Investigation into the circumstances surrounding the death of a man at HMP Cardiff in March 2009

Report by the Prisons and Probation Ombudsman for England and Wales

December 2009

This is the report of an investigation into the circumstances surrounding the death of a man who took his own life using a ligature whilst alone in his cell at HMP Cardiff during the early hours of 10 March 2009. He had been in custody for just 12 days.

The man arrived at Cardiff from a local magistrates' court on 26 February. Prison staff did not consider that he represented a risk to himself. He was not made the subject of an Assessment, Care in Custody and Teamwork (ACCT) document (intended to monitor those individuals thought to be at risk of harming themselves). He took his own life in the early hours of 10 March.

I would like to extend my sincere condolences to the man's family. In particular, I think of his mother (who worked with her son to overcome his drug use) and his fiancée (who he planned to marry later in the year). I recognise that his death was both unexpected and deeply shocking for them. To lose a loved one under these circumstances is especially difficult to come to terms with.

The investigation was conducted by two of my colleagues. One of the Family Liaison Team contacted the man's family to discuss my investigation and the questions which they had about his death.

A clinical review of the healthcare which the man received in Cardiff was undertaken by a doctor from the Healthcare Inspectorate Wales on behalf of the Cardiff Local Health Board. She assessed whether the care which the man received in custody was comparable with that which he would have been offered in the community. I am grateful for her assistance.

I would also like to thank the Governor of Cardiff, as well as the staff and prisoners for offering their full cooperation whilst my investigation took place. In particular, I am grateful to the Safer Custody Manager, who liaised with my colleagues and organised the interviews.

The man did not voice suicidal thoughts to staff before he took his own life. There had not been concerns in this regard during previous custodial sentences. With the benefit of hindsight, his behaviour on 9 March was erratic and he appears to have become anxious and irrational as the day progressed. The investigators are satisfied that a number of staff took the time to speak to him and check on him. I believe that their decisions were reasonable and well intended.

I express concern with regard to failures in communication which meant that staff were not equipped with useful knowledge which could potentially have influenced the decisions they made with regard to the man's care. I make seven recommendations and repeat a recommendation from an earlier investigation regarding the possibility of testing prisoners to confirm suspicions that they are withdrawing from drugs. I also endorse two recommendations made by the clinical reviewer.

Jane Webb
Deputy Prisons and Probation Ombudsman **December 2009**

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SUMMARY

The man appeared at a local Magistrates' Court in February 2009. His Community Order was revoked and he received a short custodial sentence instead. He arrived at HMP Cardiff later that day. He was placed on the detoxification unit and shared a cell with another man who had appeared at the same court. The next day he was found with a significant quantity of illegal drugs and taken to the segregation unit. Two different assessments were completed by healthcare staff during this time to ensure that it was appropriate for him to remain on this unit. On 1 March, he returned to the main part of the prison. He shared a cell with the same prisoner, and they were located on A wing.

On the morning of 9 March, the man was assessed by a substance misuse worker from the Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS) team. She found him to be optimistic and chatty. At about 2.00pm the same day, he told his personal officer that he was being bullied and wanted to be moved off A wing for his own protection. The officer acted quickly to remove him from the wing and, following consultation with other staff, placed him on the therapeutic unit on B1 landing as a temporary measure. The man seemed to calm down once he had left A wing.

The safer custody manager was asked to come to B1 landing and speak to the man. He confirmed that the man was not voicing any suicidal thoughts and was satisfied that the correct decision had been made to temporarily relocate him. The man did not say anything further about the allegations of bullying. The safer custody manager arranged for the violence reduction manager, who was not in the prison that day, to interview the man the following day.

Shortly before 5.00pm, an officer became concerned about the man after he started claiming that both prisoners and staff were calling him names. The officer could not hear anybody doing this. A senior officer (SO) then arrived on B1 landing and agreed to speak to the man. She knew him and thought that his irrational anxiety was caused by drug misuse. The man did not want to associate with the other prisoners and so stayed in his cell.

Concerned by the man's paranoid thoughts, the SO called the healthcare department. She spoke to a doctor and they agreed that he would be examined by a psychiatric nurse the next day. The SO told the doctor that she did not need to visit the man on the wing that night. The SO felt that an assessment could wait until the morning. She was satisfied that he was not giving any indication that he might harm himself. She knew that he had never been considered to be at risk of taking his own life in the past. He had no history of significant mental health problems.

The man was locked up for the night on his own in a double cell. The SO checked on him before she left at 7.15pm, and the officer also looked in on him at 7.45pm. Both were satisfied that the man had calmed down and would be examined in the morning. At about 11.00pm, the orderly officer went to speak to the man after he rang his cell bell. The man had an unfounded fear that the IRA would harm his family. To put his mind at rest, the orderly officer decided to give the man the impression that he had contacted his family. He went away, returned about ten

minutes later and told the man that he had made a telephone call to his mother. The orderly officer thought that the man calmed down as a result.

The man took his own life using two ligatures in the early hours of the morning. One was tied around his neck, the other around his knees. An officer glanced into the man's cell whilst he was counting the prisoners at the start of the day shift, but had thought in the half-light that he was sitting up in bed.

At 7.45am, a second B1 officer unlocked the man's cell door and raised the alarm. Two officers removed the ligatures and lowered the man down to the ground. Healthcare staff attended but did not attempt to resuscitate the man, as rigor mortis had set in and they thought he had been dead for several hours. When the paramedics attended, they attached a monitor to the man, which malfunctioned and incorrectly indicated that a heart rate could be detected. As a consequence, they decided to wait for a doctor to arrive. The doctor confirmed death at 9.15am.

The man had never been considered to represent a risk of harm to himself. He did not voice any suicidal thoughts to staff during the 12 days he was held at Cardiff. He did become tearful on 9 March, but spoke to two members of staff who found him to be optimistic and calm. I am satisfied that staff made reasonable decisions and acted in his best interests. I am concerned that they were not all equipped with relevant information, and I make five recommendations to improve communication amongst healthcare staff, substance misuse workers and prison officers. I make three other recommendations and endorse two made by the clinical reviewer.

THE INVESTIGATION PROCESS

1. My colleague was formally notified of the man's death on 11 March 2009. Notices were subsequently issued to both staff and prisoners at HMP Cardiff, informing them of the investigation process and giving them the opportunity to contact the investigators with any relevant information. During his opening visit on 16 March, my colleague spoke with two prisoners.

2. My colleague made contact with the Safer Custody Manager at Cardiff who acted as the liaison officer throughout the investigation. During the opening visit, he provided all of the relevant paperwork relating to the man's time in custody. My colleague also met the Governing Governor on 16 March.

3. Having examined the man's prison record and medical file, my colleagues returned to Cardiff on 14, 15 and 20 April and 5 and 6 May. They conducted 16 interviews with staff. They also spoke to another prisoner. My colleague conducted one interview by telephone when a doctor was unable to attend the prison. My colleagues returned to Cardiff on 14 July to interview a prison officer for a second time to obtain greater clarity.

4. My colleague wrote to the local Coroner's office to inform them of the nature and scope of my investigation. He obtained a copy of the post mortem report and the results of toxicology tests. HM Coroner has been provided with a copy of my report.

5. My colleague contacted Cardiff's Local Health Board and asked that a clinical review be carried out with regard to the medical treatment which the man received in Cardiff. The purpose of this review is to establish whether the care which he was offered in prison was comparable with that he would have received in the community.

6. On 6 April, one of the Family Liaison Team contacted the man's mother and fiancée by telephone. The family liaison officer, along with the investigators, visited both women and the man's brother at the family home on 5 May. The investigators explained the progress they had made. The Family Liaison Officer talked about the investigation process and gave the family the opportunity to express any concerns which they wished the investigators to address during the investigation.

7. The man's mother wanted to know why her son was placed in a cell on his own on the afternoon before he died. She knew that his behaviour had changed during 9 March and she wanted to know more about this. She was concerned that her son had been bullied and she asked my colleagues to explore this issue. When she viewed her son's body, she observed what appeared to be bruises on his hand and asked for them to be explained. Both the man's mother and fiancée wanted to find out more about the drugs that he had brought into the prison. The man's brother wanted to know the outcome of the toxicology report. I hope that this report provides the family with a better understanding of what happened to the man whilst he was held in Cardiff.

HMP CARDIFF

8. HMP Cardiff is a category B local prison with a maximum population of 784 adult men. It is located very close to the city centre and was originally built in 1827. As a local prison, the majority of the prisoners have arrived at Cardiff after making court appearances in South East Wales. As well as prisoners remanded into custody and those serving short sentences, a significant number are serving life sentences.

