACCT case review was held. It was recorded that the man felt that it was too early for him to leave the healthcare centre as he would not feel safe and might harm himself. He told staff about the threatening letter he had received and his risk level was assessed as "raised".

52. Despite his risk level being raised, the frequency of checks made on the man after 22 September appear to have been ad-hoc with wide variation in the time between checks. The timings also mirrored the checks made on the two days prior to the risk level was assessed as being "raised". For example, on the following day, 23 September, it was recorded that checks were made at: 2.20am, 6.15am, 8.30am, 10.00am, 11.50am, 3.10pm, 5.40pm, 8.20pm and11.40pm. On 22 September, checks were made at: 2.25am, 5.30am, 7.30am, 11.45am, 3.00pm, 6.00pm, 8.20pm and 11.30pm and, on 21 September, checks were made at: 2.40am, 6.00am, 7.30am, 9.00am, 12.00pm, 2.10pm, 6.30pm, 8.30pm and 11.30pm.

53. The man's mental health and medication was reviewed by a consultant psychiatrist on 23 September. The consultant noted the man's history of depression and suggested that he should be prescribed mirtzapine (a medication used to treat depression) 15 milligrams initially to be increased to 30 milligrams. It was also noted that the man had received threats (the letter mentioned above) and was concerned that he might be injured. The medical record indicated that although the man had no plans to harm himself this "may vary depending on events/other stresses". It was also recorded that the man could leave the healthcare centre and move to a wing in the main prison "when the threats to harm him have been addressed".

54. On 24 September, the man gave a urine sample for mandatory drug testing. Three days later (on 27 September), the following entry was made in the man's record: "Settled day requesting a move to normal location as he feels he wants to move on and attend education". However, on the following day, 28 September, he was recorded as threatening to harm himself (deliberate self-harm - DSH) if discharged from the healthcare centre.

55. The man told the prison doctor on 30 September that he was not happy to take the increased dose of mirtzapine. The psychiatrist was advised and he saw the man on the following day, 1 October. Following his consultation it was decided to stop the mirtzapine and prescribe propranol (a beta blocker used to assist with treatment of hypertension and anxiety) instead.

56. Around 9.15am on 6 October, the man was taken to the segregation unit. He had failed the mandatory drug test two weeks before, and was taken there pending an adjudication hearing[3]. The following entry was recorded in the ACCT document: "Now located in [cell] P1-28 awaiting adjudication, seemed relaxed and was quite talkative in route over from H/care [Healthcare]. Seems fine". At the adjudication it was decided that the man's punishment of confinement to his cell for seven days should be suspended. He returned to the healthcare centre at around 10.15am that same day.

57. The ACCT document was closed on 8 October when the medical assessment identified that the risk of self-harm had reduced and that the man had come to terms with his situation. The post closure monitoring caremap required:

    - The mainstay in the healthcare centre until at least 20 October.
    - He should be observed four times a night.
    - He should be provided with written information of the interventions or contact points and how to access them.

    The man was also seen by a consultant psychiatrist the same day. It was recorded that he had "on-going problems since stopped amytriptyline" and his mood was low. Trazodone (an anti-depressant) was prescribed and it was also recorded that the man was "adamant that would not repeat act DSH/suicide".

58. On 9 October, the man was again seen by a consultant psychiatrist and the following entry was made in his medical record: "still to be considered a suicidal risk ... still believes he is at risk from wife's family because of letter he has received and threats to his mother".

59. The ACCT post closure review was conducted by a member of the Safer Custody team on 15 October. The Safer Custody Manager at Cardiff saw the man three days later, on 18 October. He wrote the following entry in the man's record:

    > "The man continues to describe himself as settled within health care… The man is waiting to take part in the Christmas church play and seems most motivated by this. The man states he has no thoughts of self-harm, feels he is beyond this now."

60. Around 9.00pm on 18 October, the CCTV recording shows a nurse dispensing medication to the man which is confirmed by the treatment chart. The nurse also made a visual check of the man at 10.04pm and 11.52pm that night and

[3] Adjudication - An internal hearing into breaches of prison discipline caused by prisoners. It can also be referred to as "being on a charge".

4.55am and 6.21am on 19 October. His colleague, an officer who was also based on healthcare centre on the same shift, did not go near the man's cell during this period.

