Investigation into the circumstances surrounding the death of a man at HMP Swansea in November 2004

Prisons and Probation Ombudsman for England and Wales

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This is a report of an investigation into the death of a man, at the age 26 years, at HMP Swansea in November 2004. The man was on remand, and had been in prison for about a month when he died. The purpose of the investigation was to establish the circumstances and events surrounding the man's death, including the quality of care provided by the Prison Service.

I took over responsibility for investigating deaths in prison custody in April 2004. Under transitional arrangements in force until 30 November, a senior investigating officer was appointed by the Prison Service, together with an assistant. I am grateful to them both for their investigation. My Assistant Ombudsman oversaw the investigation.

I would also like to express my thanks to the Governor of Swansea, and his staff, for the help and active co-operation that the investigators received during the investigation. The investigation has revealed both good practice on the part of the prison as well as areas where procedures and systems need to be improved.

A key part of the investigation was to make sure that the man's family had the opportunity to raise any concerns they had about his death. My colleagues were able to meet twice with the man's mother and stepfather. I am most grateful to them for being prepared to discuss their son's death at an acutely difficult and distressing time for them. I offer them both my thanks and my sincere condolences on their loss.

The man was in custody for the first time. As this report catalogues, he did not find the experience an easy one and his behaviour was damaging to himself and challenging for staff. His parents have expressed concerns over the court's decision to impose a custodial remand. Although I have not studied the decision in detail, I have made a recommendation designed to draw the sad circumstances outlined in this report to the attention of the Local Criminal Justice Board and to the Office for Criminal Justice Reform.

In the anonymised version of this report, the names of those involved have been removed, and some very minor amendments made to the text of the report. Otherwise, the report is as I first produced it in June 2005.

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PRISONS AND PROBATION OMBUDSMAN

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Summary

At the time of the man's arrest on 1 October 2004, he was living in a tent next to some friends. It seems that he resisted arrest, and on 4 October he was remanded in custody at HMP Swansea. He had never been in prison before. All the charges for which he was arrested were eventually dropped, but the charges incurred during the course of his arrest remained.

While the man was in police custody he was considered to be at risk of suicide. When he arrived at Swansea a suicide warning form was opened. The man was a difficult prisoner to care for, in that he was often volatile and disturbed. Between 5 October and 18 October, the man made six self harm attempts.

After the man's first self harm attempt, he was placed temporarily in a safer cell. After his second attempt, on 11 October, he was placed in the health care unit. While there, he threw a meat pie at a member of staff. He was therefore placed in the segregation unit. At a subsequent adjudication hearing, the man pleaded guilty to assaulting an officer. He was punished by being given seven days cellular confinement. Shortly after the adjudication, on 12 October, the man made a third self harm attempt. Concerns about his wellbeing resulted the next day in the punishment of cellular confinement being remitted, and the man returned to the wing. On 15 October, the man barricaded his cell and subsequently became aggressive and grabbed an officer by the shirt. He was restrained using control and restraint techniques, and was again placed in the segregation unit.

The first review of the man's F2052SH was shortly after this incident. The review was not multi-disciplinary. The F2052SH remained open. On 16 October there was a second adjudication hearing, at which the man pleaded not guilty to assaulting an officer by grabbing his shirt. The hearing was adjourned so that the relevant officers could attend. The man remained in the segregation unit. Later that day, the man made a fourth self harm attempt and he was placed overnight in the 'buddy' suite with two Listeners.

The next day, the man was reported to be shouting, screaming and threatening to smash things in the 'buddy' suite. He was moved back to the segregation unit. On 18 October, the adjourned adjudication hearing was reopened and adjourned once more. The man remained in the segregation unit, where he made a fifth self harm attempt. Two hours later, he made a sixth self harm attempt. He was put in a safer cell, and a risk assessment resulted in the man being monitored every 15 minutes. This was gradually reduced as the man became calmer, and he was subsequently moved to a normal shared cell. On 21 October, the F2052SH was reviewed and closed, although staff continued to monitor the man for a further 48 hours. On 27 October, the adjourned adjudication was reopened once again. The man pleaded guilty, and was given a suspended punishment.

While he was in prison, the man's mental health was assessed several times. The first occasion was on 12 October, when a prison Community Psychiatric Nurse assessed the man just prior to his first adjudication. She thought the man had some symptoms suggesting psychosis. On 14 October, when at court, a Community Psychiatric Nurse also said that the man might have psychotic features. But

subsequent assessments by a prison doctor and a doctor instructed by the man's solicitors concluded that he did not have a mental disorder.

Between 21 October and 1 November, the man's behaviour remained unstable, but there were no further self harm attempts. On the morning of 1 November, the man was upset by other prisoners laughing at him after he said he would put a gypsy curse on them. Later that day, staff confiscated the man's shirt because it had on it derogatory remarks about the police. The man subsequently spent some time with a Listener. A nurse then saw him in the heath care unit, because the man had been refusing to eat anything other than free fallen fruit. The man agreed to compromise over his diet by eating vegetarian food.

At about 11am, two staff were doing a routine security check of the cells. They spoke to the man, who said that he was alright. At about 11.30am, the man asked one of the officers if he could go and find someone who would lend him tobacco. She said other prisoners would be back for lunch shortly, and he could ask then. It seems that the man subsequently shouted or kicked in his cell. A wing cleaner alerted staff to this, but they did not respond. At about 11.40am, when other prisoners were returning from work to the wing for lunch, the man was discovered hanging in his cell. Sadly, attempts to revive him were unsuccessful, and he was pronounced dead at 12.15pm.

I have concluded that staff made reasonable attempts to help the man during his time in prison, although there were several procedural and other failings. I have made a number of recommendations to prevent these recurring. I have also commended the actions of staff and a prisoner involved in the attempts to resuscitate the man, and identified some areas of good practice.

The investigation

Since April 2004, I have had responsibility for investigating all deaths in prison custody. But under transitional arrangements in place between April and November, most of the investigations have been conducted by Prison Service investigators acting under the supervision of my office.

My Assistant Ombudsman oversaw the investigation into the man's death. A member of staff from the Prison Service Wales Area Office conducted the investigation. An assistant helped him with some of the specialist medical parts of the investigation.

Notices were issued to staff and prisoners telling them of the investigation and its terms of reference, and offering them the opportunity to participate. I received two letters from prisoners, one of which was anonymous.

The investigators visited the prison and saw those parts of the prison where the man would have been, including the cell where he died. They reviewed all the relevant documentation, and interviewed a number of staff and prisoners. They commissioned a review of the medical care the man received while he was in prison. They also commissioned a review of the medication he was receiving.

My Assistant Ombudsman met with the man's mother and stepfather, at the prison, and again with a Family Liaison Officer from my office, at their home.

Swansea prison

Swansea is a local category B prison, taking prisoners directly from the local courts. It has up to 348 prisoners, and 265 staff.