9. Whilst at Cardiff, the man stayed in the detoxification unit (where drug users can withdraw under supervision), before moving to the segregation unit (effectively a completely separate part of the prison for those who have not complied with the rules). He returned to a mainstream prison wing and was then taken to the therapeutic unit (intended for those prisoners who do not cope well with normal prison life) for his own protection.

10. The Local Health Board commissions Serco (a private company) to provide primary healthcare to prisoners in Cardiff. The prison has 24 hour nursing cover and 16 inpatient beds. During weekdays the core healthcare staff work until 5.00pm. Four nurses continue to work between 5.00pm and 8.00pm. Two nurses then work between 8.00pm and 9.00pm and from 9.00pm overnight one nurse remains in the healthcare centre with a member of the prison staff. That nurse will respond to emergencies and can contact the healthcare manager out of hours if need be. Using an out of hours telephone service, they can obtain medical advice, ask a doctor from a local surgery to attend or summon an ambulance if they have serious concerns about a patient.

11. All prisoners undergo a health screening during the first night reception process upon arrival at Cardiff. Doctors from a city centre practice come into the prison seven days a week to hold surgeries. There is a dedicated healthcare team on the detoxification unit consisting of three full time and two part time nurses. A mental health in-reach team is provided by Cardiff and Vale NHS Trust.

12. HM Chief Inspector of Prisons, completed an inspection of Cardiff in January 2008. She found that prisoners were ‘much more likely to report feeling safe than at other local prisons’, in the most part due to ‘good relationships between staff and prisoners’. The support offered to newly arrived prisoners was praised and the healthcare offered to prisoners was thought to generally be of a good standard. Detoxification procedures were found to be working well and the Inspectorate had no concerns about either the working of the segregation unit or the use of force by discipline staff. Of particular note, HM Chief Inspector of Prisons 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.’

13. HM Chief Inspector of Prisons found that not all staff had been trained in the use of the ACCT document, and she recommended that this training be fully implemented. Similarly, she recommended that all staff receive anti-bullying training. In general, the quality of completed ACCT documents was good.

14. During the inspection the relationships between black and minority ethnic prisoners and staff were found to be less successful and it was considered that complaints of racist incidents were not always effectively dealt with.

15. The most recent annual report published by the Independent Monitoring Board (IMB) at Cardiff covers the year from September 2007 to August 2008. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.)

16. The IMB report commends the work of staff on the therapeutic landing, who 'show a great degree of patience and understanding'. Similarly, the IMB describes how staff working on the segregation unit 'maintain their commitment to the prisoners in their care'. The segregation unit was found to be 'always clean and tidy' and 'well managed by dedicated staff'. Adjudication hearings were found to be 'professionally conducted'. The IMB expressed concern that the new healthcare centre was not yet being fully utilised. When the investigators visited the prison, this remained the case.

17. The IMB considered that ACCT documents were being used appropriately to help prisoners who were thought to be at risk of harming themselves. The Board noted that a member of the Safer Custody team was available seven days a week to offer advice to staff. 304 incidents of bullying were reported in the year from September 2007 to August 2008.

Previous deaths in custody

18. Since 2004, the Ombudsman's office has investigated nine previous deaths at Cardiff, five of which were self-inflicted. Two of the previous investigations have relevance to the circumstances in which the man died.

19. The Ombudsman investigated the self inflicted death of a prisoner in June 2007 and found that either a drug test or a mental health assessment would have helped staff in determining how to help the man. In the event, staff thought he might have been withdrawing from drugs. A very similar situation occurred on the evening before the man took his own life, when a member of staff thought he was under the influence of drugs and agreed with the doctor that he should undergo an assessment with a psychiatric nurse. Toxicology results have since shown that he had almost certainly not used drugs that day. Again, as was the case during the earlier investigation, staff were unable to accurately identify why his mood had altered. This has prompted me to repeat the earlier recommendation regarding the need for urine testing when staff wish to confirm that a prisoner is withdrawing from drugs.

20. In relation to another prisoner who also took his own life in June 2007, the Ombudsman recommended that the Governor and the safer custody team consider how best to increase the trust between staff and prisoners and thus the likelihood of incidents of bullying being reported. Staff had been unaware that the man was being bullied because it did not seem that he had felt able to tell them. Although the scenario is similar, the man was able to tell staff he was being bullied and steps were quickly taken to move him to another unit.

KEY FINDINGS

26 February – 8 March 2009

21. The man appeared at a local Magistrates' Court on 26 February 2009. He was under the supervision of the Probation Service, having been made the subject of a Community Order on 7 July 2008. The Order required him to complete 24 months of supervision and 12 months of drug treatment. It was no longer considered to be workable after the man became verbally aggressive to probation staff and damaged office property. He did not attend a review relating to his drug treatment on 9 February, as well as five other appointments arranged with his probation officer.

22. The court revoked the Order and resentenced the man for the original offences of theft committed in February and May 2008. He received a 77 day custodial sentence, comprising 63 days for theft and 14 days for the non-payment of fines.

23. The supervising probation officer had completed an OASys document relating to the man before the Order was revoked. (An OASys assessment examines the individual's likelihood of committing further offences and the risk of serious harm which they represent to themselves and others.) The officer recorded in the assessment that the man did not have any history of either self harm or suicidal thoughts.

24. The man arrived at HMP Cardiff at about 4.00pm on 26 February and underwent a first reception healthcare screening. Neither mental health concerns nor a history of self harm were identified when he spoke with the nurse. He had no history of psychiatric treatment.

25. A cell sharing risk assessment was completed before the man was placed on a wing. (This document explores a prisoner's potential vulnerability or the possible harm they might do to other prisoners.) The officer who completed the form recorded no particular concerns and noted that the man had never been the subject of the Assessment, Care in Custody, and Teamwork (ACCT) process. (An ACCT document is opened when staff have reason to believe that a prisoner may be thinking of harming themselves or taking their own life. The prisoner is kept under observation and their case is regularly reviewed to monitor the risk they present to themselves.) The man shared a cell with another prisoner who appeared at the Magistrates' Court that day and arrived at Cardiff with him.

26. During the reception process, the man's alcohol and drug misuse were assessed. As part of his drug treatment whilst working with the Probation Service, he began a methadone treatment programme and was prescribed 65mg per day of this heroin substitute. The man said he had been misusing alcohol before coming into custody. His community doctor was contacted and confirmed that the man was prescribed 20mg daily of diazepam (a benzodiazepine often referred to as Valium used to treat alcohol withdrawal) at a reducing dose twice daily until 4 March. He had also been prescribed this

medication in the community. It was agreed with his treatment provider in the community that the man would continue to be given the same ‘maintenance’ dosage of methadone whilst he was in prison. This prescription would stop him from suffering withdrawal symptoms and ensure that he could resume treatment in the community upon his release.

27. The man was placed on the first floor landing of G wing, in the detoxification unit. A six day course of diazepam on a reducing dose began on 26 February and was completed on 4 March. He was also prescribed 14 day courses of carbamazepine (to prevent epileptic fits, which can occur during alcohol detoxification) and thiamine (a vitamin B supplement). The man collected the medication from 26 February until 6 March, but did not complete the full 14 day schedule.

28. At 9.00am the following morning, 27 February, staff on G wing thought that they could smell fumes coming from the cell the man and other prisoner shared. When officers went into the cell, both prisoners seemed to be under the influence of drugs. Although an initial search did not produce any illegal substances, the man’s cellmate was then found with a small packet in his hand. Staff went on to discover a significant quantity of drugs when they searched the cell. The man told them that the drugs belonged to him, although his cellmate was also implicated.

29. A little while later, at 10.50am, two officers began a full search of the man in his cell. They wanted to find out if he had concealed any more drugs. He started to remove his clothes and it was suspected that he had a small package of drugs underneath the foreskin of his penis. He wanted a member of healthcare staff present before the officers took any further action. They agreed, but before this could happen the man took the package and tried to swallow it. The officers used authorised control and restraint procedures to restrain the man and prevent him from doing so. Another officer, who was standing outside the cell, overheard the commotion and assisted his colleagues.

30. One of the officers took hold of the man’s right arm, the second officer the left arm and the third officer his head. He was taken out onto the landing and forced to the ground on the third officer’s instructions (using restraint procedures approved by the Prison Service) when he did not comply with the staff. An SO arrived and supervised the control and restraint.

31. The man was brought to his feet and the SO placed him in handcuffs. He stopped resisting and complied with the officers so the restraint applied to his arms and head was released. He was supported by the officers as they walked from G wing to the segregation unit (where prisoners who have broken the prison’s rules are held). When they arrived in the unit, the handcuffs were removed and the man was taken into cell P1-03. Another SO and officer oversaw a full search of the man and instructed him to remove his clothes.