**19 October 2009**

61. When interviewed as part of this investigation, the nurse confirmed that there are three levels of observation. Level 1 is constant watch, level 2 is high level observations and level 3 is normal observations. The nurse said that he believed that the man was on level 3 observations. However, when prisoners are located in the healthcare centre the observation levels should be intermittent. The nurse defined as this as prisoners being observed four times an hour. When interviewed the nurse said:

> "As far as I was concerned the man was on normal obs (observations) … we do rounds three or four times an hour. In the course of doing the rounds we had a couple of people on the inpatient facility who would often tend to stop and have a chat. One person in particular who's noted for spending lots of time talking to staff and you know if you're doing a round you're going to spend ten minutes talking to him which obviously will knock the next check going round then back a little bit."

62. When asked about issuing medication, the nurse said:

> "I tend to take my time doing the medication round. So I tend to actually have a chat to the ones I give medication to. My routine basically is to give them medication first, watch them taking it and then start talking to them so obviously if they're going to palm[4] it then its much more difficult to do so but certainly I'd no concerns about the man taking his medication. … I normally ask them to get a drink of water first, get them to come perhaps with a drink of water. I put the medication into a pot which then goes in their hand and they take it by the hatch in front of me and then we can have a bit of a chat at the same [time]."

63. The nurse confirmed that he had not seen any indication that the man intended to take his own life. The nurse said:

> "Certainly for the last couple of weeks [before his death] he appeared to be quite bright and cheerful. He had come to terms with the situation he was in. He was in for murder I believe. … Certainly in the last two or three weeks that I'd been with [the man] he appeared to be quite positive and as I said come to terms with the situation. There was no obvious evidence of suicidal ideation with him to my knowledge anyway."

[4] Palm – This is when a prisoner does not ingest/take their medication but instead hides it in their hand or mouth. The medication can then be thrown away, stock piled or sold to other prisoners.

64. The CCTV footage showed that, at 7.39am on 19 October, two nurses dispensed medication from the mobile trolley. It appeared that one of the nurses gave medication to a number of prisoners, including the prisoner in the cell next door to the man. At no time did any healthcare staff attempt to give medication to the man or look into his cell.

65. However, according to a statement completed by of the nurses for the Governor after the man's death, at around 7.45am he opened the man's observation hatch in the cell door. The nurse wrote, in his statement, that as the man appeared to be asleep he decided to administer his medication once his cell was unlocked. The man's treatment chart shows the morning dose of prescribed medication appeared to be signed for by a member of staff. The nurse's written statement did not match the CCTV record which showed that, after 6.21am, no member of prison staff checked the man or tried to give his medication to him.

66. The CCTV recording shows that at 7.41am, cleaners and vulnerable prisoners[5] were unlocked. Seven minutes later, the cleaners were seen putting cartons of milk through the cell door hatches (including the man's cell) which my investigator has confirmed was the usual practice. At 8.06am, the vulnerable prisoners went back to their cells and the other prisoners on the healthcare centre were unlocked. An officer unlocked the man's cell door but did not look inside.

67. At around 8.13am, two prisoners in the healthcare centre, went into the man's cell but were unable to obtain a response from the man. They immediately informed staff that they thought that the man was dead. In his statement to the police, one of the prisoners said:

> "As I got closer, I saw what appeared to be sick on the pillow next to the man's mouth area. At this point I thought something might be wrong with the man. I then approached the man closer and touched his left arm, which was furthest from the mattress. His arm felt cold and his skin tone appeared to be grey. At this point I did suspect he was dead."

68. The Inpatient Manager and a Health Care Assistant (HCA) went to the man's cell. They found the man lying on his right hand side on his bed. In her written statement completed soon after the death, the HCA wrote:

> "I observed the inmate lying on his bed. He was lying on his side facing the wall. He was covered with a blanket with his shoulders exposed. A small amount of blood was visible on his pillow. Both myself and [the Inpatient Manager] checked for radial and brachial pulse [pulses found at the wrist and elbow respectively] but this was absent upon touching I noted that his skin was cold and he was rigid."

[5] Vulnerable prisoners - Prisoners who are separated from the general population of the prison. This can be due to a number of reasons including: the nature of their offence, publicity surrounding their case and trouble coping with being in prison.

