

**The circumstances surrounding the death of a male prisoner
at HM Prison Cardiff on 6 February 2006**

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

July 2006

This is the report of an investigation into the circumstances surrounding the death of a male prisoner at HM Prison Cardiff on 6 February 2006. The prisoner, who was aged 56, was found hanging in his cell shortly after 6.00am. At the time of his death, he was serving a life sentence for causing grievous bodily harm.

A post mortem examination conducted on 8 February 2006 by a pathologist, confirmed that the prisoner's death was caused by hanging.

The investigation was carried out by two of my colleagues. I also commissioned an independent clinical review of the management of the prisoner's health needs while he was in custody.

I should like to thank the Governor and staff at Cardiff for their ready help and co-operation during the course of my investigation.

The prisoner had given staff no reason to suppose he might make an attempt on his life, and in general terms Cardiff prison emerges well from this investigation. I have been particularly pleased to note the comments from the prisoner's family about the support and care they received in the aftermath of his death. However, the investigation also draws attention to gaps in Cardiff's emergency response procedures. Although they had no adverse effect on the events described in this report, unless remedied they could do so on a future occasion.

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1. Summary

The prisoner appeared before magistrates on 21 May 2003, charged with causing grievous bodily harm. He was remanded in custody at Swansea prison that day. He had been in prison many times before.

A Prisoner Escort Report, completed by a police officer, drew attention to a risk of self-harm or suicide as the prisoner had attempted to take his own life after the loss of his second wife in 1999. However, during the health screening process carried out upon his arrival at Swansea prison, the prisoner was not considered to be suicidal.

On 11 September 2003, the prisoner was sentenced to life at Merthyr Tydfil Crown Court. He was given a tariff - the minimum time he should serve for the purposes of retribution and deterrence before parole can be considered - of two years and nine months. After being sentenced, he was transferred to Parc prison near Bridgend where, for the first 24 hours, he was kept in the healthcare centre for observation as a precautionary measure. Although he was tearful the next day about being given a life sentence, he was not considered to be suicidal. On 12 September, he was discharged from the healthcare centre to a residential wing.

The prisoner spent a further 13 months at Parc, engaging in offending behaviour programmes, and gaining for himself a reputation as a hard working and respectful man. At no stage during that period did he show any signs of being depressed, anxious or suicidal.

On 29 October 2004, the prisoner was transferred to Cardiff where there is a dedicated lifer unit. He was not seen by a doctor when he arrived.

The prisoner's time at Cardiff was similar to his experience at Parc. He engaged successfully in further offending behaviour programmes and worked hard. He undertook a National Vocational Qualification (NVQ) level two in Performing Manufacturing Operations.

In March 2005, the prisoner received news that a close family member had been admitted to hospital and he was visibly distressed by this news. However, he soon recovered and continued to apply himself to his work.

Although the prisoner was initially unclear and somewhat apprehensive about the implications of being given a life sentence, he presented himself in a favourable light in anticipation of a parole review scheduled to take place in April or May 2006. He seemed to approach his time in custody positively. The only time he came to the attention of the doctor was in December 2005 when he complained of pains in his shoulder.

However, in January 2006, the prisoner made it known that he was having difficulties in his relationship with his partner. On one occasion she failed to visit as planned. He told a psychologist that he thought his partner was having an affair. He explained that during a visit his partner had reassured

him that the affair was over. He told the psychologist that he felt better having received that reassurance. However, during the afternoon of Sunday 5 February, he made several attempts to telephone his partner but on each occasion there was no answer. A member of staff helped by using an official phone to try to call the prisoner's partner on an alternative number, but this too failed. When told by the same member of staff that he would help him to make another attempt to contact his partner the following morning, the prisoner seemed to accept and showed no adverse reaction.

The prisoner was found hanging in his cell just after 6.00am the following day. A letter found in his cell contained his apologies for taking his own life and an explanation for doing so.

The investigation found that although, shortly before his death, the prisoner was anxious about his relationship with his partner, at no stage did he show any signs that he was contemplating taking his own life. I am satisfied that the prisoner was properly cared for at Swansea, Parc and Cardiff prisons.

When he was discovered hanging, it was clear to those who found him that the prisoner was already dead. As a result, the cell was not entered immediately, no attempts were made to revive him and no ambulance was called. In the circumstances, these decisions were not of critical importance. However, in a different set of circumstances they might be. I therefore make recommendations about the need to improve local contingency plans for the management of any life-threatening situation. I also draw attention to an example of good practice.