32. As he did so, the man was seen trying to reach down the back of his boxer shorts. He was instructed to crouch down and another package fell onto the

floor as he lowered his underwear. Once the search was finished and he was locked in his cell, the officers involved completed the appropriate 'Use of Force' documents at about 11.00am.

33. When my colleagues spoke to an SO who knew the man from previous custodial sentences and was working on the segregation unit that day, she said that he was not aggressive once he arrived on the unit, and accepted the reason for his relocation. She remembered that the man's mood seemed noticeably heightened by drugs and that he was beginning to withdraw from whatever he had been using. She thought that the man was quite heavily under the influence of drugs and remembered that he asked for cold food because he did not feel able to eat a hot meal.

34. A nurse visited the man to complete an Initial Segregation Safety Algorithm as required by Prison Service Order 1700 (this process assesses whether the prisoner is fit to be held in segregation). She had no concerns about the man's mental health. As regards his physical health, she recorded that he had grazed knees and a sore wrist following the control and restraint, but no significant injuries. The man subsequently asked to speak to a Listener (a prisoner who is trained by the Samaritans to speak confidentially with others who might be distressed). The Listener was provided but it emerged afterwards that the man had only wanted to ask for tobacco.

35. The man was placed on report. At 9.30am the following day, 28 February, he was subject to the adjudication process (a disciplinary hearing in front of a governor). The SO remembered in interview that the man's mood was still altered and that he spoke to the governor quite flippantly, albeit in a friendly manner. The outcome of the adjudication and any punishment were postponed whilst the police investigated the matter. Because the amount of drugs was of a significant value, the man faced the prospect of being charged with bringing the drugs into prison with the intention of supplying them to other prisoners. (Such an offence carries a substantial penalty.)

36. The man remained in the segregation unit (where he was monitored with a camera in case he had any more drugs secreted on his person) on 28 February. The prison doctor was working that day and completed a second Segregation Safety Algorithm. (She was not asked to check the man, but told the investigators that she always visits the prisoners on the segregation unit as a matter of routine when she works on a Saturday.)

37. The prison doctor confirmed that the man was suitable to stay on the unit. They discussed his tinnitus, a problem with his hearing which he had had for about three years. She offered to refer him for further treatment, but he told her not to bother, as he was being released soon. Instead, she advised the man to make an appointment with his doctor after he was released. The prison doctor found the man relaxed and good natured and later recalled that he had joked with her. She thought that he looked well. She was unaware of the reason the man was being held in the segregation unit and did not have access to his medical record when she assessed him.

38. The same day the man spoke with the Samaritans on the telephone, was visited by the chaplain and telephoned his mother. He returned to the main prison population the next day, 1 March. The man was placed in a cell on the first landing of A wing and continued to share with his cellmate, who had also been released from the segregation unit following the drugs find. The movements officer on A wing that day agreed to their request to share a cell. He was unaware that both men had been implicated in the significant drugs find two days earlier.

39. The man's stay in the segregation unit had interrupted his initial placement on the detoxification unit. Had he remained on the detoxification unit, he would have been assessed by a substance misuse worker from the Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS) team within 48 hours. Instead, a member of the healthcare team made a referral to the CARATS team on 2 March.

40. Three days later, on 5 March, the man's fiancée visited him. The next day he was moved to the fourth landing on A wing, and continued to share a cell with the same cellmate. The man was assigned a personal officer. The officer spoke with him and remembered him being in a quiet mood but happy to share a cell with his the same cellmate. The personal officer was aware of the drugs find which was still being investigated by the police. He thought the man was adapting well to life on the landing and had no cause to be concerned about him. The same day, 6 March, the CARATS team received the referral from the healthcare team. It had been sent via the internal post system.

41. A prisoner who was a good friend of the man told my colleagues that the man continued to promise drugs to other prisoners in the days after his supply was confiscated even though there was no prospect of him being able to honour his promise.

9 March

42. A member of the CARATS team interviewed the man and completed an initial assessment of his substance misuse at about 9.45am on 9 March. They spoke for about 45 minutes and she confirmed that he was being prescribed methadone and diazepam. The man did not report any physical or mental health concerns to her. They discussed the issue of self harm and the man told her that he had no problems in this regard.

43. During their interview the CARATS worker found the man to be motivated, optimistic and 'chatty'. She told my colleagues that he had a 'very positive' attitude. The man did not report any significant worries and spoke about the future and his forthcoming marriage. He told her that he was coping with his sentence and expected to be released in a matter of weeks. The CARATS worker completed a care plan to treat the man's drug dependency. She did not know about the large quantity of drugs which the man was thought to have brought into Cardiff and which had been confiscated.

44. The man collected his daily prescription of methadone at midday. At about 2.00pm, he asked his personal officer if they could speak in his cell. The man was upset and said that he was being bullied by another prisoner. He alleged that one particular prisoner was spreading rumours that he had made racist remarks out of his cell window. The man did not explain why other prisoners might be doing this. When he spoke to the investigators, the personal officer remembered that the man was tearful and frightened of going back onto the landing. He feared for his safety. The personal officer told the man that he could stay and try to deal with the problem on the landing. Alternatively, he could apply for vulnerable prisoner status under Prison Rule 45 (meaning that he would be removed from the mainstream prison population for his own protection). The man chose to apply for rule 45 and move off A wing.

45. The personal officer locked the man in his cell to keep him safe and went to collect the necessary rule 45 paperwork. He returned and helped the man to complete the form and pack his belongings. They then went to the wing office, where an SO gave the man the option of moving temporarily to the therapeutic unit on B1 landing as an alternative to asking for 'rule 45' protection and the stigma which can be associated with this.

46. The man chose to move to the therapeutic unit on B wing. He was moved within 20 minutes of speaking to his personal officer. It was felt by staff that this was a safe environment until the specific allegations of threats could be explored. (Had the man chosen vulnerable prisoner status, he would have been moved back to the segregation unit and then most likely transferred to another prison.)

47. His personal officer took the man down to the therapeutic unit on B1 landing, where he was temporarily allocated an empty cell. (The therapeutic unit takes vulnerable prisoners who struggle to cope with prison life or who have mental health concerns.) The man did not fit the profile of the usual prisoner found on the unit but it was not intended that he stay there in the longer term. He was placed there solely for his own protection.

48. On the way to B1 landing, his personal officer discussed the issue of self harm with the man, who told him that he was not having suicidal thoughts and expressed his relief at leaving A wing. His personal officer noticed that the man immediately became more relaxed and stopped crying. His attitude changed and he became happier.

49. When they arrived an officer on the landing had a conversation with the man, explaining the rules of the therapeutic unit. A second officer told my colleagues that the man asked not to share with anybody else. Space was available and the officer placed the man on his own in a double cell. They did not discuss the reasons he had come to the therapeutic unit, but the second officer observed that the man was 'fine' and seemed relieved to have been moved. (The second officer finished his shift shortly afterwards, at 4.30pm.)

50. After he returned to A wing, the man's personal officer decided to call the violence reduction manager. However, the violence reduction manager was

off duty and instead he spoke with the safer custody manager. In the absence of the violence reduction manager (who would normally address issues of bullying), the safer custody manager agreed to interview the man. The purpose of the interview was to address the alleged bullying, rather than the risk of self harm.

51. When they spoke in his cell on B1 landing at about 3.20pm, the man told the safer custody manager that he had reconsidered asking for rule 45 protection because of the negative associations this can have amongst other prisoners. He was reluctant to open up to the safer custody manager or elaborate on the nature of the bullying. The safer custody manager perceived that the man was content to have been moved from A wing and no longer wished to get another prisoner into trouble, for fear of potential repercussions. He admitted that he had problems to deal with both inside and outside the prison and had been misusing illegal drugs in custody on top of his daily methadone prescription.

52. The Safer Custody Manager touched upon the issues of self harm and suicide during the interview. The safer custody manager knew that the man had not previously been subject to the ACCT process. The man told him that he had not self-harmed in the past and had never considered taking his own life. The man seemed optimistic and spoke about his fiancée, his forthcoming marriage, his family and his imminent release.

53. The man expressed a preference for a single cell. The safer custody manager checked that the man's pupils were not dilated and satisfied himself that he was not currently under the influence of drugs. He remembered the man speaking coherently and appearing calm. The man seemed more relaxed than the safer custody manager expected him to be following the rapid move from A wing.

54. The safer custody manager organised for the man to speak about the alleged bullying with the violence reduction manager the following day when he was back on duty. He was satisfied that the man had been moved away from the wing which was causing him anxiety and he thought that the therapeutic unit was an appropriate place for the man to be held temporarily whilst the bullying allegations were explored. Their interview lasted about 25 minutes.