In its last standards and security audit in October 2003, Swansea was rated ‘good’. There were no reported concerns about the health care provided by the prison.

The Prison Service gives all prisons a star rating from one to four, based on various assessments and internal audits. Swansea has a three star rating.

The last deaths in Swansea were in November 2003.

Events leading to the man's imprisonment

In September 2004, the man was living in a tent beside some friends. His mother says that towards the end of September 2004 he was arrested three times. On the first occasion, the man was sitting in a caravan when some local youths turned up with a gun and fired it at the caravan. The man picked up an axe in the hope that this would scare them off. They then drove their car at the man, and he hit it with the axe. The man was subsequently arrested. The second time, a small amount of cannabis was apparently found when he went to the police station to make a statement about the youths coming back. The third time, he was arrested for allegedly stealing two packets of bacon. During the course of this arrest, on 1 October 2004, the man's mother says he kicked the inside of the police car and bit a police officer on the shoulder.

While in police custody on 1 October, the man indicated that he was considering suicide. He was seen by a police doctor, who said that he was fit to be detained and interviewed, although he should only be interviewed with a appropriate adult present. The doctor assessed the man's risk of self harm as 'medium'. He was to be seen every half an hour.

On 2 October, the police doctor reviewed the man's condition. The man said he was claustrophobic and could not stay in custody or he would kill himself. He also spoke of a previous incident of self harm.

On 4 October, the man appeared in court, charged with assault on a police constable, criminal damage and actual bodily harm. It appears that these charges arose from his actions when he was arrested on 1 October. He was remanded in custody at Swansea prison, and was due to appear again in court on 8 October. The man then became aggressive in court, and had to be restrained. When locked in a cell, he banged his head against the door, and had to be treated for an injury to his forehead. The remand warrant noted that he appeared very unwell, and might be at risk of suicide.

The man's time at Swansea

4 October – reception

The reception officer at Swansea heard banging from the escort van and was told this was the man. On the evening of 4 October, the reception officer interviewed the man in the reception unit. He says he found the man's behaviour very strange, and that he was difficult to interview as he kept going off at tangents. The man said that his threat to commit suicide was a ploy not to be remanded in custody. The reception officer was very concerned about his mental state, and decided to open a suicide warning form (known as an F2052SH). The agency nurse on duty that evening did not agree that this was necessary, but the reception officer checked with a senior nurse, who agreed with his concerns. At 8pm the agency nurse therefore opened an F2052SH and recommended that the man should be monitored until he was seen by a multi- disciplinary team.

The agency nurse and the reception officer also completed a cell sharing risk assessment form. They decided that the man was a medium risk (that is no immediate risk to his cellmate, but required regular review). The medical screening section of the form was poorly completed, and did not indicate why the man was assessed as a medium risk.

The man was placed in a shared cell on F wing, which is the induction wing. He was initially tearful, but later that evening was noted as happier. He was monitored at intervals throughout the night.

The man had told the reception officer that he had no next of kin, and this was recorded on his core prison record. However, when another member of staff interviewed him on F wing, as part of the induction process, he gave the name and address of his mother as his next of kin. This information was recorded on the man's personal officer's record, but not transferred to his core record.

The wing officer noted that it was the man's first time in custody. He said the man felt hard done by and was looking for sympathy, and that he might take a few days to settle.

5 October – first attempt at self harm

At 9am the next morning, the man was seen by a prison doctor, who noted that he was upset at the situation he was in, but not actively suicidal. At 10am (14 hours after it had been opened), the residential unit manager decided how the F2052SH should be managed. He noted that the man was getting on well with his cellmate, who appeared to be offering him help and advice, and that he was slowly adjusting to prison life. He therefore decided that the man could be managed on the wing, rather than in the health care unit. The man was to be encouraged to participate in wing activities, and staff were to be approachable and offer him help when appropriate. He was to remain on the F2052SH. No decision was made about monitoring the man, and what might be appropriate monitoring periods.

Nonetheless, staff continued to monitor the man every hour or so. By the afternoon, entries in the F2052SH indicate that the man was crying and saying that he felt suicidal and wanted someone to talk to. One note said that, when the man was refused something, he said he was suicidal, and that he was being manipulative. Another note indicated that the man did not know the meaning of suicidal, although the officer introduced him to a Listener. (A Listener is a prisoner, trained by the Samaritans, who provides a listening ear to prisoners who feel troubled or suicidal.) The man subsequently spent some time talking to the Listener.

At 7.25 that evening, the man's cellmate rang the cell bell and said that the man was trying to hang himself with his jumper. A Senior Nurse saw the man, and he was put into a safer cell on F wing. (This is a cell that has been designed without ligature points, and to minimise the opportunity for a prisoner to self harm.) There is no record of this incident in the man's medical records.

6 to 10 October

On 6 October, the prison doctor saw the man, and concluded that, although he was annoyed with his situation and felt he should not be in prison, he was not actively suicidal. The man was moved from the safer cell back to his original cell on F wing, on the doctor's instructions.

By 7 October, 72 hours after the F2052SH was opened, prison procedures require that there should have been a multidisciplinary review of the man's case, involving staff from different parts of the prison, such as wing staff and health care staff. No such review was conducted.

On 8 October, the man appeared in court via a video link. The offences which he now appeared to be facing were assault of a police constable, actual bodily harm, possession of cannabis and theft of bacon. The charge of criminal damage does not appear. The case was adjourned to 14 October 2004.

On 9 October, there are notes on the F2052SH that the man was refusing food and demanding a fruit diet, although he collected his lunch. The next day he was still asking for a fruit diet and declining food. He was considered to be acting bizarrely, shouting, kicking, and ringing the cell bell making inappropriate requests. There is a note that staff were spending a lot of time trying to pacify him. At some point that day (the record is not timed), the prison doctor saw the man again and noted that he was not eating well due to his food beliefs. The doctor advised the man about taking fluids.

11 October – second attempt at self harm, location in health care and then in segregation unit

At 11am on 11 October, the man asked to see a doctor about treatment for lice. He was told someone would come after lunch. Meanwhile, the man shaved his head, and was subsequently reprimanded for doing so.

After lunch, the man's cellmate was relocated. At 2.15pm the man was seen breaking things in his cell, and then trying to hang himself with his sweatshirt. Staff

attempted to enter the cell, but found the door had been jammed with a piece of picture board. When the door was eventually opened, the man was found in a slumped position suspended by his sweatshirt. However, he was treated by health care staff and made a speedy recovery without complete loss of consciousness. He was walked to the health care unit, where he was examined and found to have no physical ill effects. The man said he was upset that his cellmate had been moved, and that he did not want to be alone. It was agreed that he would remain on the ward overnight and, if he remained stable, return to the wing the next day.

At 5.05 that evening, the man threw a meat pie at a health care officer, catching him on the shoulder. No one was injured. However, the man was moved to a cell in the segregation unit. He was held there under prison rule 53(4), pending the outcome of the governor's first enquiry into the charge that he had assaulted an officer by throwing a meat pie.