2. Investigation methodology

The investigation began on Thursday 9 February 2006 when my investigators met with the Deputy Governor, the chairman of the local Independent Monitoring Board (IMB), and the chairman of the local branch of the Prison Officers' Association (POA) at Cardiff. My investigators explained to them the nature and scope of the investigation and the report handling process.

On the same day, notices were issued to staff and to prisoners announcing the investigation and inviting anyone with concerns or information relating to the prisoner's death to make themselves known to my investigators.

On 14 March 2006, my investigator and my Family Liaison Officer visited the prisoner's sister and niece at their home to ascertain whether the family had particular matters they wanted the investigators to consider. The family praised both the manner in which they had been informed of the prisoner's death by prison staff and the support they had received from the Governor. The family expressed no specific concerns.

During the investigation, a number of medical, nursing and discipline staff were interviewed. Two prisoners also expressed their willingness to be interviewed but one later declined. The other, who was interviewed informally, wished to remain anonymous.

3. The deceased prisoner

The prisoner was born in December 1949.

In the 1960s and 1970s, he appeared before the courts on many occasions. As a result, he was sent to Approved School, to Borstal and to prison. Alcohol and drug related violence featured strongly in his behaviour.

In 1974, he married his first wife. During their marriage, the prisoner continued to commit crimes and he spent many years in prison. In 1989, his marriage ended.

Two years later, the prisoner remarried. Tragically, his second wife died of cancer in 1999. The prisoner took this badly and became depressed.

On 15 May 2003, he had an argument with another man and struck him about the head several times with the butt of a replica gun and a metal bar. He was later arrested and charged with causing grievous bodily harm. On 11 September 2003, he was sentenced to life. He was given a tariff of two years and nine months. He was initially held at Swansea prison. After being sentenced, he was transferred to HMP Parc. On 29 October 2004, he was transferred to HMP Cardiff.

At Cardiff, he was described as polite, respectful and very hard working. He tended to keep his own company. His death came as a shock to all who knew him.

The prisoner was 56 years old when he died.

4. Cardiff prison

Cardiff prison, situated in the town centre, is a local and training prison. It can hold up to 754 adult male prisoners. The prison has six residential units, one of which is used exclusively to hold life sentence prisoners. The prison also has a detoxification unit for up to 52 prisoners and a healthcare centre that provides 24 hour nursing and medical cover and beds for up to 16 in-patients.

In February 2005, Cardiff was inspected by Her Majesty's Chief Inspector of Prisons. The report of that inspection commented as follows:

“Two years ago we described Cardiff prison as being at a crossroads as it struggled with competing pressure, including the inexorable rise in population. This unannounced follow up inspection records that Cardiff had achieved a great deal despite these unpropitious circumstances. We found that most of our recommendations had been implemented and in some key areas, the prison had gone significantly further.”

Lord Carter of Coles, a non-executive member of the Home Office's Group Executive Board and author of the Report of the Review of the Correctional Services that led to the establishment of the National Offender Management Service (NOMS), visited Cardiff on 21 December 2005. He commented on his visit as follows:

“I have been in a large number of prisons both in this country and in other parts of the world and against that background I have to say that Cardiff was one of the best establishments that I have ever visited. From the first moment the appearance of the building, the friendly attitude of staff and the air of professionalism were manifest.”

During the course of this investigation, my investigators too found that Cardiff was a friendly and progressive establishment. Staff/prisoner relationships were good and the wings were kept spotlessly clean.

5. Events prior to 6 February 2006

HMP Swansea: 21 May 2003 - 11 September 2003

On 21 May 2003, the prisoner appeared at Merthyr Tydfil Magistrates' Court, charged with causing grievous bodily harm. He was remanded in custody at HMP Swansea. The Prisoner Escort Report (PER), completed by the escorting staff for the journey between court and prison, noted that he was of a violent nature and presented a risk of self-harm. The signature of a Police Constable is shown on the form. My investigators were unable to trace that officer to verify why the police considered the prisoner to be at risk of self-harm. However, the Police Liaison Officer (PLO) at Swansea advised that the note almost certainly refers to the fact that, shortly after the death of his second wife in 1999, the prisoner considered taking his own life. The PLO did not think the note referred to any current (2003) desire by the prisoner to harm himself.

Upon his arrival at Swansea, the prisoner underwent a reception health screen conducted by a Healthcare Officer (HCO). The prisoner then told the HCO he had never suffered from any serious illness and that he had no worries about his general health. The prisoner admitted that he had used drugs in the past and was used to "drinking socially". He disclosed that he had been in prison before and that he had expected to be sent to prison for his current offence. The HCO noted on the health screen form that the prisoner told him that he was not currently taking drugs.