55. Between approximately 4.30pm and 5.00pm, the prisoners on the therapeutic unit were locked in their cells whilst other prisoners returning from workshops to the main part of the prison went through the landing. During this period, the man rang his cell bell twice. An officer went to his cell and spoke to him on both occasions. The man was anxious that other prisoners were shouting and calling him a 'nonce' (a slang term for a sex offender) because he had considered asking for rule 45 protection.

56. The man was agitated and his behaviour concerned the officer, who tried to reassure him that nobody was calling him names. The officer could not hear any shouting and promised to have a chat with the man once the cells were unlocked again. The man was convinced that other prisoners were talking

about him and that he could hear a female voice, although there were no female staff on the wing at the time. The officer thought the man's anxiety was not that unusual in a prisoner who had just moved to the therapeutic unit.

57. Just before 5.00pm, an SO came onto the wing. The officer told her that the man had been behaving oddly since he arrived on the therapeutic unit. The SO told the officer that she would talk to the man to try and resolve the problem.

58. The SO told my investigators that the man appeared tearful, anxious and paranoid. She spent several minutes chatting to him. He kept repeating his concerns about being labelled a sex offender by the other prisoners. Because of his agitated behaviour and irrational worries, the SO thought that the man had probably been using drugs. His speech was rambling and she did not feel that he was fully aware of his surroundings. He sat curled up on the bottom bunk with his back against the wall and a blanket wrapped around him.

59. Shortly afterwards, dinner was served and the man was the last to emerge from his cell. He went to the back of the queue and then became agitated and upset. He went back to his cell and slammed the door. The SO went to speak to him and he told her that the other prisoners were calling him a 'nonce'. She had watched him join the queue and told him that she had not seen anybody speak to him. She expressed her concerns to the man that drugs were affecting his behaviour. She offered to fetch his dinner for him and he accepted. She gave him his meal on a tray and collected an empty plate 15 minutes later. She was concerned that the man should eat and was relieved to see that he seemed to have done so.

60. The SO noticed that the man seemed to be feeling cold and was shivering, which she attributed to drug withdrawal. He told her that 'it's not the drugs this time', but the SO was sure that he was under the influence of something. She told my colleagues that he 'wasn't making much sense' and was 'completely paranoid'. The man was confused and preoccupied with what others were saying about him. She tried to reassure him and remind him that there was absolutely no reason for other prisoners to imply he was a sex offender. After speaking with the man for about another 15 minutes, she offered to telephone the healthcare team to organise for a member of staff to assess him in the morning and he agreed.

61. During interview, the SO said that she was not overly concerned about the man when she telephoned the healthcare department and spoke to the doctor shortly after 5.30pm. She knew that he had eaten and thought it would be best if he got some sleep before being assessed by healthcare staff in the morning. She did not think that the man needed to be assessed by the healthcare team that evening. The SO told the doctor that the man was tearful, 'extremely paranoid' and believed irrationally that the other prisoners were implying that he was a sex offender.

62. The prison doctor was writing up her notes in the healthcare department when the SO telephoned. She recalled in interview that the SO told her that the man needed to be assessed, but that it was not urgent. The doctor offered to visit him immediately, but the SO told her that this was not necessary, and that an assessment in the next couple of days would be sufficient.

63. They discussed the possibility of self harm, and the SO told the doctor that the man was not expressing suicidal thoughts. The doctor remembered the SO telling her that she knew the man quite well, that he had no history of self harm and that he was 'not that sort of [prisoner]'. The doctor was satisfied that the SO's opinion was valid and based on prior knowledge of the man. She did not recall the SO suggesting that the man might be under the influence of drugs. When the SO spoke to the investigators, she could not remember if she mentioned her suspicions about drug use to the doctor.

64. When she was interviewed, the prison doctor remembered the SO saying that the man needed to talk to somebody in the next few days to relieve his anxiety. (The SO thought that she had asked for the man to be assessed the following day.) The doctor knew that the man was in a single cell, and thought this was probably the correct decision because of his anxiety about the other men on the unit. She knew about the drugs find on 27 February, and thought that this explained the man's anxiety.

65. Because of the anxiety the man was experiencing, the doctor and the SO agreed that he should be examined by a psychiatric nurse, who would be able to spend more time with him. At the suggestion of the safer custody manager, the prison doctor made a note in the 'Patients' Treatment and Appointment Diary' on 10 March stating that the man needed an urgent referral to a psychiatric nurse. (Routine referrals can take up to three weeks, but the doctor prioritised the man's appointment to ensure that it took place within three days.) She added in her diary entry that 'wing staff were concerned' about him. The doctor recorded that the man was in a single cell but was not suicidal. She completed a 'Crisis Intervention Request Form' to make the referral, marking 'CPN' (Community Psychiatric Nurse) at the top of it. (This was not the correct form, but she knew that it would achieve the desired outcome.) The doctor felt that the SO was satisfied with the outcome of their conversation.

66. When talking to the SO on the telephone, the prison doctor did not realise that the man was the same prisoner she had assessed in the segregation unit on 28 February. Had she made the connection, she told my colleagues that with the benefit of hindsight, she might have been more alarmed about the situation. There was a stark contrast in mood between the prisoner described to her on the telephone and the man she met two weeks earlier.

67. Following her conversation with the SO, the doctor went to check the man's medical record for any history of self harm. She could not find the records. (She told my investigators that the file had not followed the man as he had moved around the prison, and was probably still on the detoxification unit, where he spent his first couple of days. Prisoners' medical records are

supposed to remain in the healthcare centre, but can be taken away if, for example, a referral is made. A tracer card should be placed in the filing cabinet to indicate where the file has been taken.)

68. Because the man denied having suicidal thoughts, the SO did not open an ACCT document. She went to tell him that he would be assessed by the healthcare team the following day, and he seemed calmer. She told my colleagues that nothing about the man's behaviour suggested that he was thinking of harming himself. She thought that his anxiety was related to drug misuse.

69. Towards the end of the association period the man had blocked the observation panel in his cell door with toilet paper. The SO told him that the obstruction would have to be removed and he agreed. At about 7.15pm, all the prisoners including the man were locked in their cells for the night. The SO suggested that the man give his decision to move to the therapeutic unit some thought overnight, and they would discuss it again in the morning. She told him that the officers would make sure that the healthcare staff came to assess him the next day. She advised the man to speak to one of her colleagues if he had any further worries. The man seemed less distressed and frantic and she considered that he had calmed down. He was still wrapped in a blanket and shivering and the SO assumed that he was detoxifying. During the late afternoon and early evening, she did not make any entries in the wing observation book about her concerns.

70. Before he finished his shift, one of the officers also checked on the man at about 7.45pm. The man was calm and the officer told him not to worry and that he would see him the following morning. He would make sure that a psychiatric nurse came over to assess the man. The man thanked him and they said goodnight. The officer had no other concerns about the man when he left for the night.

71. Another officer was responsible overnight for the four landings on B wing, including B1. He was based in an office on the second landing where the cell bell indicator panel is located. At the start of his shift, shortly after 7.45pm, he completed a count of all the prisoners he was responsible for, looking through the observation flap on each cell door. He told the investigators that he would have checked on the man during the count. He said that the impression he gained during the handover from the day shift was that there was 'nothing to be concerned about' with regard to the man.

72. The officer responsible overnight said at interview that he knew the SO had spent time with the man before the cells were locked and that he had been anxious earlier in the day. (The officer said that the SO had passed this information onto the orderly officer in charge of the running of the prison overnight, who then told him.) However, the officer responsible overnight was not aware that the man had been referred to a psychiatric nurse.

73. The orderly officer started his shift at 8.45pm. As part of his duties, he visited each wing at various stages throughout the night to check on the staff. The

orderly officer was visiting B1 landing at about 11.00pm when he noticed on the indicator panel that the man had pressed his cell bell. Because the officer responsible overnight was on another landing the orderly officer went to the man's cell and spoke to him through the observation flap.

74. During interview, the orderly officer remembered that the man was agitated about the safety of his mother and girlfriend, who he thought might be in danger. He was standing in his cell with the light on and seemed panicky and tearful. He was worried that his family were being targeted by the IRA. The orderly officer thought this unlikely and that his fear might have resulted from recent television news coverage of a terrorist incident in Northern Ireland.

75. The man asked if he could telephone his mother's address to check that she and his fiancée were safe. During the night, prisoners cannot be unlocked except in the event of an emergency. The orderly officer therefore told the man that this was not possible. The man asked the orderly officer if he could make the call on his behalf. Wanting to calm the man and reassure him, the orderly officer said he would contact his mother for him. The man gave his mother's contact details.

76. Attempting to reassure him, the orderly officer told the man that he would be gone for about ten minutes. He went away and did not actually make the telephone call, because he did not wish to disturb the man's mother very late at night and unnecessarily worry her. He believed that the man's anxiety was not connected to any genuine threat to his family. Instead, he returned to the man's cell a few minutes later and told him that he had spoken with his mother and that she was safe and well. Feeling that this news had calmed him 'right down', he told the man to settle, get some sleep and call his mother after unlock in the morning. The man thanked him.