69. When interviewed for this investigation, the Inpatient Manager said:

> "I actually called the man, I called his name to see if he was asleep. Because he looked as though he was fast asleep, the covers were over him, he was lying on his right side, he looked like he was just asleep. I called him, there was nothing, no answer. I went around to him and I went to sort of like shake his shoulder like … you are waking somebody up and I called his name. But as soon as I touched him he was ice, it was very icy and as I sort of put my hand on him it was like his whole body moved, it wasn't [just] his shoulder, he was very rigid. I looked over, he was very sort of mottled, his eyes were closed. There was blood and that, only a little bit but it was around his nose and mouth. I checked for a pulse in the neck and on his wrist. There was nothing at all, he was so cold."

70. When staff discovered that the man had died they summoned immediate assistance by using an emergency alarm bell rather than using the prison radio system or telephone. An ambulance was called at 8.31am. The paramedic arrived at the cell shortly afterwards and pronounced at 8.50am that the man was dead.

71. Other prisoners were immediately told of the death and they were also asked whether they required anything or wanted to speak to a Listener. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) All the prisoners who were on ACCT monitoring were reviewed.

72. The head of Safer Custody, a Chaplain and the Deputy Governor told the man's mother of his death later that morning at around 11.00am. A member of staff from the Safer Custody Team was appointed as the prison's family liaison officer. He kept in contact with the family and assisted with the funeral arrangements. Cardiff also offered financial assistance with the costs of the funeral. The man's funeral took place on 29 October and the service was conducted by the Chaplain. The man's mother later told my family liaison officer that she had appreciated the help and support she received from prison staff in the period following her son's death.

73. After a death, prison managers must hold a "hot debrief". This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other. After he returned from visiting the man's family, the Deputy Governor held a hot debrief in the early afternoon of 19 October. It is not clear who attended as some staff were still being interviewed by the police at that time. During the meeting it was thought that the man might have died of natural causes but that this would need to be confirmed by the Coroner. The only areas of concern raised at that time were the importance of preserving evidence in the cell for the police and the use of the emergency alarm bell to summon assistance.

74. After the man's death, letters to his mother and a friend were found in the internal postal system. In the man's letter to his friend he wrote:

> "I've got things in place. I just want you and … to be my bearers, and pop up to see my mum every so often like you promised my friend. I've even got the music sorted …, you know me … I like to be organised."

75. In the man's letter to his mother he wrote:

> "I'm sorry about everything mum I've really put you through the mill haven't I. This is the last time mum no more crap off me anymore. Just get through this and its all plain sailing, don't worry about me cause I'll be up there with [his partner] and my dad. I had to do it mum couldn't go on anymore without her."

76. The man's mother and brother visited the prison on 11 November to visit his cell. His belongings were handed to the family before they left.

77. Due to concerns raised by the Head of Safer Custody about the checks on prisoners not being carried out correctly by staff in the healthcare centre and the fact that nurse's statement did not match the CCTV record, the former Governor of HMP Cardiff decided, after discussing the issues with my investigator, to commission an internal disciplinary investigation. It was conducted by a Governor from HMP Usk. Following the internal investigation, disciplinary action was taken against two members of staff.

78. The post mortem examination was unable to establish the cause of death. The interpretation of a subsequent toxicology report, dated 25 November 2009, suggests that the concentrations of tramadol (a pain relief medication, 7.52 milligrams per litre) and dihydrocodeine (10.6mg/L) were high and consistent with a recent overdose of the drugs. (Therapeutic concentrations of tramadol are usually less than 1 mg/L and deaths attributed to the drug are normally associated with concentrations of greater than 6mg/L. Deaths attributed to dihydrocodeine alone are typically associated with concentrations greater than 2-3 mg.)

79. The man had only been prescribed dihydrocodeine. Only one other prisoner on the healthcare centre was prescribed tramadol. He was later interviewed by a detective from South Wales Police but stated that he had not given his medication to the man. Neither the detective nor the investigator were able establish the source of the non-prescribed medication. The inquest into the man's death was completed on 10 May 2011. The jury concluded their narrative verdict with the following comment:

> "The man was intent on taking his own life. Full adherence to prison policies and protocols may not have prevented him from doing so. However, in this instance, failure to follow the procedures and protocols reduced the likelihood of preventing the man from taking his own life."

## ISSUES

### Concerns raised by the man's family

80. As mentioned earlier in the report, the man's mother met the investigator and the family liaison officer. The family gave them a letter sent to the man dated 15 September (the date of his partner's funeral). The letter was allegedly from the man's partner's father, and consisted entirely of a lyric from the song "Sympathy for the Devil".