In answer to a number of questions about his mental health, the prisoner told the HCO that he had not suffered from any psychiatric illness and had never attempted suicide. The prisoner also said he did not currently feel suicidal. The HCO noted that the prisoner did not appear to be excessively withdrawn, depressed or anxious.

The following day, the prisoner was seen by a prison doctor, who noted in the medical record that there was evidence of a laceration on his arm, that he was on a normal diet and not taking any medication. The doctor described the prisoner as "stout and strong" and as being in good general health. He also described the prisoner's mental condition as "average" and made the following closing comment in the medical record:

"Psych 20 yrs ago suicidal"

My investigators asked the doctor to clarify the significance of this comment. He confirmed that, although he could not recall the details of his interview with the prisoner, he would have asked him if he had any psychiatric history. The doctor believes that the prisoner told him that 20 years previously he had been suicidal.

A cell sharing risk assessment completed that day concluded that, although the prisoner had a history of violence, his risk of harm to others was low and he could therefore be allocated to shared accommodation. The prisoner was

not considered to be suicidal and, appropriately, was not therefore made subject to any formal self-harm monitoring procedures.

Whilst at Swansea, the prisoner was tried at Merthyr Tydfil Crown Court. At no stage during or after his frequent appearances at court was any risk of suicide evident. On 11 September 2003, he was sentenced to life imprisonment. He was given a tariff of two years and nine months. (The tariff is defined as the minimum period of imprisonment that must be served for the purposes of retribution and deterrence.) On the same day, the prisoner was transferred to Parc prison near Bridgend.

HMP Parc: 11 September 2003 - 29 October 2004

Upon his arrival at Parc, the prisoner underwent a full health screen. During this procedure, it was noted that he had no history of self-harm, that he did not currently have any ideas of self-harm or suicide, and was not showing any current signs of anxiety or despair. Although it was not felt necessary to subject the prisoner to any formal self-harm monitoring procedures, the nurse who completed the health screen decided to admit him to the healthcare centre for a 24-hour observation period because he had just been sentenced to life imprisonment.

The next day, the prisoner was seen by another prison doctor, who wrote in the medical file that there were no indicators of any mental health problems and no current self-harm issues. However, the doctor did record, "20 years ago jumped off a building". No details of this event are recorded in the prisoner's file. On the same day, the doctor assessed the prisoner as fit to participate in activities in the prison's gymnasium.

The following entry was made in the prisoner's core record on 12 September:

"In good spirits this morning - breakfast time - but later on was tearful about sentence - it had just dawned on him."

The cell sharing risk assessment carried out on this occasion noted that the prisoner preferred to be put in a cell on his own because he acknowledged that he could sometimes become angry and aggressive. It was considered that, although the prisoner presented no immediate risk of harm to others, the risk would have to be reviewed regularly.

Later that day, the prisoner was discharged from the healthcare centre to A Wing, where he was allocated a single cell (A2-67). The medical record contains no references to the fact that the prisoner was discharged.

On 15 September, a Prison Custody Officer (PCO) completed a reception assessment. The PCO commented that the prisoner was "a very experienced inmate who seemed to have a good attitude" and that "no problems were expected". On the same day, another PCO carried out an induction assessment of risk. In the box on the proforma marked "Victim Awareness", the PCO noted that the prisoner had no self-harm history.

Further entries were made in the prisoner's core record showing that, in general terms, he remained in relatively good cheer. He seemed at his happiest when talking about his children. At other times, however, he became subdued when talking about his sister's illness.

On 13 March 2003, the following entry was made in his core record by a PCO:

"The prisoner is the most hard working cleaner on A4. Great help to staff. Would be suitable for open conditions as soon as his life sentence conditions allow."

On 6 April 2004, the following further entry was made:

"The prisoner is an exceptionally efficient wing cleaner and also helps staff anyway he can. His attitude and behaviour cannot be faulted."

The prisoner remained at Parc a little over a year, until 29 October 2004. Prison Service policy requires that a sentence plan is drawn up for all life sentence prisoners. Sentence plans should set out targets that help prisoners to reduce their dangerousness and address their offending behaviour sufficiently for them to be considered for safe release into the community. The records show that, whilst he was at Parc, the prisoner was set a number of offending behaviour targets relating to his use of drugs and alcohol and the need to improve his thinking skills. He completed a Reasoning & Rehabilitation (R&R) programme on 16 June 2004. The programme aims to enhance pro-social behaviour by improving cognitive deficits associated with offending through a number of carefully constructed group exercises. The prisoner attended all but one of the required sessions. He said that he had enjoyed the course and that it had helped him to think about different ways to solve problems in his life.