77. The orderly officer felt that he had resolved the man's anxiety. The man seemed happier and so the orderly officer did not call the member of the healthcare team working the night shift to assess him. The orderly officer told the officer responsible overnight about his conversation with the man, but did not record the incident in the wing observation book. Contrary to what the officer responsible overnight told my colleagues, when the orderly officer spoke to the man during the night, he said he was unaware of the concerns the SO had had about the man's state of mind in the early evening. The orderly officer had no further dealings with the man during the night.

78. One of the prisoners in the cell opposite recalled the man repeatedly activating his cell bell between 11.00pm and midnight and speaking with the member of staff who responded. He remembered the man sobbing loudly, but also recalled the efforts that the officer went to to calmly reassure him. (I assume that the prisoner opposite witnessed the orderly officer checking on the man.)

79. When he spoke to the investigators, the officer responsible overnight told them that he had no contact with the man during the night and did not go to his cell again after the initial count. He did not make any entries in the wing

observation book about the man. He said the orderly officer had told him shortly after 11.00pm that he had spoken to the man, but that the problem was resolved, he was now fine and ‘there was nothing to worry about and no need to check him’.

80. The officer responsible overnight did not believe that there was any reason to make further checks on the man during the night. He said the man did not activate his cell bell again after the orderly officer left the wing. He continued to make regular checks on prisoners subject to ACCT documents, but did not make random checks on other prisoners. The man was not checked again after about 11.00pm.

10 March

81. At some stage in the early morning, the man hanged himself. He tied a ligature made from a bed sheet around his neck and attached it to the slats of the bunk above him. He tied a blanket around his knees and also attached it to the bunk above. The officers who found him later that morning thought that he had shuffled off the mattress, causing his body to bow, his weight to drop and his windpipe to be crushed.

82. The officer who had left the previous evening returned for his next shift at around 6.50am on 10 March. He arrived on B wing at about 7.00am and spoke with the officer responsible overnight, who told him there had been no problems during the night. Before the officer responsible overnight left, the other officer began the day shift by accounting for all the prisoners, looking briefly through the observation flap in each cell door.

83. Between 7.00am and 7.30am, the officer looked in on the man, believed him to be sitting up in bed and said, ‘Morning, everything alright’. Glancing into the dimly lit cell very quickly, the officer mistakenly thought that he was alive. The unusual method the man had used to hang himself meant that he was facing the door and appeared to be sitting on the bed. (His head was near the window and his feet towards the door.) The man had hung a sheet over the back of the bunk nearest the window, which prisoners often do to stop daylight from waking them too early.

84. Returning to the B wing office, the officer met the orderly officer, who told him about his discussion with the man during the night and the action he had taken to calm him down. They confirmed that the man was due to be assessed by a CPN later that morning. Because officers cannot unlock cells on the unit without a colleague being present, the officer then waited for his colleague to begin his shift. Once his colleague arrived as scheduled at about 7.30am, they began the process of unlocking the landing cleaners. The cleaners placed a carton of milk outside each cell and then the two officers began opening the other cells, with each officer taking one side of the landing.

85. At about 7.45am, the newly arrived officer unlocked the man’s cell to give him his milk. He switched the light on as he opened the door and immediately realised that something was wrong. He saw the ligature around the man’s

neck and blood around his mouth. He sprang the lock on the door and raised the alarm, calling to the other officer for immediate assistance. The newly arrived officer went to the bed and supported the man's weight whilst the other officer untied the ligature around his neck. (The material was too thick for the officers to attempt to use their ligature knives.) The other officer used his radio to inform the control room of the emergency. Once he had helped the newly arrived officer to untie the blanket from the man's feet, they moved the man from the bunk onto the floor of the cell.

86. The healthcare team, led by the practice nurse, rapidly responded to the 'code blue' request sent over the radio. The practice nurse was allocated the call sign 'Hotel 3', meaning that he was the designated first responder in the event of a medical emergency. He brought the emergency response bag with him and, upon arrival, asked for an ambulance to be called. Resuscitation was not attempted. The man was cold and rigor mortis had set in, meaning that his body had stiffened in the seated position in which he was found. (If rigor mortis is evident prison staff are not expected to start resuscitation.) Blood had drained to the base of the man's body (this condition is known as hypostasis). These observations allowed the safer custody manager and the practice nurse to agree that the man had died earlier that night and they could do nothing to save him. The man did not leave a suicide note.

87. The movements officer contacted the control room by radio at about 7.47am to ask for an ambulance. The Ambulance Service records show that they received a call from the prison at about 7.50am. The ambulance was mobile at 7.52am, reached the prison at 7.56am and the paramedics arrived on B1 landing at 8.00am. They agreed that resuscitation should not be attempted and attached an electrocardiogram (ECG) monitor to the man in order to certify death.

88. The machine gave a false reading suggesting that a heart rate was present. (My colleagues spoke to a variety of members of staff who attended the emergency, and all concurred that the man died well before the officers found him. He was cold, and could not be moved from the seated position the rigor mortis had left him in.) In the circumstances, the paramedics were unwilling to certify death without a doctor, given the confusing readings provided by the ECG monitor. The readings were thought to be caused by the amount of metal fixtures and fittings in close proximity to the man, which interfered with the device. The healthcare principal officer (PO) offered to provide the paramedics with the prison's own ECG monitor, but it was felt that the best option was to await the expert opinion of a doctor.

89. The head of healthcare contacted the control room and asked for the duty doctor to be notified. She also asked staff to contact another doctor, who was in any case due to come to the prison to hold a surgery at 9.00am.

90. The prison doctor does not carry a pager. She left home at 8.20am and arrived at her practice at 8.30am. She did not receive a telephone call either on her landline number before she left home or on her mobile telephone before she went straight into a meeting at 8.30am. (When she returned to her

mobile phone at about 10.30am, she noticed that she had missed calls from the healthcare PO and immediately contacted the prison. She subsequently went to the prison later that day to support staff members.) The doctor due to hold a surgery told the investigators that she did not receive a telephone call before she arrived at the prison at about 9.00am to begin her normal shift.

91. The Governor of Cardiff had reached B1 landing ten minutes after the man was found. Another governor had arrived on the landing and agreed with the duty governor that he would open the command suite (a designated office next to the prison's control room from where staff coordinate the response to an emergency). When he arrived in the suite, the governor who had agreed to open the suite found that the room was not ready for use. The 'wipe clean' wall boards were covered in writing from a previous emergency exercise. He also found that the three keys used to open cabinets where emergency materials are kept were not clearly labelled.

92. The two officers who found the man were both sent to a quiet room as soon as healthcare staff arrived in the cell. At about 8.40am, one of the officers was spoken to by the care team and then he and the other officer were sent home by the duty governor at about 9.30am.

93. When the doctor who was due to hold a surgery reached the prison gate, the head of healthcare had left a message for her and she was instructed to go directly to B1 landing. Arriving on the unit, she looked at the ECG printout and then went into the cell to examine the man. She was accompanied and supported by the head of healthcare. The doctor checked for heart sounds and breathing, and confirmed rigor mortis and hypostasis. She thought that the man had been dead for several hours and certified death at 9.14am, an hour and a half after he was found. The paramedics then left the prison.

94. Having identified the man's next of kin, the Governor, the safer custody manager and the prison chaplain left Cardiff at about 9.00am to break the news to his family. They arrived at his mother's house at 9.40am. Having visited her, they then tried to telephone the man's fiancée. Because they were initially unable to contact her, they began the return journey to Cardiff. However, they then managed to get in touch with the man's fiancee and retraced their steps to visit her immediately.

95. The man's personal officer was asked by the police to identify his body later that morning. A hot debrief meeting involving staff members present during the emergency was held at 2.30pm that day. (This meeting allows staff to discuss the effect the death has had on them and to identify any immediate lessons which need to be learnt from the emergency.) At 3.30pm, the Governor and a colleague visited the family again.

96. A confidential critical incident debrief arranged by the staff care and welfare service was conducted over 17 and 18 March. Staff were provided with the appropriate support following the man's death and were offered the chance to speak with the care team if they felt the need. The man's funeral, paid for by

the Prison Service in accordance with national instructions, was held on 24 March.

ISSUES

Substance misuse

97. Before he entered prison, the man misused drugs (including heroin) and alcohol. When he arrived at Cardiff, it was agreed that his prescription for methadone would continue. He was maintained on the same daily dose of 65mg of methadone until 9 March.