81. The man's family wondered whether the implied threat in this letter was noted by staff when checking correspondence. They wondered whether the issue was discussed with the man when he received the letter. The family also wanted to know how the sender was able to address the letter using the man's prison number.

82. The man told staff in the healthcare centre about the letter, and he also mentioned it at his ACCT review meetings. The following entry was written in the man's medical record on 21 September: "… received letter which he perceived to be threatening (from family of wife) and this has worried him". The man raised the issue of risk of retribution again when he saw the Head of Safer Custody on 18 October. The Head of Safer Custody intended to ensure that this issue was considered when the man moved from the healthcare centre to normal location.

83. I conclude that action was being taken to deal with the letter and the implied threat therein, as part of the decision making process about where the man would be located in the prison. However, it is not clear how the letter came to be addressed to the man with his prison number. The investigator was unable to find a satisfactory response to this question.

84. The family were also concerned that a prisoner, and not a member of prison staff, discovered that the man had died. The investigator informed the family that the Governor of HMP Cardiff shared these concerns and had commissioned an internal investigation of the actions taken by staff. The investigator also agreed to clarify the sequence of events on 18 and 19 October.

85. When interviewed as part of this investigation, the nurse declined to comment on the discrepancy between his statement to the Governor and the CCTV footage.

86. I consider that the observation procedures employed by staff in the healthcare centre at Cardiff were poor. The man was not checked as frequently as required for a prisoner located in the healthcare centre (intermittent, which is described as four times an hour). He was only checked four times by a nurse during the period from 8.00pm on 18 October and 6.30am on 19 October. No checks were made by his colleague. The man was also not checked after 6.30am on 19 October. The nurses on duty the next morning did not issue any medication to the man. Although it was suggested in a written statement that

this was because he was asleep, the CCTV record clearly shows that the nurses did not go near the man's cell. The officer who unlocked the man's door but did not interact with him and therefore did not realise he had passed away.

87. According to the records it would appear that the nurse did not carry out the actions described in his statement to the Governor. I am pleased that an internal disciplinary investigation was carried out and that action has been taken to review the procedures for observing prisoners in the healthcare centre. I am content that the matter has been dealt with and the issues raised were addressed promptly.

88. As mentioned previously, after the man's cell was unlocked, it was not discovered that he had died until two prisoners raised the alarm. I find this unsatisfactory. Checks on the man had failed to take place as they should have done and, when found, he appeared to have been dead for some time.

89. Whilst I could find no written requirement in Cardiff's local roll check procedures that staff should check prisoners for signs of life when they unlock the cell, I believe that they should ensure the wellbeing of prisoners when they do so. I recognise that, in this case, the man was already dead and such a check would not have altered the outcome. However, by not checking his wellbeing, a dead man was left in an open cell unattended for nearly ten minutes. Had the two prisoners not gone in and found the man, it is possible this would have been much longer. This is clearly unacceptable. The Prison Officer Entry Level Training (POELT) manual states:

> "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

From the interviews and CCTV footage, it is clear that this procedure was not followed.

**The Governor of HMP Cardiff should review the procedures for unlocking prisoners and ensure that when a cell door is unlocked the member of staff interacts with the prisoner to ensure that there are no immediate issues that may need attention.**

90. As mentioned previously, when it was discovered that the man had passed away, staff used an emergency alarm bell instead of using the prison radio system. Following the hot debrief and information discussed at interview I believe that this matter has now been resolved internally at Cardiff.

**Clinical care**

91. As noted, a review of the man's medical care was undertaken by staff from Healthcare Inspectorate Wales (HIW).

92. The review found that many aspects of the care provided to the man had been "questionable and flawed". As mentioned previously, opportunities were missed which could have helped to identify his risk of self-harm and to ensure more timely care and treatment. Following his first self-harm attempt on 4 September, ACCT procedures were put in place. However, HIW judges that the man's care appeared to have been "fragmented" and that there "was a lack of care planning by healthcare staff and inconsistent nursing input".

93. Despite the man confirming that he had taken a drug overdose in the past and that he suffered from anxiety, he was not referred to the mental health team for assessment following his admission to Cardiff. The man was on remand for the murder of his partner and this made a referral for a mental health assessment all the more important (Page 2 of the First Reception Health Screen form clearly states in bold and capital letters: "If charged with murder or manslaughter, refer for mental health assessment"). HIW believes that had appropriate, and required, action been taken, and the man referred for a mental health assessment, his first suicide attempt might have been averted.