Whilst at Parc, the prisoner showed no signs of being at risk of self-harm or suicide. Although a number of entries were made in his medical record, none was suggestive of any mental health problems.

On 29 October 2004, the prisoner was assessed by the prison doctor as being fit for transfer to Cardiff. He was transferred that day.

HMP Cardiff: 29 October 2004 - 6 February 2006

Upon his arrival at Cardiff, the prisoner underwent a cell sharing risk assessment. The officer who conducted the assessment noted that the prisoner had never been, and was not currently, subject to any formal self-harm monitoring procedures. The prisoner was assessed as presenting a low risk of harm to others. He was allocated a single cell in E Wing, the prison's lifer unit.

There is no evidence that the prisoner was seen by a doctor when he arrived at Cardiff. The first entry made in his medical record is dated 7 January 2005. As was the case at Parc, few entries were made in the medical record at Cardiff and none referred to any mental health problems.

Numerous entries made in the prisoner's core record, principally by his Lifer Officer, show that he was regarded as a polite and respectful man who applied himself diligently to his work and to his offending behaviour courses. At interview, the officer told my investigators that the prisoner was initially confused as to how long he would have to remain in prison, but later became more knowledgeable about the life sentence system as it applied to him.

On 6 March 2005, the prisoner was told that a close family member had been placed in the intensive care unit at a nearby hospital. The prisoner was described as "ok but tearful" when he received this news. There are no other references to that event in his record.

On six occasions in the year he spent at Cardiff, the prisoner underwent voluntary drugs tests and proved negative on each. His behaviour was consistently of a high standard. He undertook further offending behaviour courses in keeping with the provisions of his sentence plan. In particular, he attended a course designed to help him develop a greater understanding of victim issues. The prisoner also undertook a NVQ level 2 in Performing Manufacturing Operations.

He always attended work punctually, and tended to keep company with few other prisoners. He was always polite to staff.

On 29 June 2005, the prisoner raised a formal complaint that, after having been at Cardiff for eight months, he had not been seen by a psychologist. He was concerned that a progress report was due to be written about him in September, that he had not yet commenced a CALM course (Controlling Anger and Learning to Manage it), and that he was still a category B prisoner. He was anxious that these factors could have an adverse effect on his parole application.

The prisoner received a holding reply to this complaint on 6 July. He was told that his allocated psychologist was currently on holiday. Arrangements were to be made for her to see him on her return. At interview, the psychologist told my investigators that she saw the prisoner on a number of occasions after she returned from her holiday and that she got to know him quite well. She regarded him as a straightforward and open man who was family orientated and highly motivated by his relationship with his partner and child.

The prisoner completed the CALM programme on 5 December 2005. At the end of the course, he expressed the view that it had helped him "to learn new relaxation techniques and to look at different points of view clearly, and not just in a judgemental way".

The prisoner also undertook counselling with a Probation Officer over a six week period. He felt that these sessions were beneficial. The Probation Officer discussed with him aspects of his history of drug and alcohol abuse, as he had been assessed as not being in need of any formal intervention by the local CARATs (Counselling, Assessment, Referral and Throughcare) team. The Probation Officer was particularly keen for him to address his propensity to drink to excess when he was not in a relationship.

On 26 October 2005, the prisoner's parole review report was completed by his Lifer Officer. The prisoner was described as "a quiet, polite person who causes staff no problems on the wing."

In the weeks leading to Christmas, the prisoner saw his psychologist on a number of occasions in connection with his forthcoming parole review. She told my investigators that the prisoner often talked about this partner and child during these interviews.

On 9 December 2005, a prison doctor saw the prisoner when he attended the healthcare centre to report that he was experiencing pain in his shoulder. This was the only contact the doctor had with him prior to his death. At interview, the doctor told my investigators that she regarded him as a relaxed, straightforward, nice and communicative person. She also said that, although he had been prescribed medication on a number of occasions for minor physical ailments, he had never been prescribed anti-depressants or sleeping tablets.

In January 2006, the prisoner told his Lifer Officer that he was having difficulty in his relationship with his partner. The officer told my investigators that the prisoner had also told him that he had experienced some difficulties when his partner failed to visit him on one occasion.