98. The clinical reviewer is satisfied that the man was prescribed the appropriate medication to assist a managed withdrawal from alcohol misuse. He completed the main part of the detoxification process (a course of diazepam on a reducing dose from 26 February to 4 March) but did not complete the full 14 day courses of carbmazapine and thiamine (intended to help with the side effects of detoxification). The man appears to have chosen not to collect this medication after 6 March. The reason he did not complete the detoxification process was not recorded in his medical file. The clinical reviewer makes the following recommendation, which I endorse.

    If a prisoner does not complete the detoxification process, the Head of Healthcare should ensure that staff note the reason why in their medical record.

99. The man was referred to the CARATS team by a member of healthcare staff on 2 March. The CARATS team received the referral on Friday 6 March and arranged an assessment on the next working day, Monday 9 March. A CARATS worker assessed the man. Normally, she said that prisoners with a drug problem would be seen by her team within 48 hours of their arrival on the detoxification unit. However, because the man was found with drugs on 27 February and taken to the segregation unit, the normal referral process was interrupted. The man did not return to the detoxification unit and instead moved onto A wing.

100. Given that the usual referral process was interrupted, I consider that the delay in the assessment taking place was understandable. However, I am concerned that the apparently slow internal postal system meant that the referral took four days to reach the CARATS team. In order to avoid a similar delay in future, sending referrals to the CARATS team electronically could be explored by the management team.

101. When he spoke to the safer custody manager on 9 March, the man admitted that he had been misusing illegal drugs as well as taking his methadone prescription. He was found with a significant quantity of different illegal drugs in his cell on his second day in Cardiff, and it was thought that he had brought them into the prison from court. The man also had a number of small packages secreted in his body which were confiscated. He seemed to have used some of the drugs when he came to the attention of staff. The SO noticed that his behaviour was odd when he was in the segregation unit between 27 February and 1 March. He was disoriented and giggly and it was thought that he was under the influence of drugs.

102. The SO also thought that the man was under the influence of drugs a week later in the afternoon and early evening of 9 March. She saw him shivering and thought he showed signs of paranoia. However, the toxicology report showed that the only substances present after death were methadone, diazepam and carbmazapine. In other words, prescribed drugs in quantities that were to be expected. The results confirmed that the man had not misused illegal drugs before he died, although the toxicologist stressed at the end of her report that,

> 'In cases involving hanging, death may have occurred before any ingested drug could be absorbed into the blood. Hence, it is difficult to determine whether excessive ingestion of drugs has occurred immediately prior to death.'

103. However, the clinical reviewer told my colleagues that, if the man had been under the influence of drugs at about 5.00pm on 9 March (when the SO became concerned about him), there would have been enough time (prior to the orderly officers final conversation with the man at about 11.00pm) for them to be absorbed into his blood stream and show up on the test results. (At the earliest the man died around midnight.) The man's stomach was empty, indicating that he had not eaten his meal either, as the SO thought he had. It seems almost certain that the man was not under the influence of additional illegal substances during the afternoon and evening before his death.

104. As I have noted, the orderly officer spoke to the man around 11.00pm and noticed that he was agitated and tearful. He was making baffling claims about the IRA harming his family. It may be that he had taken an illegal drug at this stage, and took his own life impulsively immediately afterwards. In these circumstances, there is a remote possibility that the drugs had not been absorbed into his system and therefore did not register in the blood and urine tests completed by the toxicologist. However, I note that the orderly officer thought that the man calmed down once he was told that his mother was safe, which seems to indicate that his anxiety was not connected to drug use.

Bullying

105. When the man asked to be moved to the therapeutic unit on 9 March, he told the personal officer that he was being bullied. He named a specific prisoner and said that he was being accused of making racist remarks from his cell window. (I note that staff told my investigators that the prisoner concerned is white. The man was also white.) The man wanted to be moved for his own protection. This happened unexpectedly and he had not given any indication previously to staff that he was the subject of bullying. The personal officer acted swiftly and appropriately by removing the man from A wing.

106. Once the man had been moved to B1 landing, his personal officer thought he should be assessed by the violence reduction coordinator (who is responsible for exploring allegations of bullying). However, the violence reduction coordinator was not working that day, and in his place the safer custody

manager, who works alongside him, conducted an interview with the man. The man was reluctant to disclose any further details with regard to the bullying. The safer custody manager arranged for the violence reduction coordinator to interview the man the next day.

107. After the man died, two prisoners made claims regarding the allegation of bullying. One wrote to his partner stating that the man had been threatened by three black prisoners who accused him of being racist. Staff intercepted this letter and this prisoner was interviewed by a governor and the violence reduction coordinator on 11 March. He declined to elaborate on the allegation during that interview.

108. On 12 March, the prisoner who shared a cell with the man told a member of the CARATS team that he had heard about three black prisoners going into the man's cell. He implied that these prisoners were upset after rumours had circulated about the man using racist language. This CARATs worker did not find the cellmate's account particularly credible. She submitted a Security Incident Report.

109. Later that month, on 23 March, the safer custody manager and the violence reduction coordinator interviewed the prisoner who the man had named when he asked to be moved from A wing on 9 March. This prisoner denied knowing the man well or having any significant interaction with him. Without prompting, he alluded to drugs and said he had nothing to do with them, which confused his interviewers.

110. After the man died, the cellmate asked to share a cell with the prisoner the man had named on 9 March. Both men were subsequently monitored covertly by staff. The cellmate transferred to HMP Shrewsbury on 31 March and was later released, whilst the other prisoner was released from Cardiff on 7 April. (The cellmate has yet to be either questioned or charged in connection with his alleged role in bringing drugs into Cardiff.)

111. My colleague interviewed the cellmate when he visited Cardiff on 16 March. The cellmate said that he was not aware of any particular person bullying the man. He confirmed that he had heard allegations of racism against the man from other prisoners.

112. It was difficult for prison staff to substantiate the rumours that circulated after the man died. Steps were taken to interview the prisoners who it was thought might provide more detailed information, but they were reluctant to discuss the matter any further. Their subsequent departures from Cardiff stymied further lines of enquiry and meant that the investigators did not speak to them.

113. The prisoner who the man identified on 9 March alluded to drugs. Whatever difficulties the man might have encountered were quite possibly linked to the significant quantity of drugs he was alleged to have brought into the prison on 26 February. They were all confiscated the next day. Both the police and prison staff suspected (with good reason) that the man had agreed to bring

the drugs into custody to supply them to other prisoners. There were too many drugs of different kinds to have been solely for his personal use.

114. The man presumably planned to take the drugs into Cardiff before he was resentenced and secreted them on his person prior to arriving at court. The drugs would have been worth a great deal more in prison than in the community.

115. When the man returned from the segregation unit on 1 March, it seems likely that he would have had to explain to other prisoners what had happened to the drugs they were supposed to receive from him. A prisoner who was a good friend of his told my colleagues that the man continued to promise drugs to other prisoners after his supply was confiscated even though there was no prospect of him being able to honour his promise. When the other prisoners realised this, it seems safe to presume that they would have been displeased.

116. The investigators have been unable to substantiate either the claims of racist remarks said to have been made by the man or the subsequent reprisals by prisoners from a black or minority ethnic background. There is no evidence that the man held racist beliefs or that he was involved in any previous racially motivated incidents in custody.

117. It can be unhelpful to speculate on what often amounts to hearsay. The facts tell us that the man arrived at Cardiff with a large amount of drugs on his person. They were confiscated, which would almost certainly have had consequences for him. The man told his personal officer that he was being bullied and the personal officer acted quickly in removing him from A wing. He was taken to the therapeutic unit for his own protection and was no longer the subject of bullying. This was the appropriate measure for prison staff to take at the time. The matter was followed up by the safer custody manager and the violence reduction coordinator planned to meet the man on 10 March.

118. We cannot know what impact this stress had on the man. He did not leave a suicide note. He does seem to have been worried about his family's safety in the hours before he died, albeit he was making irrational claims about the IRA targeting them. It is possible that the man feared that they would be victimised if he did not repay the debt he might have owed.

The Governor should remind staff of the importance of assessing the vulnerability of any prisoner alleged to have committed a serious offence within the prison.

Communication

119. A number of failures to communicate information may also have had an impact on the man's situation. When the CARATS worker interviewed him on 9 March, she had not been told about the significant amount of drugs which the man was alleged to have brought into custody. She told my colleagues that the information would have affected her assessment of the man's drug misuse and caused her to ask him different questions. The referral to the

CARATS team came from the healthcare team after the man was released from the segregation unit, rather than from the detoxification unit where the drugs were found, which perhaps explains why the breakdown in communication occurred.

The CARATS team should be informed when a prisoner is alleged to have illegal drugs.