All prisoners in the segregation unit have to have a medical assessment within two hours of being placed there. The medical assessor completes a Segregation Safety Algorithm to say whether there are health care reasons against keeping the prisoner in the segregation unit. The segregation diary shows that the prison doctor visited prisoners on the segregation unit that day, but the entry is not timed. At 5.30pm the doctor completed the safety algorithm for the man. He indicated that there were no medical reasons why the man should not be in cellular confinement. The form used for the man had already been used for another prisoner, with the previous entries blanked out.

No case review of the F2052SH took place after the decision to segregate, at the earliest opportunity, as prison procedures require.

12 October – adjudication and third self harm attempt

A Probation Officer visited the segregation unit as part of his duties. He says the man was agitated and in some discomfort. He was sufficiently concerned to asked a nurse to visit the man, in case he had any mental health problems. (Prison procedures require that a mental health assessment is routinely undertaken of all prisoners at risk of suicide or self harm who are placed in the segregation unit, and the reviewed care plan implemented.) The nurse, a community psychiatric nurse, visited the man early on 12 October. She noted that he felt frightened, as it was his first time in custody. He said that he had tried to hang himself because he felt isolated and alone in his cell. The nurse said that the man had some symptoms suggesting psychosis, and that he should continue to be monitored. She discussed the man's case with an officer from the segregation unit, and a governor. But there is no evidence of a review of the man's care plan as a result of the assessment.

The nurse was to see the man again later in the week. There is no evidence that this happened.

Later that morning, the governor conducted the adjudication of the charge that the man had assaulted an officer by throwing a pie at him. The man pleaded guilty, and said he had thrown the pie out of frustration. The wing report prepared for the adjudication said that the man was demanding and immature, had several outbursts

of bizarre behaviour, seemed to enjoy the attention he received, and was a drain on staff resources. The governor decided that the man should be punished by receiving seven days cellular confinement and 14 days loss of private cash. He said at interview that even though the offence was minor, it was in full view of other prisoners and he thought the punishment was fair. He knew that the man was on an open F2052SH, and that this was his first time in custody. He says he understood that assessments showed that the man had no mental illness, but that his behaviour was bizarre. He says there were concerns about returning the man to health care, with a small staff and the possibility of confrontation, but there were also difficulties in keeping him on the wing.

At 1.07pm, an officer was walking past the man's cell, and saw him sitting on the window ledge with a sheet knotted and tied around his neck. Staff entered the cell and removed the man from the window ledge. He was seen crying during the afternoon, but seemed better later in the day.

13 October – return to wing

At 1.30pm on 13 October, the man was moved from the segregation unit to a cell on A wing. The reason for this move is not recorded anywhere. However, the Probation Officer says he was concerned about the man and asked for a meeting. The governor says there was a discussion with wing staff to see if the man could be given another try, and that he agreed to the punishment of cellular confinement being remitted. By then, the man had served two days of the seven day punishment.

14 October – court appearance

On 14 October, the man was taken back to court. He kicked and shouted in the van. When he arrived at court he was seen by a court Community Psychiatric Nurse, to assess his mental health during progress of the court case. She said that the man might have some psychotic features, and was impulsive and angry. She thought he presented a risk to himself. She had gained only limited information, and she recommended that the man have a forensic assessment as soon as possible. She also noted that the man had some degree of learning disability which might affect his understanding. Her report was sent to Swansea, although it is not clear when it arrived.

At this point, the charges the man faced remained assault of a police constable, actual bodily harm, possession of cannabis and theft of bacon. The hearing was adjourned until 11 November, and was to be reconvened via video link because of the risk that the man would self harm.

15 October – return to the segregation unit

At 9.30am on 15 October, the man covered the observation panel to his cell and barricaded the door with a mattress and other cell furniture. Two prison officers persuaded the man to uncover the observation panel and remove the barricade, and they entered the cell. They said that he was agitated and incoherent. They recorded that they were preparing to remove the mattress from the cell, to prevent the man from using it again as a barricade, when he became verbally aggressive, and

grabbed hold of one of the officers by his shirt. The man was restrained using control and restraint techniques, and taken to the segregation unit. He was held in the segregation unit pending the governor's first enquiry into the charge of assaulting an officer (under prison rule 53(4)).

At 11.30am that day, officers reviewed the man's F2052SH, as they were required to do following his placement in the segregation unit. The reviewers noted that he was very emotional and constantly tearful, but showed no signs of suicide or self harm. He was to continue to be provided with help from staff, and his behaviour monitored. The case review did not specify the level of observation for the times that the man was left alone, as prison procedures require.

The review was carried out by segregation unit staff. There was no one from health care present, and so the review was not multi-disciplinary. There was no mental heath assessment.

No safety algorithm was completed by medical staff to say whether there were any medical reasons why the man should not be held in the segregation unit.

During the course of the day, the man was tearful from time to time, and at 6.15pm he asked for a Listener. After talking to the Listener he seemed better, but at 10.30pm he was admitted to the 'buddy suite' in the health care unit with two Listeners.

16 October – adjudication, fourth self harm attempt and relocation to healthcare

At 10.30am on 16 October, there was a second adjudication hearing. The record of the hearing shows that the prison doctor considered the man to be fit for cellular confinement, but this decision does not appear to have been taken using the safety algorithm (see above). The man was charged with assaulting a prison officer by grabbing his shirt. He pleaded not guilty, and the case was adjourned for the officers to be present. A note says that he threw a tantrum at the adjudication, but quietened down after a talk.

The man remained on the segregation unit pending the adjourned adjudication hearing. The prison records show that the man was still being held in the segregation unit under rule 53(4), pending the governor's first enquiry, even though the first enquiry had been held. He continued to be tearful, although officers noted that he recovered quickly.

During the day, the man was seen by a member of the prison's Independent Monitoring Board (IMB), and by the duty governor. The IMB member says the man was upset because his bail application had been turned down - he thought because he was of no fixed abode - but that his mood lightened during the course of the discussion. The IMB member says the duty governor talked to the man about his family, his living conditions and the effect that prison was having on him. He explained the help that was available to the man, and that phone cards were being obtained for him so that he could ring his solicitor, and also make sure that his horse was being properly looked after. The IMB member says that the man's attitude

brightened during the conversation with the governor, and he was aware of all the help available to him.

At 10.15pm, neighbouring prisoners to the man used their cell bells to tell an officer that the man had said he was going to hang himself and they had heard a dropping noise. The man was found upset and with a red ring round his neck.

It was agreed with a governor that the man should be placed in the 'buddy' room with two Listeners overnight, and be reviewed by health care staff in the morning. A health care officer also called in to see him. The note of the visit says there was no indication of any act of self harm, the man did not claim to be suicidal but that he was annoyed at being adjudicated upon and being in a cell without a television. The note says he was therefore relocated to the health care unit with two Listeners.