On Thursday 2 February, the psychologist saw the prisoner again. On this occasion, he talked to her at length about his partner. He told her that, during January, he thought his partner was having an affair. The prisoner explained that he was proud of the fact that he was able to deal calmly with this difficulty. He said that his partner had visited him and had reassured him that the affair was over. As a result, he felt better.

Events during the evening of 5 February 2006

During the afternoon of Sunday 5 February, the prisoner attempted to telephone his partner but on each occasion there was no answer. He therefore approached an officer to ask him if he could be allowed to make a further call that evening. At interview, the officer told my investigator that, at about 6pm, he unlocked the prisoner to allow him to call his partner. However, once again, there was no answer. The officer asked the prisoner if there were any other numbers on which he might be able to contact his partner. The prisoner replied that there was another number, but he could not use it as it was not included on his telephone account. The officer therefore called the number from an official phone. Again, there was no answer. The

officer told the prisoner that he would help him make contact with his partner the following morning. According to the officer, the prisoner accepted that offer and, when taken back to his cell, gave no adverse reaction or cause for concern.

The officer told my investigators that, at about 7.30pm that evening, he completed a roll check on the prisoner's landing. He remembers seeing him writing at his desk when he checked his cell. The officer saw nothing in the prisoner's demeanour that was suggestive of any risk of an imminent attempt on his own life. Shortly afterwards, the officer went off duty for the night.

Another officer was on duty in E Wing during the night of 5/6 February. When he took over from the day shift, no issues of concern were brought to his attention about any prisoner. The officer said that he was accompanied that night by an Operational Support Grade (OSG).

Between 8:45pm and 9pm, the officer checked cell E3.9. He opened the shutter on the cell door and saw the prisoner inside. The officer said that the cell light was off, but that the prisoner seemed fine. The officer had no cause to suspect anything was wrong. At interview, the officer pointed out that prisoners are not checked throughout the night unless they are subject to self harm monitoring procedures.

The wing was patrolled regularly throughout the night. There were no incidents of note. The prisoner did not press his cell alarm at any stage. My investigators spoke to the prisoners who were located in the adjacent cells. Neither had any conversations with the prisoner during the night and neither heard any unusual noises coming from his cell.

6. Events on 6 February 2006

The night patrol officer explained to my investigators that, at about 5:55am the following morning (6 February), he commenced his early morning roll check of E Wing. He checked the prisoner's cell at about 6:03am. He switched on the cell light from the outside of the cell and looked through the observation panel in the cell door. The officer said that he could see the prisoner suspended from the window of his cell by a ligature made from a bed sheet. The prisoner was facing away from his bed and was in a sitting position.

The officer went to the end of the wing to call for assistance over the radio out of earshot of other prisoners who might have been awake. He alerted the controller to a "Code Blue" incident (i.e. a hanging) and asked for the Night Orderly Officer (NOO) to attend. The NOO, who was on the centre, between A and D Wings, some 50 metres away from the officer, had his own set of keys that he could use to gain access to the prisoner's cell. The officer therefore did not break the seal on the pack containing his own set of emergency keys. In a statement given to the police, the officer said that he would not enter a cell on his own if he found a prisoner hanging. However, at interview, he told my investigators that this was not an accurate record of what he said to the police. He confirmed that he would enter a cell on his own in such circumstances. When asked why he did not enter the prisoner's cell immediately, he said that he knew at that point it was too late to be able to save the prisoner. He could see that the prisoner's face was blue, there was no noise, and there was dried blood on his face and chest. The officer said his instincts told him that the prisoner was dead.

When the controller received the officer's call for help, he switched the radio net to talk-through, whereby all stations could hear what was being said by everyone else on the net. The NOO heard the call for assistance, and, according to the officer, arrived at the prisoner's cell within about ten seconds. In the meantime, the officer tried to open his own sealed pack of keys. The NOO arrived before he succeeded, and used his own keys to unlock the prisoner's cell door.

The Night Orderly Officer went into the cell and was followed first by one officer then by another. On entering the cell, they noticed that the prisoner was wearing only track suit trousers and trainers. His chest was bare. His body was supported by an officer to enable the NOO to cut the sheet away from his neck using a special knife. While this was being done, it became evident that rigor mortis (rigidity of the joints and muscles) had set in. All three officers then laid the prisoner on the floor and placed pillows under his body to prevent him from rolling to one side. The NOO made a call for assistance to a staff nurse in the healthcare centre. Believing that the prisoner was already dead, no-one called an ambulance. They waited for the staff nurse to arrive. An officer said that, when the staff nurse arrived, he saw that there were no signs of life and asked for the doctor to be called. At interview, the staff nurse told my investigators that, when the Code Blue message was announced over the radio, he was in an office in the healthcare

centre. He explained that, whenever he received such a message, he would respond under the assumption that he was facing a life-threatening situation rather than a death.