120. Similarly, the movements officer did not know about the adjudication regarding the drugs find when he allowed the man to share a cell with his cellmate when they left the segregation unit. Both men were alleged to have brought drugs into prison, and both faced being charged with the serious offence of possessing drugs with intent to supply them to other prisoners. In these circumstances, allowing the men to continue sharing a cell was something that should have been considered carefully. Whilst it was not obligatory to separate the two men, it would have been good practice to avoid the possibility of the two co-defendants influencing or interfering with each other, and separate wings would have been more appropriate. The movements officer was not privy to the relevant information, although he told the investigators that it would not have affected his decision.

The Governor should consider whether it is wise for prisoners who are jointly implicated in committing an offence in custody to share a cell. Staff asked to locate the prisoners should be told the facts of the alleged offence before they make the decision.

121. The prison doctor did not know the reason the man was held in the segregation unit when she completed a Segregation Safety Algorithm on 28 February. She was unable to locate his medical record either, as it had not followed him from the detoxification unit. She therefore made her assessment without access to all of the pertinent information.

122. No history of suicidal thoughts or self harm was detailed in the medical record, but the prison doctor would not have been able to know this. Although the doctor's dedication in checking the prisoners in the segregation unit and her concern for the man are to be commended, healthcare staff should check the prisoner's medical record for relevant information before the algorithm is completed. Prison Service Order 1700 requires the member of staff to record their findings in the medical record after they have completed the assessment.

123. When she spoke to the SO on the telephone on 9 March, the prison doctor was again unable to refer to the man's medical record, which had still not been returned to the central filing system in the healthcare centre.

The Head of Healthcare should review the movement of prisoners' medical records to ensure that staff can promptly locate them.

The Head of Healthcare should ensure that all healthcare staff who carry out Segregation Safety Algorithms consult the prisoner's medical record and make an entry about their findings.

124. Late in the evening on 9 March, the orderly officer spoke to the man, who was agitated and expressed an irrational fear about his family being targeted by the IRA. The orderly officer dealt with the situation, tried to reassure the man and left the therapeutic unit thinking that he had calmed him down. He told my colleagues that he was unaware of the SO's earlier interaction with the man and the decision to refer him to a psychiatric nurse. (The officer responsible overnight thought he had been told about the SO's earlier dealings with the man by the orderly officer, but the latter did not think he knew the information when he spoke to the man.)

125. It is difficult to know whether the orderly officer would have made a different decision (such as calling a healthcare worker across to examine the man) had he been aware of similar concerns earlier that day and identified a pattern of anxious behaviour. The SO had not noted her concerns in the wing observation book on B1 landing, and the orderly officer did not make a note of his later interaction either.

Staff should make clear entries in the wing observation book and the prisoner's wing history sheet when they have concerns about an individual's state of mind.

Whether an Assessment, Care in Custody, and Teamwork (ACCT) document should have been opened

126. The investigators spoke to a considerable number of staff who met the man at various times between 26 February and 9 March. None of them ever felt that he was at risk of harming himself or taking his own life. At no stage was a member of staff sufficiently worried about him to consider opening an ACCT document. Throughout the man's time in Cardiff, he was asked a number of times whether he had considered harming himself, and on each occasion he said 'no'.

127. The man's decision to take his own life was unexpected. This was not his first time in custody. He had not been the subject of an ACCT document during previous custodial sentences. There was no history of deliberate self harm other than apparently accidental overdoses from misusing drugs. The man was described as a good natured prisoner who fitted in with the prison regime. He did not present as somebody who was particularly depressed or chaotic. He knew that he would be released within a matter of weeks and he talked about his forthcoming marriage.

128. However, as I have considered in the section titled 'Bullying', the man may have had significant anxieties about the drugs confiscated from him on his second day in custody. It seems likely that he brought the drugs into Cardiff to sell them on to other prisoners. Even when he no longer had the drugs, it appears that he continued (perhaps unwisely) to tell prisoners that he could supply them. It is possible that he was trying to repay a debt by smuggling drugs into Cardiff. If this was the case then his predicament may have been aggravated when the drugs were taken off him.

129. The man faced the prospect of a much longer prison sentence if he was convicted of possessing drugs with the intent of supplying them to other prisoners. He might not have been released as he hoped, within a couple of weeks, but could instead have been remanded into custody until a trial was held.

130. On 9 March, the man was interviewed by the CARATs worker in the morning and the safer custody manager in the afternoon. Neither was given any reason to believe that the man was thinking of taking his own life. The CARATs worker remembered the man being optimistic and having a positive attitude.

131. The safer custody manager assessed the man after he transferred to B1 landing. He had calmed down after being brought to the therapeutic unit by his personal officer. The safer custody manager asked the man about any suicidal thoughts, as did his personal officer when he escorted the man across from A wing. (The personal officer noticed that the man's mood improved after he was removed from A wing.)

132. One of the officers noticed that the man became agitated later in the afternoon after he settled onto B1 landing. He became anxious that the other prisoners were labelling him as a sex offender even though they were not. He continued to behave unusually, refusing to come out for dinner and sitting shivering in a blanket on his bed.

133. From about 4.30pm on 9 March, the man's state of mind seemed to deteriorate. Having spoken to all four members of staff, my colleagues consider that the officer, the SO, the prison doctor and the orderly officer acted with the best of intentions. I do not believe they could realistically have predicted that the man might harm himself. On balance, I am satisfied that it is not reasonable to have expected them to open an ACCT document and keep the man under additional observation.

134. All four staff were required to make difficult judgement calls. There were certainly indicators that all might not be well, and the man presented as irrational and agitated. However, he did not voice suicidal thoughts and there was no supporting history of self harm. Staff showed considerable concern when the man's mood altered and took the action they thought appropriate at the time.

135. An SO was sure that the man was under the influence of drugs in the late afternoon and early evening. This seems to have been a reasonable assumption given his history of substance misuse and his presentation on the day. However, the toxicology report appears to disprove this assertion. Although the man was experiencing feelings of paranoia and anxiety he had not used drugs. The SO knew the man quite well from his previous stays in Cardiff. She spent a considerable amount of time chatting with him, fetching his meal and then calling the doctor.

136. It certainly seems to have been an appropriate decision by the SO and the prison doctor to refer the man to a psychiatric nurse the next day. He was presenting with anxiety and seemed to be behaving oddly. The doctor offered to visit him at the time, but the SO thought this was unnecessary. I consider that this was a reasonable decision. The SO had spent time talking to the man and knew that he had not been the subject of an ACCT document in the past. She satisfied herself that the man was not having suicidal thoughts after his arrival on B1 landing. Because there was no perceived risk of him harming himself, the decision not to have him assessed by the doctor immediately, but to book a less urgent appointment, was understandable.

137. In the Ombudsman's report of an investigation of the self-inflicted death of another prisoner at Cardiff in June 2007, I commented on a similar set of circumstances:

> 'Although his behaviour was bizarre, [the man] did not present as suicidal. It was … reasonable for staff to consider him as non-urgent.'

138. The Ombudsman's report of the earlier investigation commented on the difficulties staff had in understanding whether the man's symptoms of anxiety and odd behaviour were due to drug withdrawal or mental health problems. I suggested that a urine test or mental health assessment would have clarified the situation. Whilst the SO arranged for a psychiatric assessment, there does not seem to have been a facility available to dismiss or confirm her suspicions about the man's drug misuse. I therefore amend my recommendation from the earlier report in the hope that it assists staff identify why a prisoner's mood has altered:

    The Governor should consider whether urine drug tests could be carried out on prisoners (with their consent) if they are behaving unusually and staff suspect that they are experiencing serious withdrawal symptoms or are under the influence of drugs.

139. The SO told the man about the appointment with the psychiatric nurse the next day and checked that he had calmed down before she finished her shift. An officer also checked that the man was calmer before he left for the night.

140. The orderly officer was the only other member of staff to have any contact with the man that night. He took time to speak to the man more than once, something confirmed by a fellow prisoner who was awake in a nearby cell. The orderly officer listened to the man's concerns and dealt with them calmly. He offered reassurance and felt that he had reduced the man's agitation.

141. It does not seem that the orderly officer was fully aware of the SO's dealings with the man earlier that evening (as I have already highlighted). Had the orderly officer known that the man's agitation was part of a pattern, it might have affected his decision about what to do. The orderly officer told the investigators that he would have taken the man over to the healthcare centre and placed him in a cell with a camera if he thought there was a possibility of

him taking his life. However, the man did not express any suicidal thoughts to him.

142. The man's death was unexpected and would seem to have been a very sudden and impulsive decision. He never voiced his intention to any staff. He planned for the morning by hanging a sheet over the back of his bunk to block the sunlight coming through the cell window and stop himself being woken early.

143. The man took deliberate actions to kill himself in the early hours of the morning. He used an unusual method, tying two ligatures to the top bunk and, I assume, shuffling his weight off the lower bunk. This meant that the officer mistakenly thought that the man was sitting up in bed when he glanced through the observation flap.