17 October – return to the segregation unit, fifth self harm attempt

At 8.40am there is a note in the F2052SH that the man had breakfast, and that a prison officer was in health care to discuss his relocation. There is no note of the outcome of this discussion.

At 10.10am on 17 October, the man was reported to be shouting and screaming and threatening to smash things up in the 'buddy' suite. He was moved back to the segregation unit. Prison records again show that he was held under prison rule 53(4), pending the governor's first enquiry into a charge. At 10.25am, the man was found hanging from the window bars, using a ligature made out of a full bed sheet. When officers entered the cell, the man was able to lift himself. He said he had tried to hang himself because he did not want to be in prison for something he had not done.

The prison doctor saw the man at 10.35am. He noted that his disruptive behaviour continued, and that when spoken to he was unable to sustain reasonable behaviour. The doctor considered the man to be agitated, but fully aware of his actions and their consequences. He said there was no evidence of mental illness, and that the man was fit to be held alone. At interview, the doctor said that by this he meant that there was no evidence of psychosis, and that, although the man's behaviour was not normal, he did not have a major psychiatric problem.

At 1.45pm there is a note that the man threw a temper tantrum, but calmed down when counselled by staff. Later that day, when the man was given his medication, it was noted that he had 'palmed'. (This refers to trying to conceal his medication and not taking it.) The man was given a warning about this. He subsequently collected his evening meal, and there is a note that there were no problems 'other than the usual moans and groans'.

18 October – sixth self harm attempt

At 11am on 18 October, the adjudication was adjourned again until the officers involved in the incident could be present. At 12.55pm, the man was seen hanging from his cell window. He was relocated to a safer cell on F wing.

As a result of the man's self harm attempts and irrational behaviour, a risk assessment review was carried out by two governors, two prison officers, two senior officers, the Probation Officer and two healthcare staff. The review notes suggest that the man had made two self harm attempts. It was agreed that he should remain in the safer cell, and be checked four times each hour.

Later that day the man seemed calmer, and the duty governor instructed that the watch be reduced to twice an hour. At 6.45pm, the man spent some time with a Listener.

19 to 20 October

Over the next two days, the man seemed much more positive. At 10.05am on 19 October, the duty governor reduced the watch to normal for someone on an F2052SH. (No level of observation had in fact been set for the times that the man was alone.) On 20 October, the man asked to move to another cell on F wing so that he could share with another prisoner, and this was agreed.

21 October – F2052SH closed

On 21 October, the wing manager, the Probation Officer, a psychiatric nurse and the man met to review the F2052SH. The man was said to be more settled on F wing, and that the difference in his behaviour was 'remarkable'. He had been in touch with his girlfriend and some members of his family. There was no evidence that he was considering suicide, and he was said to be asking to come off the F2052SH. The consensus was that the document should be closed. Staff were to continue to monitor the man over the next 48 hours. The wing manager subsequently made a note in the wing observation book of the need to continue monitoring the man.

The wing manager's first contact with the man had been on 13 October, when he returned from leave. He said at interview that other staff briefed him about the man, and he read the wing observation book. He knew that the man had once previously tried to hang himself, but at the interview was not clear about other attempts. However, he said he had access at the review meeting to the F2052SH, and would have known then of the previous attempts. The psychiatric nurse had not been involved with the man prior to the review. He said at interview that he believed the man had been placed on the F2052SH because of his bizarre behaviour associated with 'magic mushroom' use, but that he was said to have improved of late. He said that he had been asked to attend the meeting to make a brief mental health assessment, and that the man showed no signs of mental illness at the meeting. He had leafed through the F2052SH on the day of the review. He knew from other staff that the man had a history of self harm attempts, but was not aware that the most recent attempts had been three and four days before the review hearing. The Probation Officer knew the man well, and had been involved in getting him removed from the segregation unit and back to the wing on 13 October. He said in interview that at the review meeting the man was positive and forward looking. He thought the man's attempts to hang himself were attention seeking rather than genuine, but the Probation Officer's main concern had been to avoid a death in custody, whether deliberate or accidental. He said that, even with hindsight, he still thought the decision to close the F2052SH at that point had been correct. But even if the

F2052SH had remained open, it would almost certainly have been closed at the next review.

22 to 28 October

On 22 October, the Crown Prosecution Service wrote to the man at Swansea to say that various charges against him had been dropped. The only charges that remained were those relating to what happened when he was actually arrested on 1 October – assault of a constable, criminal damage and actual bodily harm. All the substantive charges for which he had been arrested had been dropped. The prison has no record of this letter, which may have been faxed to the wrong number. But the man's subsequent conversation with a doctor instructed by the man's solicitors suggests that he was aware of the decision, perhaps having been told by his solicitors.

On 23 October, the man was noted to be very upset, and that he plastered his meal over the observation glass in his cell. His behaviour was considered to remain bizarre.

On 25 October, when the man's induction was complete, he was moved to A wing. On 26 October he was moved to another cell within A wing.

On 27 October, the man's adjourned adjudication for assaulting an officer by grabbing his shirt was heard by a governor. The wing report for the adjudication says that for the two days the man had been on A wing he had been a constant drain on staff resources, by being demanding, unprepared to accept the authority of staff, causing a disturbance and making no effort to conform to the rules or routine. This time the man pleaded guilty to the offence, saying he had been paranoid about what was going to happen, and that he was sorry. As a punishment, he was given seven days cellular confinement and seven days loss of various privileges, all of which were suspended for one month.

29 October – psychiatric assessment

A doctor was asked by the man's solicitors to carry out a psychiatric assessment, including an assessment of the man's ability to plead in the court proceedings. The interview took place in the health care unit at Swansea on 29 October, and lasted about an hour and a half. The investigator has not seen a copy of the doctor's full report, which she says will be available at the inquest. Her note made that day in the medical records indicates that the man had odd behaviour and speech, and talked of communication with spirits and dead relatives, but that this did not affect his functioning. She said that he was an angry young man believing he had been falsely accused. He said he would kill himself if he was convicted. The doctor indicated that his suicide attempts related to protest rather than mental disorder. The investigator spoke directly to the doctor, and she said that she did not consider the man to have a mental disorder, and that he was fit to plead in his court case. She said that he became angry and agitated only when he talked of his arrest and imprisonment. She commented that the man was aware that some of the charges against him had been dropped.

After the man's death, the police found a wing application in his pocket. The application was dated 29 October 2004. The man said on the application that he was looking for work. His application was for a move to D wing. He had decided to give up smoking and feared he would develop other drug habits. He said he felt very depressed on A wing and had friends on D wing. He said he feared that he might even take his own life if he was not moved soon, and that he also feared the officers on A wing. There is no evidence that the man handed this application to staff or that he talked with them about moving to D wing.