He said that he broke the seal on his emergency keys so that he could have unfettered access through all the gates leading to E Wing. He collected the emergency equipment bag from the office and proceeded towards E Wing, some 700 yards away. The staff nurse estimated that it took him about five minutes to reach the wing. He was directed to the cell by a member of the security staff. On arrival at the cell, he saw the NOO and an officer at the cell door. The prisoner was lying on the floor. The staff nurse noticed that the prisoner's face was blue, his eyes were open but unresponsive, and there was a clear ligature mark around his neck. Whilst trying to find a pulse in each arm, the staff nurse noticed that there was rigidity in the prisoner's limbs. The staff nurse also tried to find a pulse in the neck. No pulse was found. The nurse, who confirmed that he was very experienced in such matters, thought that the prisoner had been dead for some time. He told my investigators that he signalled to the NOO that he thought that the prisoner's death was not recent and that there was no purpose in attempting resuscitation. He also said to the NOO that confirmation of death would have to be given by a doctor. The doctor was informed of events at about 6:20am by the gate officer and by the staff nurse. When asked why an ambulance was not called, the staff nurse told my investigators that the prisoner was very clearly deceased and that calling an ambulance would have served no purpose.

The staff nurse said that they then left the cell, locked the door and placed a piece of paper over the shutter so that no-one could see inside. According to the staff nurse, the only person to enter the cell after that was the doctor who pronounced life extinct at 6:45am. At interview, the doctor confirmed that she received two telephone calls at home at about 6:20am, one on her home telephone number and, simultaneously, another on her mobile phone. The call made to her home number was from the gate officer who told her that there had been an incident at the prison. The second call was from the staff nurse who told her that there had been a death. The staff nurse gave her brief details of what had happened.

The doctor, who lives quite near the prison, arrived shortly afterwards and was taken to the prisoner's cell. She told my investigators that she saw him lying on the floor of the cell with his head towards the window. He was lying parallel to his bed. She remembers seeing the staff nurse and an officer in the cell but could not remember who that was. The doctor examined the prisoner. She found no respiratory effort, no pupil response, no reflex, no breath, and no pulse. She described his face as very engorged and his facial skin as mottled. She also said that there was a mark on his neck that was suggestive of a cut caused by a tight ligature. There was evidence of burst blood vessels around the prisoner's neck where the ligature had been. The doctor also noticed dried blood on the prisoner's mouth and chest. She thought that this blood had probably come from his throat after choking.

The doctor described the prisoner as quite stiff and cold. She speculated that he had been hanging for some time and had been dead for at least an hour. She believed that he was dead when found. My investigators asked her to comment on the fact that an ambulance had not been called and that no attempt had been made to revive the prisoner. The doctor expressed the view that there was no reason to doubt the opinion of the staff nurse who had assessed the prisoner as deceased. It was very apparent to her that he had been dead for some time. The doctor took the view that, in circumstances where it was clear that there was no evidence of life, it was reasonable to decide not to call an ambulance and not to attempt resuscitation.

At the end of her interview, the doctor added that she thought that the prisoner's apparent suicide was an impulsive and therefore an unpredictable act. He had not presented as a vulnerable person when she saw him in December.

A letter found in the prisoner's cell contained an apology for taking his own life and an explanation for doing so.

Staff debrief

At about 9am on 6 February, the Governor personally saw each member of the night staff to debrief them on the events that had occurred and to offer them his support.

Informing the prisoner's family

Immediately afterwards, the Governor, the Chaplain and the Suicide Prevention Co-ordinator travelled to the home of the prisoner's relatives to inform them of his death in person. The family members later told my investigator and my Family Liaison Officer that they were full of praise for the sensitive and sympathetic way in which all three members of staff had behaved towards them.

Funeral

The prisoner's funeral was held on Friday 17 February 2006. The Deputy Governor of Cardiff attended on the Governor's behalf. The costs of the funeral were met in full by the establishment.

Prisoners' magazine

The February edition of the Cardiff prisoners' magazine entitled "Inside" was dedicated to the prisoner and to another prisoner who died at Cardiff in December 2005.

7. Consideration of issues arising from the investigation

(i) Did the prisoner give any indication of an intention to take his own life upon which staff might have been able to act to prevent his death?