**The Head of Healthcare at HMP Cardiff should make sure that regular audits are undertaken of key documents such as the First Reception Health Screen form to ensure that they are being completed correctly. Such reviews are important in relation to highlighting gaps and identifying related training needs.**

94. HIW also notes that, on arrival at Cardiff, the mansard that he had various health problems, including alcohol misuse and acute anxiety. However, no record has been found that this was confirmed with his community doctor, or that his medical records were ever requested.

**The Head of Healthcare at HMP Cardiff should put mechanisms in place to ensure that all available information about the medical and mental health history of a prisoner is obtained.**

95. Her Majesty's Chief Inspector of Prisons (HMCIP) 'Expectations' document[6], against which it assesses prisons in England and Wales, expects that prisons will undertake a second healthcare assessment within 72 hours of admission. Such assessments provide an opportunity for a more detailed assessment of healthcare issues and needs. Cardiff does not undertake second assessments as a matter of routine and neither the staff from HIW nor my investigator found any evidence of the man being offered such an assessment.

**The Head of Healthcare at HMP Cardiff should ensure that secondary healthcare assessments are made part of the routine procedures for prison admission. These assessments should include a full medical assessment with urine and bloods being screened.**

[6] HMCIP, 'Expectations: Criteria for assessing the conditions in prisons and the treatment of prisoners', 2009., Section 4, Expectation 28

96. As mentioned previously, the man was put onto a detoxification programme after he arrived at Cardiff. However, there was no evidence of a care plan being put in place or of general observations being undertaken prior to his attempt to harm himself on 4 September. The man had complained to the prison doctor on 26 August of nausea and sweating but routine clinical observations were not started. He moved from the healthcare centre to normal location on the same day but no rationale was set out in the records provided to the investigator and HIW.

**Assessment Care in Custody and Teamwork**

97. Following his first self-harm attempt, an on going record of significant events, conversations and observations was put in place and ACCT review meetings were held. A Caremap, which was initially completed on 5 September, was developed and updated in a timely manner following each ACCT review meeting. An urgent referral to psychiatric services was also made. However, the clinical review highlights a number of anomalies that led HIW to believe that the ACCT process and psychiatric support were not effectively linked.

98. The psychiatrist who assessed the man immediately following his self-harm attempt on 4 September, stated in his report that he should no longer take amitryptyline as it "can be serious in overdose if he secret[e]s it". The psychiatrist also stated that "meds can be continued if they can observe him/supervise meds". While the medication was stopped immediately, there is no reference in the man's medical records for the need to observe or supervise him when he was taking his medication.

99. Some of the information documented as part of the first ACCT review interview does not accord with information already gathered about the man's history from the First Reception Health Screen and the psychiatric assessment undertaken on 4 September. Specifically, the interview note records that:

> "The man stated that he had no previous incidents of self-harm in his life" and that the man had "No history of anxiety … attacks … States no problems with sleeping."

100. The man's medical records provide very little evidence of nursing observations and care. HIW are surprised by this given that the man's amitriptyline had been stopped immediately after his hospital admission and side effects due to withdrawal from this medication should have been expected. Under normal circumstances, patients are weaned slowly off medication such as amytriptyline.

101. The care plan was not amended or added to after it was drawn up on the 5 September. This is in contrast to the Caremap which was updated immediately after each ACCT review. It is important that when a prisoner has more than one need, for example detoxification and self-harm, that complementary care plans are in place. The Caremap cannot and should not replace the need for a care plan which should cover the health needs of the patient in greater detail.

**The Head of Healthcare at HMP Cardiff should ensure that care plans are in place for those prisoners with on-going health problems to ensure that holistic care is provided.**

102. The Safer Custody Team at Cardiff manages all Assessment, Care in Custody and Teamwork (ACCT) cases. Members of the team review prisoners and, when ACCTs are closed, they closely monitor the prisoner to ensure that they remain actively supported. However, the recommendations made at ACCT reviews regarding the level and frequency of observations do not appear to have been complied with. The psychiatrist did not attend all ACCT reviews and it is unclear to whether discussions were always supported by an up to date psychiatric assessment.