144. On balance, I am satisfied that reasonable decisions were made by staff based on what the man told them. He did present as anxious and tearful on 9 March, but they took steps to help and reassure him, for example by moving him onto a different wing, interviewing him, ringing the doctor and offering to contact his family. I consider that the decision to refer him for psychiatric assessment, but not to open an ACCT document, was justified based on the fact that the man had never previously spoken about suicidal thoughts. For the same reasons as I have just discussed, it was also not unreasonable for staff to place him in a single cell for the night.

Confirmation of death

145. The man was found in his cell at 7.45am. My colleagues spoke to a number of staff who attended the emergency, and there was no doubt in their minds that the man had died several hours earlier. He was cold, his body was stiff and fixed in a seated position. It is clear that rigor mortis had set in by the time the man was found. In this situation, staff are not expected to start resuscitation, as it is an indication that death has occurred.

146. The paramedics were called and reached the therapeutic unit at 8.00am. They agreed that the man had died and attached an ECG machine for official confirmation. Unfortunately, due to a fault, the monitor gave a false reading and indicated a heart rate. Although all the healthcare staff knew the man had died, the paramedics wanted a doctor to confirm death and override the erroneous reading provided by their equipment.

147. The head of healthcare asked the control room to contact the duty doctor and the doctor who was due to begin a surgery in the prison at 9.00am. The duty doctor was available on her home landline until 8.20am, and on her mobile phone until 8.30am. After this she went into another room at her surgery away from her mobile phone. When she returned to it later in the morning, she found messages from the healthcare PO.

148. The doctor who was due to begin a surgery did not receive a telephone call. She arrived as normal at 9.00am at the prison gate, where the head of

healthcare had left a message directing her to B1 landing and informing her that there had been a death in custody. The doctor who was due to begin a surgery made her way promptly to the therapeutic unit and, accompanied by the head of healthcare, carried out the appropriate checks and certified death at 9.14am.

149. It is unfortunate that the ECG monitor did not work as it should have done. It is also regrettable that, despite the head of healthcare's instructions, neither doctor could be contacted earlier to avoid a delay of over an hour in confirming death. Nonetheless, it is clear from the interviews that the man died before his cell was unlocked. I am satisfied that all of the appropriate measures were taken, and the paramedics acted with the best of intentions in waiting for the doctor. The clinical reviewer makes the following recommendation, which I endorse. (However, I note that the remit of the Ombudsman's investigation does not extend to the Ambulance Service, and therefore I can only draw their attention to the recommendation.)

The Welsh Ambulance Service should satisfy themselves that their ECG monitors are functioning correctly.

Post mortem results

150. Having viewed her son's body, the man's mother was concerned that it seemed as if his fingers were broken. The post-mortem report concluded that the man died as a result of hanging, after tying a ligature around his neck. The author found that the man's fingers were not broken but were bruised. He commented,

> 'There were a few marks of blunt force trauma, particularly bruises, on other parts of the body, specifically two knuckles of the right hand. None of these injuries were characteristic of 'restraint'.'

151. The post mortem makes it clear that the man took his own life and there is no evidence of any other person restraining him. The police investigation similarly concluded that this was a self inflicted death. I hope that the pathologist's conclusion puts the man's mother's mind at rest.

Cell bell recording

152. The cell bell records for B1 landing on the night of 9 and 10 March could not be retrieved after the man died, as the computer had developed a serious fault. The prison was not able to say precisely when the computer developed the error but staff said that it probably occurred at some point in the preceding two or three weeks. The machine was corrupted beyond repair and had to be replaced, leaving the prison without a cell bell recording system for over a month afterwards. The data relating to cell bell records was initially retrieved onto a CD-Rom, but was corrupted and could not be recovered.

The Governor should remind staff of the importance of regular checks to ensure that the cell bell recording system is functioning correctly.

Command suite

153. After the man was found, a governor went to open the command suite. (This is located next to the control room and is the focus of communication whilst an emergency is ongoing.). He discovered that the room was not ready for immediate use. The 'wipe clean' wall boards were still covered in writing from a previous emergency. The keys used to open cabinets where emergency materials are kept were not clearly labelled.

154. I am pleased to learn that, when the governor spoke to my colleagues, he told them that both problems were swiftly rectified. He said that new electronic interactive wipe boards have been installed. They were used during a subsequent emergency and found to be very effective. The keys and cabinets in the command suite have now been clearly labelled to avoid any further confusion.

Use of mobile phones during an emergency

155. When the investigators spoke to some members of staff, they expressed their frustration at not being able to carry a mobile telephone during the emergency. (In order to reduce the likelihood of prisoners gaining access to mobile telephones, it is now an offence for staff or visitors to carry one inside a prison.) On the morning the man was found, it was felt that the limited communication afforded by landline telephones was insufficient for the amount of communication required with external agencies such as the coroner, police and doctors.

156. Since 10 March, it has been decided that, in the event of an emergency, staff will be able to use six mobile telephones located in the command suite. They are normally reserved for officers escorting a sick prisoner to hospital or the unlikely event of both the radio net and landline telephones failing.

CONCLUSION

157. I consider that the man's death could not realistically have been predicted or therefore prevented. A number of different staff showed appropriate concern for him on 9 March and acted reasonably based on the information available to them at the time. Their actions were well intentioned. Their judgement in not opening an ACCT document was understandable. The man's decision to take his own life seems to have been both unexpected and impulsive. My investigation has drawn particular attention to a number of failings to effectively communicate information within Cardiff, and I hope that some lessons can be learned in this regard.

RECOMMENDATIONS

1. If a prisoner does not complete the detoxification process, the Head of Healthcare should ensure that staff note the reason why in their medical record.

   The prison accepted this recommendation. The Head of Healthcare agreed that nursing staff would provide the reason for a prisoner not completing a prescribed detoxification process in their medical record.

2. The Governor should remind staff of the importance of assessing the vulnerability of any prisoner alleged to have committed a serious offence within the prison.

   The prison accepted this recommendation, replying as follows:

   'Any prisoner who is alleged to have committed a serious disciplinary offence is assessed, this is achieved by the completion of the Segregation algorithm and the judgement of the adjudicating Governor.'

3. The CARATS team should be informed when a prisoner is alleged to have illegal drugs.

   The prison partially accepted this recommendation, replying as follows:

   'The CARATS Team will be informed once a prisoner is proven to have been in possession of illegal drugs. There is a concern, especially for life sentence prisoners who are subject to parole hearings, that if a CARATS File is initiated on suspicion only, this might influence a decision regarding an individual's release by the panel.'

4. The Governor should consider whether it is wise for prisoners who are jointly implicated in committing an offence in custody to share a cell. Staff asked to locate the prisoners should be told the facts of the alleged offence before they make the decision.

   The prison partially accepted this recommendation, replying as follows:

   'Individuals can be located together if they are co-defendants of a crime in the community. Once an offence is committed in custody this should not automatically stop two prisoners sharing a cell as they may be a support to each other. All facts should be provided to wing staff of the offence committed within custody and a risk based decision can then be made regarding location.'

5. The Head of Healthcare should review the movement of prisoners' medical records to ensure that staff can promptly locate them.

   The prison accepted this recommendation. The Head of Healthcare has issued a notice to healthcare staff regarding this matter.

6. The Head of Healthcare should ensure that all healthcare staff who carry out Segregation Safety Algorithms consult the prisoner's medical record and make an entry about their findings.

   The prison accepted this recommendation. The Head of Healthcare has issued a notice to healthcare staff regarding this issue and agreed to regularly monitor compliance.

7. Staff should make clear entries in the wing observation book and the prisoner's wing history sheet when they have concerns about an individual's state of mind.

   The prison accepted this recommendation. The Governor indicated that quality control checks of personal officer scheme files and wing observation books will be carried out.

8. The Governor should consider whether urine drug tests could be carried out on prisoners (with their consent) if they are behaving unusually and staff suspect that they are experiencing serious withdrawal symptoms or are under the influence of drugs.

   The prison accepted this recommendation. The Governor confirmed that Cardiff conduct regular mandatory and voluntary drug testing.

9. The Welsh Ambulance Service should satisfy themselves that their ECG monitors are functioning correctly.

   No response had been received from the Welsh Ambulance Service at the time the final report was published.

10. The Governor should remind staff of the importance of regular checks to ensure that the cell bell recording system is functioning correctly.

    The prison accepted this recommendation. The Governor has asked the works department to remind staff of the importance of regular checks to ensure that the cell bell recording system is functioning correctly.

THE FAMILY'S RESPONSE TO THE DRAFT REPORT

The Family Liaison Officer spoke to the man's brother towards the end of November 2009. He told her that the family did not wish to make any comments about the draft report.