The Prisoner Escort Report (PER) completed by the police in May 2003, prior to the prisoner's reception at Swansea prison, noted that he might be at risk of self-harm because he had apparently considered taking his own life after the death of his second wife in 1999. However, the prisoner was not considered to be suicidal on the day of his arrival at Swansea. In September of that year, he was sentenced to life imprisonment and transferred to Parc prison. A reception health screen carried out upon his arrival at Parc concluded that the prisoner was not showing any current signs of anxiety or despair and was not suicidal. However, the next day, the prisoner was described as "tearful about his sentence", the effect of which "had just dawned on him".

Thereafter, at no stage did the prisoner display any obvious signs that he was depressed or contemplating suicide. On the contrary, staff thought that he was coping well with his imprisonment. The prisoner was a hard worker and was regarded as a polite and respectful man. Even when he became concerned that his partner did not answer the telephone whenever he tried to speak to her during the weekend prior to his death, he still gave no signs to staff or to other prisoners that he wanted to take his own life.

The evidence shows that at no stage were there any obvious signs to suggest that the prisoner was planning to take his own life.

(ii) Could staff have entered the prisoner's cell more promptly when he was discovered hanging?

When the officer discovered the prisoner hanging in his cell at about 6.00am on 6 February, he went to the end of the wing to call for assistance over the radio out of earshot of other prisoners who might have been awake. He did not open his own sealed pack of keys and enter the cell immediately. The officer said that he knew straightaway that the prisoner was dead and radioed the controller to alert him to a "Code Blue". The officer knew that the Night Orderly Officer was in possession of a set of keys that were not sealed and that he was a short distance away from the prisoner's cell. At interview, both members of staff said that the time lapse between the officer discovering that the prisoner was hanging and the Night Orderly Officer opening the cell door was approximately 10 seconds.

Given the evidence that the prisoner was already dead when the officer discovered him hanging, this delay was not of critical importance. However, in a different set of circumstances, it might be. I also believe that it is unsafe for staff to make assumptions, before entering the cell, as to whether a prisoner is dead.

The Governor should include explicit instructions in his local contingency plans to ensure that, in the event of the discovery of a life-threatening situation, staff enter the cell immediately, if necessary by using their sealed pack of keys, even if they believe that the prisoner in the cell may already be dead.

(iii) Should attempts have been made to resuscitate the prisoner? Should an ambulance have been called?

Prison Service Order 2710 (Follow up to deaths in custody) says at paragraph 2:

“The first person on scene must summon help and request local emergency clinical assistance. If establishments use codes to alert clinical staff to the type of emergency that will be needed, local contingency plans must explain clearly the code definitions. Local contingency plans must provide for the summoning of an ambulance and alerting key personnel and state clearly who should do this.

“If the apparent death has taken place in a cell, the first person on scene must enter the cell as soon as possible, following the local strategy for safely doing so. Local protocols must contain clear instructions covering cell entry, especially for night patrols. If the death has taken place elsewhere in the prison, follow the local strategy for clearing the area of other prisoners. Carry out emergency first aid procedures described in Annex C of PSO 2700 “Suicide and Self-Harm Prevention” until clinical staff arrive. Prompt assistance - even a few minutes - may save a prisoner’s life. Give a concise report to clinical staff, who must then assume responsibility for the casualty.”

Annex C of PSO 2700 offers the following guidelines for emergency first aid:

“All cases:

- Summon help and request emergency medical assistance and first aid equipment.
- Enter the cell as soon as possible, following the local strategy for safely doing so.
- Give concise report on handover to healthcare staff.

“Hanging:

Support the body to reduce constriction. Staff should be aware of the potential for injury to themselves from such a process, and should consider utilising any alternative methods of support, such as items of cell furniture.

Cut the prisoner down.

Cut and then release the ligature immediately the prisoner has been cut down, preserving the knot if possible.

Place the prisoner on his/her back on a flat, solid surface.

Check for signs of life, i.e breathing, pulse, any movement of the body.

If not breathing and/or no pulse is present, clear airway and attempt resuscitation using a face mask with non-return valve, unless rigor mortis has clearly set in. (Rigor mortis is a condition of extreme stiffness affecting the arms and legs after death, making it virtually impossible to bend the wrists, elbows or knees.)

If conscious/revived, place in recovery position.”