30 to 31 October

On 30 October, the man told a prison registered mental health nurse that he was now on hunger strike. The nurse noted that due to the timing and manner in which he raised this, it was not possible to have a rational discussion with him. The next day he was continuing to maintain that he was on hunger strike. The nurse discussed this with the prison doctor. The man was to be weighed and have a urine sample taken twice weekly while on hunger strike, to have his intake of food assessed, and to be observed and monitored. The doctor was to assess the situation daily.

The nurse says that on the evening of 31 October the man's cellmate told her that the man was having a hard time at the moment. At the time she thought he was referring to another prisoner, but next day she realised he was referring to the man who is the subject of my investigation.

1 November

On 1 November, the prison's Operational Meeting noted that the man was refusing to eat anything, other than free fallen fruit, although he had been drinking. He was to be seen by a doctor that day, and arrangements were being made for him to see a psychologist.

During breakfast that morning, another prisoner says that the man was upset because some prisoners were laughing at him after he threatened them with a gypsy curse.

A prison officer on the wing said at interview that there was also that morning an incident where the man's shirt had been confiscated by another officer. It seems that the shirt may have had on it derogatory remarks about the police. The wing officer says he told the officer who confiscated the shirt that he would have to take the shirt to reception to place with the man's property, and that this was duly done. The wing officer said the man was muttering about this, but he was not aggressive.

At about 8.40am, the man asked the wing officer and another officer if he could see a Listener. This was arranged, and the man spent some time talking to the Listener. During this time, another officer opened the cell door so that the Listener could go and fetch some matches. This officer says he spoke to the man who said he was anxious about his court case. The Listener subsequently asked one of the prison officers on duty if the man could be given some work, and it was agreed that this

could be arranged. The Listener told my investigator that the man was talking to him about the future, and he did not think he was suicidal.

Later that morning, the registered mental health nurse went to see the man on A wing, and took him to the health care centre for an interview. She noted that he said he was unhappy about being kept in prison and the way he felt he had been treated. He was worried about his horse (which he said was being cared for by a friend), angry that his dietary needs were not being met and worried about the court hearing on 11 November. The nurse noted that she gave the man time to express his frustrations. She said that he had no thoughts of suicide or self harm at the present time, and in this respect referred to the note of the interview of 29 October, conducted by the doctor instructed by his solicitors. The man agreed to start taking fluids, and to compromise over diet by eating vegetarian food while in prison. He was to be offered health care support to help him on the wing. The nurse then returned with the man to the wing. He was locked in his cell, and the nurse discussed his case with the two officers on the wing. She told the investigator that when she spoke to the man she was aware of only one previous self harm attempt.

When the nurse left the man, he was alone in his cell because his cellmate was at work. The time was around 10.30am, or slightly later. Towards 11am, two wing officers were doing a routine check of the locks, bolts and bars in the cells. They went into the man's cell, and asked if he was alright. He said that he was. One of the wing officers said at interview that the man was fine at that point, and did not seem upset or angry.

It seems that after the cell check, the man banged or kicked his cell door, although there are differing accounts of what exactly happened, how long it went on for, and what action was taken by staff. These accounts are set out below.

An ex-prisoner wrote to me during the course of the investigation. He says he was in the cell opposite the man's on 1 November, and that the man was banging on his cell door for quite a while. He says two prisoner cleaners were out on the wing at that time, and they heard the man banging. One of them went to the office and told staff that someone was banging. The officers said they knew who it was, and took no notice of him. The ex-prisoner said he could not estimate how long the banging went on for.

The investigator interviewed both prisoner cleaners. One cleaner said he heard shouting and banging at about 11.15am, which went on for about two minutes. It was not normal noise but sounded as though someone was 'kicking off' or upset. He told one of the officers in the wing office that it sounded as though someone was having a nightmare. The officer said not to worry, he knew who it was, and went back into the office. The other cleaner said he heard angry shouting, and a couple of kicks, which went on for about two minutes. He did not do anything about it, and he was not sure that officers responded.

Another prisoner, in a cell two doors down from the man, says that the man was kicking his cell door for a long time that morning – perhaps 15 to 20 minutes – and had rung his cell bell, but that no one came to his cell.

An anonymous letter from a prisoner says that half and hour before the man was found, he was kicking his door in distress.

One of the wing officers who did the lock check says that, after the check, the man either rang the cell bell or called to her as she walked past. The time would have been about 11.30am. The man asked her about finding someone who would let him borrow tobacco. She explained that prisoners would shortly be back from work, and it would be lunchtime, so he could then go and see if he could find anyone who would lend him tobacco. She said she thought that when she walked away he kicked his door, which was quite normal for him. She thought it was just frustration. If she had thought the man was anything other than normal she would have gone back, but she did not feel this was necessary because when she went back to the office prisoners were coming back from work.

Another officer on the wing said at interview that shortly after the routine lock check, perhaps at about 11am, the man shouted from his cell. He said the man was not kicking the cell door. He is not sure if anyone responded to the man's shout.

A third wing officer said that there was some shouting on the wing, about something 'racist'.

At about 11.40am, when prisoners were returning to their cells from work, the officer who had done the lock check, and was the last person to speak to the man, was called by prisoners to say that the man was hanging. It seems that prisoners had looked in the observation flap, and seen the man in his cell. The officer went as quickly as she could and entered the cell. A second officer heard shouting and saw the first officer running to the cell, and he entered after her. A prisoner also entered the cell and helped the two officers support the man while they unwound the sheet from his neck. There was no knot. The man was laid on the floor. The prisoner then left the cell and other officers quickly arrived. One officer began mouth to mouth resuscitation, and another began chest compressions. A Senior Nurse subsequently arrived and took over the co-ordination of the resuscitation attempts. An ambulance was called at 11.52am. At 12.15pm the prison doctor pronounced death.

Although not required in this case, no staff were carrying ligature cutters. A prisoner who was nearby during the attempts to resuscitate the man, and who could hear but not see what was happening, has reported that staff could not find some of the equipment in the emergency medical bag during the attempts to resuscitate the man. The investigator's interviews with staff support the view that not all staff were familiar with the contents of the bag. However, there is no evidence that this delayed the attempts to resuscitate the man.

Events after the man was found

The Governor carried out a staff debriefing, which included all staff immediately involved. The Prison Chaplain, at the Governor's request, counselled prisoners. Staff made comprehensive notes while events were fresh in their minds.

Because the man's core record did not have details of his next of kin (although the man had given this information to the wing officer when he arrived on the wing and it was recorded in the personal officer's file), there was a short delay in breaking the news to the man's mother. The prison contacted the police who went to see the family later that day. The Chaplain then spoke to the man's mother on the telephone. She says the Chaplain behaved insensitively in saying that the prison had done all it could for her son. She says she spoke to the Chaplain again on 2 November, when he was again insensitive. The Chaplain says the conversation on 1 November was understandably very difficult, and he was trying to say that people had spent a considerable amount of time with the man that morning.