103. A number of records completed between 11 and 14 September refer to the fact that the man was complaining about his medication and was unable to settle. No consideration was given to the fact that the man may have been suffering from symptoms of withdrawal from amitriptyline. A note of a ward round assessment undertaken by the psychiatrist on 14 September indicated that he was not appear to have been made aware of the man's request for "sleepers" and unhappiness with his medication. It is understandable that there should be concern over the man's repeated request for medication to help him sleep. However, staff did not appear to have been aware or sensitive to the fact that the man's partner's funeral was due to take place on 15 September and refused to give him medication on the proceeding evening. There is no record that alternative discussion/counselling was provided.

104. It is important that trigger points are recorded on ACCT documents. The use of ACCT is covered in Prison Service Order (PSO) 2700, "Suicide and Self Harm". At section 4.10.1, it is noted that people accused of homicide are at particular risk of harming themselves, and those accused of homicide of a family member or domestic partner present "an exceptional risk of suicide". The PSO states that "Care of such prisoners will require close monitoring of trigger points, for example during any trial or around key anniversaries". The funeral of the victim should be considered as such a trigger point, and the information shared among staff. The man's request for medication around the time of the funeral should have alerted staff to a heightened risk, which should have been recorded on the ACCT document.

**The Governor of HMP Cardiff should ensure that trigger points are accurately recorded on ACCT documents, and that staff are aware of the increased risk that can occur at these points.**

105. At the third ACCT review it was decided to reduce the man's risk of self-harm to "low" and allow him to move out of the healthcare centre. However, a psychiatrist was not at the meeting and there was no evidence of a psychiatric report being prepared and considered at the ACCT review. Despite the man's risk level being assessed as "raised" at the fourth ACCT review, the frequency of checks after 22 September appear to have been ad-hoc, with wide variation in the time between checks.

106. On 8 October, the fifth and final ACCT review took place, and the monitoring procedures were closed. The man's risk was assessed as "low" and he was to remain in the healthcare centre until at least 20 October. Observation levels were reduced to four times a day and night. However, it was noted that healthcare normal observation levels were intermittent (defined as up to four times an hour). The caremap was amended to reflect the decision to close the ACCT and an initial post closure review date was set for 15 October. A psychiatrist was not at the review meeting and again there was no evidence of a psychiatric report being made available for discussion and consideration. The last psychiatric assessment was undertaken on 1 October, when the man's medication was changed.

107. Staff continued to support the man after the ACCT was closed to ensure that he did not have further concerns. He was engaging with staff and making arrangements to be involved in the Christmas play. There were no indications that he intended to harm himself. Therefore, staff were very surprised when they discovered that he died and initially thought that his death was natural causes. It was only after the discovery of the letters he had attempted to post to his friend and mother that it was thought that he may have taken his own life.

108. However, according to the medical records in the days leading up to his death, the man's behaviour appears to have become more difficult and he was reported as agitated, surly and uncooperative. No consideration appears to have been given to the fact that he may have been exhibiting signs of withdrawal from mirtzapine or other medication. The reviewer suggests that the man may have been exhibiting signs of withdrawal from dihydrocodeine. The concentration of this drug was 10.6mg/L in the post mortem femoral blood. Fatalities attributed to dihydrocodeine are typically associated with blood concentrations greater than 2-3mg/L.

109. The clinical reviewer at HIW concludes that important medical information was not always shared and that psychiatric reports were not always available at ACCT reviews. HIW considers: "the level of nursing input to be wanting" and that "the man's complaints about his medication were not taken seriously enough by healthcare staff". HIW does not think that staff properly escalated concerns about the man's constant requests for sedatives and the issues that intermittently arose about his behaviour. Links between the man's behaviour, changes to his medication and possible anxiety and depression do not appear to have been made.

110. HIW also drew attention to the lack of a referral for mental health assessment upon the man's admission to HMP Cardiff and that the warning given by the specialist psychiatric registrar (on 4 September) appears to have gone un-heeded. The registrar clearly identified a risk of the man secreting his medication and therefore recommended that he was observed while taking his medication. While it is clear that the man was given his medication it is not clear whether he was observed taking it. Although he had taken an overdose of tramadol, which he obtained from an unknown source, the clinical review states: "… we should not let this issue divert us from the fact that the amount

of dihydrocodeine in his femoral blood indicates that he would have died from the amount of this medication alone".

**The Head of Healthcare at HMP Cardiff should ensure that appropriate safeguards are in place when medicines are given to prisoners.**

111. HIW also states that the Head of Healthcare has a key role to play in ensuring the provision of good healthcare to prisoners at HMP Cardiff. HIW states that it is the responsibility of the Head of Healthcare to:

> "… to know the strengths and weaknesses of all her staff, to ensure established processes and requirements are complied with and to know on a daily basis the challenges staff are facing with regard to individual patients."