The investigation found that, in the opinion of the prison doctor, the prisoner had been hanging “for some time” and had been dead for at least an hour before he was found. At interview, the doctor told my investigators that she had no reason to doubt the opinion of the staff nurse who had assessed the prisoner as deceased at about 6:10am. The doctor took the view that, in circumstances where it was clear that there was no evidence of life, it was reasonable to decide not to call an ambulance and not to attempt resuscitation.

However, I draw attention to the comments made by the clinical reviewer at paragraphs 29 - 35 of her report. These are repeated in full below:

“There may be questions over the fact that no ambulance was called and no resuscitation initiated. I am fully satisfied that the staff nurse was competent to make the decision that resuscitation would be impossible because death had occurred some considerable time prior to him being found. The doctor’s evidence corroborated the staff nurse’s findings and decision.

With regard to the ambulance, Cardiff’s contingency plan in the event of finding a hanging, states:

‘Ask for immediate medical assistance and ambulance.’

Evidence shows that a Code Blue was called immediately. However, whether by a deliberate decision or by default, an ambulance was not called. At interview, the staff nurse was confident that he saw at once that an ambulance was unnecessary. However, in other circumstances, the time gained in calling an ambulance at once, rather than waiting for the attending nurse to ask for one, could make a difference to the outcome of resuscitation.

Also in the contingency plan is the instruction:

‘If the prisoner is not breathing, attempt resuscitation.’

This simple statement reflects what the Resuscitation Council (UK) in their publication ‘Decisions Relating to

Cardiopulmonary Resuscitation (CPR): A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing February 2001' call the 'presumption in favour of attempting resuscitation'.

The guidance continues:

'Where no explicit advance decision has been made about the appropriateness or otherwise of attempting resuscitation prior to a patient suffering cardiac or respiratory arrest, and the express wishes of the patient are unknown and cannot be ascertained, there should be a presumption that health professionals will make all reasonable efforts to attempt to revive the patient. Anyone attempting CPR in such circumstances should be supported by their senior medical and nursing colleagues. Although this is the general assumption, it is unlikely to be considered reasonable to attempt to resuscitate a patient who is in the terminal phase of illness or for whom the burdens of the treatment clearly outweigh the potential benefits. Local policies in hospitals should particularly include instructions for junior doctors on what to do in an emergency situation where there is no consultant immediately available.'

However that guidance is primarily aimed at hospitals or where death is expected. More applicable in the emergency circumstances prevailing in a prison is the following extract from section 10.1 of the Resuscitation Council (UK)

Guidelines:

'If the health care team is as certain as it can be that attempting CPR would not restart the patient's heart and breathing, the patient cannot gain any clinical benefit from an attempt. Consensus within the team about likely clinical outcome should be the aim, and decision making must be based on clinical assessment of the patient's condition and up-to-date clinical guidelines.'

In his statement and his interview, the staff nurse demonstrated that even without the benefit of the support of a medical team, he made the correct clinical assessment that attempting CPR would not restart the prisoner's heart and breathing. As the Resuscitation Council (UK) states:

'All establishments that face decisions about attempting resuscitation should have in place local policies for decision making.'

When the first people on the scene are not health professionals this guidance must be especially clear and simple. The Night Orderly Officer demonstrated how lay

people can use common sense to assess that death took place some time before the body was found. It may be appropriate to use words such as 'unless rigor mortis is present' to qualify the contingency instruction to attempt resuscitation."

The clinical reviewer makes the following recommendations:

- **Staff should be reminded that the contingency plan requires that an ambulance should always be called in the event of a hanging, at the same time as medical assistance is called for.**
- **The Governor should convene a multidisciplinary team including health professionals to review and revise the contingency plan for handling a hanging, taking cognisance of the Guidelines published by the Resuscitation Council (UK).**

I draw attention to these comments and endorse the recommendations she has made.

8. Summary of recommendations

Clinical

1. Staff should be reminded that the contingency plan requires that an ambulance should always be called in the event of a hanging, at the same time as medical assistance is called for.
2. The Governor should convene a multidisciplinary team including health professionals to review and revise the contingency plan for handling a hanging, taking cognisance of the Guidelines published by the Resuscitation Council (UK).

Local

3. The Governor should include explicit instructions in his local contingency plans to ensure that, in the event of the discovery of a life-threatening situation, staff enter the cell immediately, if necessary by using their sealed pack of keys, even if they believe that the prisoner in the cell may already be dead.

Good practice

4. I consider issuing the night healthcare worker with a set of keys in a sealed pouch to facilitate unfettered access to all areas of the prison in the event of an emergency to be good practice.

At consultation stage, the Prison Service accepted the report, including the above recommendations.