Clinical review

The investigators arranged a review of the medical care the man received while he was in prison. The reviewer's main conclusions are that:

- The heath care provided to the man should have been better documented.
- That the man's dietary concerns, and his physical and psychological care should have been approached in a more holistic fashion.
- That discussions about the man's suicide attempts should have been more clearly documented and counselling offered on a regular basis.

She adds that the man's behaviour and cries for attention should have alerted health care staff to his need for increased support and professional intervention.

A Consultant Forensic Psychiatrist was also asked to review the medication the man was receiving. The man was prescribed three drugs – Diazepam, Chlorpromazine and Cipralex. The Consultant Forensic Psychiatrist says he would expect a patient taking these drugs to be sedated, and certainly to calm down if very agitated or over aroused. The prescription of Diazepam was high, but could be explained. Psychiatrist did not understand the reason for the prescription of Cipralex, and there were no reasons set out in the medical records. The prescription of Chlorpromazine was understandable and supportable.

The man's parents' concerns

The man's parents have raised concerns that he was being goaded and assaulted by staff. The man's stepfather says that the man rang him at one point and said he had been beaten up in the prison. He subsequently telephoned the prison and was told this was not so. The man's mother is also concerned that the he mentioned in a letter about racist issues within the prison.

The investigator asked a number of other prisoners about the man's relationship with staff and other prisoners at Swansea. No one identified any problems with bullying, or of bad relations with staff. An anonymous letter from a prisoner received after the man's death made no mention of racism or bullying, and nor does the letter from the ex-prisoner. However, both prisoners' letters suggest that the man could have been treated better.

The man's mother also asks if it was appropriate for the man to have been remanded in custody, given his mental state, and the fact that all the charges which led to his arrest were eventually dropped, leaving only the charges relating to his behaviour when he was arrested. The investigator has not looked into the reasons why the man was remanded in custody, but I have some sympathy with his parents' concern.

The man's mother is also concerned that doctor instructed by the man's solicitors had not written her report before the man's death, and that she might have altered her view of his mental health in the light of this. However, notes made by the doctor at the time suggest that her view then was that the man did not have a mental disorder.

Prison procedures

Prison Service Order 2700 sets out what prisons must do when caring for prisoners at risk of suicide or self harm. In particular:

Case reviews

- All prisoners for whom the prison has opened a suicide warning form (known as an F2052SH) must have their cases reviewed within 72 hours.
- Reviews should also take place following incidents of self harm or attempted suicide.
- All reviews should be multi-disciplinary.
- The case review for each prisoner on an open F2052SH must decide on the level of supervision required and must specify this in the support plan, including the level of observation for those prisoners in shared accommodation at times when they are left alone.

Segregation of prisoners at risk

- Prisoners who are at risk of suicide or self-harm must not be routinely held in the segregation unit for the purposes of good order and discipline (under prison rule 45) unless, exceptionally, they are such a risk to themselves or others that no other suitable location is appropriate. Such prisoners must only be placed in a segregation unit in exceptional circumstances, or where all other options have been tried but considered inappropriate, and only where it is possible to provide the degree of continual care identified as necessary in the prisoner's care plan.
- A case review must be held as soon as possible to take account of events leading up to the decision to segregate. If the decision is taken to locate prisoners at risk of self-harm within the segregation unit, this must be for as short a period of time as possible, and the temporary nature of this must be reflected in the care plan.
- Special consideration should be given to prisoners on an open F2052SH who are segregated either for the purposes of good order and discipline (under prison rule 45), or who are subject to an adjudication, or have been located in the segregation unit as a result of their adjudication hearing. Adjudicators should consider the implications of the punishment they may impose on a prisoner who is found guilty at an adjudication, and who is subject to F2052SH procedures, such as removal from association, loss of canteen and cellular confinement.
- A mental health assessment must be undertaken by health care staff of all prisoners at risk of suicide or self-harm who are placed in a segregation unit, and the reviewed care plan implemented.

Contact with the next of kin

- Following an act of self harm, and after consultation with the prisoner, the nominated next of kin must be notified, unless there is a clinical reason not to, or the prisoner does not consent, or the prisoner's support plan indicates otherwise.

Reporting of incidents

Prison Service Instruction 52/2002 says that all incidents of self-harm must be recorded on form F213SH. This information must then be forwarded for entry onto the Prison Service's Incident Reporting System. Incidents of self harm are defined as 'any act where a prisoner deliberately harms themselves irrespective of method, intent or severity of injury. Noose/ligature making should also be reported'.

Management of segregation units

Prison Service Order 1700 sets out how segregation units should be managed in prisons. In particular:

- When a prisoner is placed in the segregation unit, a doctor or registered nurse should assess them within two hours. This includes completing a 'safety algorithm'.
- For prisoners who may be given a period of cellular confinement, a doctor must assess whether cellular confinement would be unsuitable or unsafe. Again, the 'safety algorithm' should be completed as part of this assessment.
- A prisoner given a period of cellular confinement who is on an open F2052SH must have a full case review within 24 hours of the adjudication decision.

Prison compliance with procedures

There is no evidence that after any of the man's six attempts at self harm he was asked about whether he wanted his next of kin notified. It is not possible to know what the man would have wanted to happen, had he been asked. His mother says that she did at some point find out from her son's solicitor that he had tried to commit suicide in prison. She telephoned the prison and spoke to a governor. She says she was told that her son was fine, and that he was just messing about.

There should have been various multidisciplinary reviews of the man's case throughout the time that he was on an open F2052SH. The only review of the F2052SH, other than when it was closed, was conducted on 15 October. The table below sets out the reviews that should have taken place.

Date	Reason for review	Whether review took place
5 October	Review after first self harm attempt	No
By 7 October	Review 72 hours after F2052SH opened	No
11 October	Review after second self harm attempt	No, although a mental health assessment was conducted early on 12 October
11 October	Review as soon as possible after decision to segregate, to take account of events leading to decision to segregate. Mental heath assessment to be undertaken of prisoners at risk who are placed in the segregation unit	No, although a mental health assessment was conducted early on 12 October
12 October	Full case review of prisoner given period of cellular confinement within 24 hours of adjudication decision	No
12 October	Review after third self harm attempt	No
15 October	Review as soon as possible after decision to segregate, to take account of events leading to decision to segregate. Mental heath assessment to be undertaken of prisoners at risk who are placed in the segregation unit	Yes, on 15 October, but not multi-disciplinary No
16 October	Review after fourth self harm attempt	No
17 October	Review after fifth self harm attempt	No
18 October	Review after sixth self harm attempt	No. Risk assessment done, but not undertaken as part of F2052SH procedures

The mental health assessment of 12 October, after the man had been placed in the segregation unit the previous day and before the adjudication decision, does not

seem to have been conducted as a matter of routine. Rather, it appears to have been prompted by the Probation Officer's particular concern about the man. Although the case was discussed with a prison officer in the segregation unit and a governor, there is no evidence that the man's care plan was reviewed as a result of the assessment.