**The Head of Healthcare at HMP Cardiff should undertake a full review of the systems and processes in place for care planning, undertaking observations and the recording and escalation of concerns. The Head of Healthcare should also be required to demonstrate how she ensures that staff are properly trained, appraised and supported.**

## CONCLUSION

112. The man arrived at HMP Cardiff on 21 August 2009 after being charged with the murder of his partner. Two weeks later he attempted to take his own life and was subsequently placed on an ACCT self-harm monitoring regime. This was closed on 8 October when the risk of harm had appeared to have reduced. On morning of 19 October, The man was discovered dead in his bed in the healthcare centre at Cardiff.

113. In light of the findings of my investigation and the clinical review, I conclude that the care provided to the man was not appropriate. Observation checks were not carried out, which led to the discovery of the man's death a number of hours after he had died. The systems for the issuing of medication were not robust. Some healthcare staff did not ensure that the opportunity to hoard medication was minimised. A poor approach to this procedure, where prisoners were not observed taking their medication, created an environment where medication could be retained. The medication could then be hoarded to be sold on to other prisoners or to be used in attempts of self-harm. I am disappointed that some healthcare staff adopted this approach and hope that the issuing of medication procedures is reviewed in light of this poor behaviour. I make eight recommendations.

## RECOMMENDATIONS

1. The Governor of HMP Cardiff should review the procedures for unlocking prisoners and ensure that when a cell door is unlocked the member of staff interacts with the prisoner to ensure that there are no immediate issues that may need attention.

   Accepted - The Local Security Strategy (LSS) point 8.02 has been amended to instruct staff to obtain a response from prisoners when carrying out roll checks.

2. The Head of Healthcare at HMP Cardiff should make sure that regular audits are undertaken of key documents such as the First Reception Health Screen form to ensure that they are being completed correctly. Such reviews are important in relation to highlighting gaps and identifying related training needs.

   Accepted - Bi-monthly audits will be completed by the Practice Manager to ensure the first reception screen form is being completed correctly. Any training needs will be identified and addressed.

3. The Head of Healthcare at HMP Cardiff should ensure that all available information about the medical and mental health history of a prisoner is obtained.

   Accepted - The Head of Healthcare will ensure that systems are in place to obtain all available information about the medical and mental history of a prisoner, particularly in complex cases.

4. The Head of Healthcare at HMP Cardiff should ensure that secondary healthcare assessments are made part of the routine procedures for prison admission. These assessments should include a full medical assessment with urine and bloods being screened.

   Accepted - All prisoners to be offered a secondary health assessment and this includes assessment of their physical and mental health needs. Bi-monthly audits will be carried out to ensure this practice is in place.

5. The Head of Healthcare at HMP Cardiff should ensure that care plans are in place for those prisoners with on-going health problems to ensure that holistic care is provided.

   Accepted - Bi monthly audits will be carried out by the in patient manager to ensure care plans identify patient needs. The audit will monitor that the care plans are holistic and are evaluated regularly.

6. The Governor should ensure that trigger points are accurately recorded on ACCT documents, and that staff are aware of the increased risk that can occur at these points.

   Accepted - A Governor's Order to be issued to remind staff of the importance of including trigger points on ACCT documents. (Particularly ACCT Assessors and

case managers). Wing managers should remind staff during morning briefings, prior to unlock of important trigger points.

7. The Head of Healthcare at HMP Cardiff should ensure that appropriate safeguards are in place when medicines are given to prisoners.

   Accepted - Administration of medication will be carried out in line with the MMC Administration of Medicines Policy. The In-Patient Manager will carry out bi-monthly audits to monitor compliance.

8. The Head of Healthcare at HMP Cardiff should undertake a full review of the systems and processes in place for care planning, undertaking observations and the recording and escalation of concerns. The Head of Healthcare should also be required to demonstrate how she ensures that staff are properly trained, appraised and supported.

   Accepted - A full review of systems and processes for care planning, undertaking observations and the recording and escalation of concerns will take place by the Head of Healthcare, supported by the In-Patient Manager, Pharmacy Lead, Mental Health Lead and Head of Safer Custody. All Staff will receive a comprehensive induction. All staff will have an appraisal which is reviewed and identify any training needs. This will be audited by the performance team bi-annually. Clinical supervision will be made available to staff.