On several occasions the man received minor injuries, and a prisoner accident form should have been completed on each occasion. The prison completed the appropriate form on only one occasion.

After each of the man's six self harm attempts, the prison should have completed a form F213SH. This allows the Prison Service to build up a picture of the scale and location of all self harm attempts across the whole estate. The prison did record all the incidents on either incident forms or a form called an F213, but did not use a F213SH on any occasion.

Conclusion

The man's death was a sad waste of a young life. He was a vulnerable and volatile young man who felt unjustly accused – perhaps with some justification as all the charges against him were subsequently dropped, except those relating to his resisting arrest. I am not in a position to comment on whether it was right for the man to have been remanded in custody on 1 October 2004. But I sympathise with his parents' concern about the use of a custodial remand in his case.

Recommendation: A copy of this report will be sent to the relevant local Criminal Justice Board and to the Office for Criminal Justice Reform for their consideration.

After the man was remanded in custody, Swansea was faced with the task of looking after a distressed, difficult and angry young man. The man had never been in prison before and his lifestyle was likely to make it difficult for him to settle into prison life and to relate easily to other prisoners and staff.

Overall, my view is that Swansea, for the most part, took reasonable care of the man. But this was because individual members of staff showed good judgement and concern, rather than the result of systems or procedures at the prison. For example, the reception officer insisted, quite rightly, that an F2052SH be opened on the man when he first arrived at Swansea. Similarly, the Probation Officer was worried about the man when he was in the segregation unit and arranged for a mental health assessment to be done. In addition, he and a governor were sufficiently concerned about the man to review and remit the rather harsh punishment meted out to him on 12 October. After the man's sixth self harm attempt his case was risk assessed, and monitoring was stepped up and then gradually reduced. He was given access to Listeners, including to the 'buddy suite' in the health care unit, and put in a safe cell where appropriate.

But the procedural arrangements for dealing with the man were not up to the task. Any officer concerned about a prisoner is entitled – and should be encouraged – to open an F2052SH. The case should then be assessed promptly by the wing manager, who should decide what initial action should be taken. If the prisoner is to be monitored, the monitoring periods should be clearly specified. In the man's case, the wing manager did not decide on initial action until 14 hours after the F2052SH had been opened, and even then no specific monitoring arrangements were agreed.

Swansea failed to comply with various Prison Service requirements to hold multi-disciplinary case reviews, and in some cases to conduct mental health assessments, 72 hours after the F2052SH was opened, after each self harm attempt, after each decision to segregate, and after the adjudication which resulted in the punishment of cellular confinement. These are not minor procedural matters, but are vital to the safety and well being of prisoners.

Nor is there any evidence that, after any of the man's self harm attempts, there was a discussion about whether his next of kin should be told. I do not know what the man might have wanted, had he been asked, but contact with family could potentially be very important for a distressed or self harming prisoner.

Recommendation: I recommend that the Governor reviews procedures for dealing with suicide and self harm, to ensure that they both comply with the relevant Prison Service Orders, and that they are up to the task of taking good care of vulnerable prisoners.

I am not convinced, however, that the Prison Service Orders make it as clear as they might what action must be taken in relation to prisoners on an open F2052SH who are placed in the segregation unit. Some information is in one document, and some in different places in another.

Recommendation: I recommend that the Prison Service reviews Prison Service Orders 2700 and 1700 to clarify and bring together all the requirements for dealing with a prisoner on an open F2052SH who is held in the segregation unit.

The failure to hold reviews of the man's case meant that it was difficult for staff to see, quickly and at a glance, exactly when he had attempted self harm, when he was segregated, and when adjudications were held. That meant that decisions about his case, and in particular the decision to close the F2052SH, were made without full knowledge of the facts by all those involved. Nonetheless, I am satisfied that the Probation Officer in particular was familiar with the man's case and that, by the time of the final review, the man was no longer showing signs of being suicidal or at risk of self harm. I accept the Probation Officer's view that, even in hindsight, the case was properly closed on 21 October.

There does seem to have been a view amongst staff that the man was being manipulative and was not serious in his attempts at self harm. However, I am entirely satisfied that, when the F2052SH was closed, the Probation Officer did not consider this to be a relevant matter. He was very clear that, whatever the man's motivations, his actions were dangerous, and that it was the prison's responsibility to prevent a death occurring, whether it was deliberate or accidental.

Once the F2052SH was closed, the man continued to be monitored for 48 hours, which I commend. Although his behaviour was far from stable, it is fair to say that the earlier pattern of regular self harm attempts did stop for a time. I do not consider that between 21 October and 1 November there was anything that should have alerted staff to open another F2052SH.

I will turn now to the tragic events of 1 November. Although there were two incidents early that morning that may have upset the man, he gave neither the Listener, nor the nurse that saw him that day, any grounds for thinking he might be suicidal. I am sure that both the Listener and the nurse will have asked themselves many times whether there was anything that they should have spotted, or could have done, that might have prevented the man's death. I am confident that they both did all they could to help the man.

Recommendation: I recommend the Governor shares with the Listener and the nurse who spent time with the man on 1 November my view that they did all they could to help the man.

There is some dispute about what happened after a wing officer saw the man in his cell at around 11.30am. On balance, I conclude that the man did make some commotion – whether he shouted, banged his door or kicked his cell – for a couple of minutes. I also conclude that one of the wing cleaners alerted staff to this, but that no action was taken. My view is that it would have been wise for staff to check on him. However, I appreciate that he had been checked by the wing officer shortly beforehand, prisoners were about to return to the wing - with all the work and security concerns that that entailed for staff - and that managing a wing is a busy and difficult task where risks have to be weighed and quick judgements made on a frequent basis about actions and priorities.

This investigation has raised some other areas of concern, to which I shall now turn.

The clinical review has identified shortcomings in the care received by the man. His heath care should have been better documented, his dietary, physical and psychological care should have been approached in a more holistic fashion, discussion about his suicide attempts should have been more clearly documented and counselling offered on a regular basis.

The investigator also identified various health care record keeping problems – of notes not always being made of medical interventions, dated and timed chronological entries not always being made, the cell sharing risk assessment not being properly completed, and there being no record of when the medical assessment carried out at court on 14 October was received by Swansea.

Recommendation: I recommend that the Governor arranges for a review, in partnership with the Local Health Board, of the shortcomings in the man's health care, to try to prevent similar problems from happening again.

There are some examples in the F2052SH of entries from staff that could be regarded as insensitive, and are unhelpful to staff who are later reviewing the case.

Recommendation: I recommend that the Governor reminds staff that entries in the F2052SH should contain information that will be useful to other staff. Comments should be open and honest, giving details of mood, signs of stress and so on. Care should be taken not to include remarks that are insensitive or flippant.

I have some other record keeping concerns. On several occasions, the man received minor injuries, but only one prisoner accident form was completed. The prison did not fill in F213SH forms, as it was required to do, after any of the man's self harm attempts. These forms are important, as they allow the Prison Service to analyse self harm attempts and develop strategies to reduce them.

Recommendation: I recommend that the Governor reminds staff that prisoner accident forms and F213SH forms are to be completed in all cases of deliberate self-harm or injury.

On 13 October the man was moved from the segregation unit back to the wing. There is no record of why this was done.

Recommendation: I recommend that the Governor reminds staff that the reasons for location moves are recorded in the F2052SH and the prisoner's history sheet.

It seems that the fax from the Crown Prosecution Service about the man's charges being dropped did not reach the prison.

Recommendation: I recommend that the Governor arranges for a check to be made to ensure the Crown Prosecution Service has the correct fax numbers for the prison.

I also have some concerns about arrangements for dealing with prisoners in the segregation unit. First, the safety algorithm completed on 11 October had already been used for another prisoner, with previous entries blanked out. Second, no safety algorithm was completed when the man was put in the segregation unit for the second time. Third, on 16 October the governor had his first enquiry into the second assault charge that the man faced. Once that enquiry was adjourned, the man continued to be held under rule 53(4) – pending the governor's first enquiry – but that was no longer appropriate. Although the man could have been held under rule 45 – good order and discipline – staff would have had to turn their minds to different considerations as to whether it was right to hold him in these circumstances. These are not trivial matters. Holding prisoners who are on an open F2052SH in the segregation unit must be dealt with very carefully indeed.

Recommendation: I recommend that the Governor ensures there is a supply of unused safety algorithm forms, and reminds staff that these forms are to be completed each time a prisoner is segregated, and about the correct legal basis under which prisoners may be held in segregation.

Once the man was discovered, staff did all that they could to try and save him. I commend all staff involved in the discovery of the man and the attempts to resuscitate him for the prompt and professional action that they took. I also commend the actions of the prisoner who helped staff to lift the man down.

Recommendation: The Governor should formally recognise the efforts made by staff involved in the discovery of the man and the attempts to resuscitate him.

Recommendation: The Governor should formally recognise the assistance a prisoner gave in attempting to save the man.

There are two further points arising from the investigation to which I should draw the Governor's attention, although they did not affect what happened to the man. First, it seems that heath care staff were not all familiar with the contents of the emergency medical bag. Second, staff were not carrying ligature cutters, which might have been needed had the ligature been knotted.

Recommendation: I recommend that the Governor ensures that all health care staff are familiar with the contents of the emergency bag, and that he considers whether it would be appropriate for all wing staff to carry ligature cutters.

There was some delay in telling the man's mother of his death, because he had given her details to an officer on the wing rather than to the reception officer. His mother's details were therefore on his personal officer's records, but not on his core record.

Recommendation: I recommend that the Governor reminds staff that, if a prisoner gives important information, such as details of his next of kin, staff should ensure that, irrespective of where this is received, the information is transferred to his core record.

The man's mother has raised some specific concerns about the way the man was treated at the prison. Some of these I have already dealt with, but there are two other issues on which I think it would be helpful to comment. I have not found any evidence that the man was subjected to bullying, or that he was ill treated by staff. Nor have I been able to find any evidence of racism in the way the man was treated.

The man's mother has also suggested that the doctor instructed by her son's solicitors may have changed her assessment of the man's health now that she knows of his suicide. However, her notes made in the man's medical record at the time of her assessment on 29 October make it clear that, even then, her view was that his suicide attempts related to protest rather than mental disorder.

Recommendations

National

I recommend that the Prison Service reviews Prison Service Orders 2700 and 1700 to clarify and bring together all the requirements for dealing with a prisoner on an open F2052SH who is held in the segregation unit.

National and local

A copy of this report will be sent to the relevant local Criminal Justice Board and to the Office for Criminal Justice Reform for their consideration.

Local

I recommend that the Governor reviews procedures for dealing with suicide and self harm, to ensure that they both comply with the relevant Prison Service Orders, and that they are up to the task of taking good care of vulnerable prisoners.

Recommendation: I recommend the Governor shares with the Listener and the nurse who spent time with the man on 1 November my view that they did all they could to help the man.

I recommend that the Governor arranges for a review, in partnership with the Local Heath Board, of the shortcomings in the man's health care, to try to prevent similar problems from happening again.

I recommend that the Governor reminds staff that entries in the F2052SH should contain information that will be useful to other staff. Comments should be open and honest, giving details of mood, signs of stress and so on. Care should be taken not to include remarks that are insensitive or flippant.

I recommend that the Governor reminds staff that prisoner accident forms and F213SH forms are to be completed in all cases of deliberate self-harm or injury.

I recommend that the Governor reminds staff that the reasons for location moves are recorded in the F2052SH and the prisoner's history sheet.

I recommend that the Governor arranges for a check to be made to ensure the Crown Prosecution Service has the correct fax numbers for the prison.

I recommend that the Governor ensures there is a supply of unused safety algorithm forms, and reminds staff that these forms are to be completed each time a prisoner is segregated, and about the correct legal basis under which prisoners may be held in segregation.

The Governor should formally recognise the efforts made by staff involved in the discovery of the man and the attempts to resuscitate him.

The Governor should formally recognise the assistance a prisoner gave in attempting to save the man.

I recommend that the Governor ensures that all health care staff are familiar with the contents of the emergency bag, and that he considers whether it would be appropriate for all wing staff to carry ligature cutters.

I recommend that the Governor reminds staff that, if a prisoner gives important information, such as details of his next of kin, staff should ensure that, irrespective of where this is received, the information is transferred to his core record.

Good practice

I commend the Governor for the way staff and prisoners were cared for in the immediate aftermath of the man's death. The comprehensive notes made while minds were fresh from the event is also an example of good practice.

The general awareness by staff of resuscitation procedures was impressive.

The decision to continue to monitor the man for 48 hours after the F2052SH was closed was commendable. It may be that the Prison Service Safer Custody Group should consider whether a period of checking on a prisoner after the F2052SH should be a routine part of prison procedures.

Comment from Swansea prison

Swansea's Governor made the following comments on this report when it was sent to him in draft.

"On behalf of all the staff at Swansea prison I would like to offer sincere condolences to [the man's] family on their loss.

I would like to express my thanks to the Ombudsman's team for the sensitive way in which they conducted their investigation having due regard for the distress that this tragedy caused to staff who were directly involved with [the man].

I would also like to thank the staff at Swansea who worked hard on behalf of [the man] and that elements of good practice identified in the report reflect the excellent staff prisoner relationships that exist at Swansea prison.

The loss of any life in prison is a tragedy, the loss of one so young as [the man] doubly so. We are responsible for the safe care of all those placed in our custody. In order that this tragic loss not be in vain we must learn from the circumstances surrounding the death of [the man] and ensure that our systems are robust enough to cope with the demands, and concerns placed on them by vulnerable prisoners. We therefore accept the findings and recommendations of the report that refer to Swansea prison and will work to address the issues they raise."