

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE
DEATH OF A MAN AT HMP CARDIFF IN JUNE 2007**

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

December 2007

This is the report of an investigation into the death of a man in June 2007. The man was found in his cell at HMP Cardiff with a ligature around his neck. He was 49 years old. I offer my sincere condolences to the man's family and friends, and those touched by his death.

A lead investigator conducted the investigation on my behalf, assisted by another colleague. The investigators and I would like to thank the Governor and staff at Cardiff for their ready cooperation during the investigation. I am particularly grateful to the Principal and Senior Officers who acted as the liaison officers. Thanks also go to the Healthcare Inspectorate Wales, for conducting a comprehensive clinical review.

The man was serving a life sentence. At various stages of his time in prison he had found it difficult to cope, and had previously attempted to end his life. Nevertheless, I am satisfied with the level of care he received during these periods.

Outwardly, the man appeared to be coping well at the time of his death and seemed to have a positive outlook for the future. However, he was struggling to cope with illness and with some bullying. I conclude that his death could not have been foreseen, but I am concerned that he did not feel able to disclose to staff his feelings about pressure from other prisoners.

I make four recommendations. These concern ways to encourage the reporting of bullying, a review of the complaints process, quick replacement of personal officers, and a review of emergency codes. I also recognise the good work carried out by Cardiff's family liaison officer.

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SUMMARY

The man was remanded into prison in December 1998. In October 1999, he received a life sentence. He found it difficult to cope with prison and was particularly vulnerable in his first few years. He spent time in HMP Long Lartin where he was under the care of psychiatrists and taking anti-depressant and anti-psychotic medication.

After feeling threatened at Long Lartin, he moved to HMP Cardiff in April 2003. He continued to struggle with his mental health and made a serious attempt on his life in May 2004. The man was subject to suicide and self-harm support and monitoring procedures. Accordingly, he received a high level of care at that time. He continued to take medication under the care of psychiatrists, and received counselling.

The man's condition stabilised and he gradually reduced his medication. Staff helped him to reintegrate within the lifer wing. He seemed to settle and made a number of friends. He continued his job in the tailors' workshop where he was liked and respected by staff and prisoners.

From July 2006, the man suffered from a chest complaint and persistent cough. After a number of tests, this was diagnosed as sarcoidosis, a chronic inflammatory autoimmune disease of unknown cause. This condition particularly affected his lungs. At times, he was in considerable pain, and his medication was altered accordingly. However, there were occasions when he found it difficult to cope and described himself as being in "agonies of pain".

The man's tariff (the minimum term of his life sentence) was reduced to ten years in March 2007. He was eager to move to a category C prison to progress through his sentence and work towards his release. The lifer team decided he needed to complete some one to one offending behaviour work with his psychologist before he could move. He completed this on 15 May, and was then recommended for progression.

In May, the man made a written complaint about the system for ordering and collecting meals. Cardiff operates a system in which the prisoners pre-order their meals. However, the man said that on several occasions when he went to collect his food the meal he had chosen had finished. Rather than accept an alternative meal he would sometimes choose to go without. The man thought that staff had been indiscreet about his complaint as he became the subject of name calling and threats. The man mentioned instances in letters to his friends and family, but did not disclose this to staff. Worryingly, he asked his sister if she could send him £2,000. Other prisoners have suggested he was being asked to hide contraband in his cell.

The man might have been feeling under pressure as well as feeling very unwell. However, staff and prisoners who spoke to him in the days preceding his death felt there were no signs of depression. He had written a birthday card to a fellow prisoner that said he would keep in touch. He had spoken to staff about being keen to progress in his sentence and towards his eventual release, hoping he could re-establish contact with his children.

Nevertheless, the man wrote to request a visit by a prison visitor, saying he was feeling down. The visit was arranged, although the man would not have been aware of this at the time of his death.

Prisoners told my investigators that the man had a “hacking cough” which sounded painful during the night of 3 June 2007. On 4 June, he said he was not going to work as he had an appointment. This was untrue. He did not collect his medication. When invited to do so, he declined saying he had not taken it for two days. Otherwise, he appeared his normal self to those who saw him.

At approximately 10.40am, an officer opened his cell door to give him a letter. He found him on the floor with a ligature made from bed sheets around his neck. The officer alerted staff and attempted resuscitation. Paramedics arrived and continued their efforts to no avail.

Staff and prisoners were shocked and saddened by the man’s death. They were offered support by the prison.

The prison contacted the man’s family to break the news of his death. The family appreciated the considerable help and advice subsequently given by the prison’s family liaison officer and I commend her for her work.

Whilst in HMP Cardiff, the man received a high level of care. He had a good relationship with his doctor and a number of staff, and had seen the same psychologist throughout his time at the prison. He had worked in the tailors’ workshop for several years and had built up trust with the workshop staff. The man’s personal officer was committed and knowledgeable. Unfortunately, she moved wings at the end of April and was not replaced between that time and his death.

The man’s healthcare needs were dealt with appropriately. Sarcoidosis is a chronic condition that causes pain and discomfort. He appeared to be acutely aware that there was no cure for the condition.

I am left in no doubt that the man felt he was being bullied, but for fear of halting his progression did not disclose this to staff. Other prisoners knew or suspected that he was being bullied, but similarly disclosed nothing to staff. As a result, there can be no criticism of staff for not being aware of the situation. However, the safer custody team in Cardiff needs to give further consideration to gaining the confidence of prisoners to report such incidents in the future.

THE INVESTIGATION PROCESS

I appointed a colleague to lead the investigation on my behalf. She was assisted by a fellow investigator. The lead investigator visited HMP Cardiff to open the investigation. On her initial visit, she met the Governor and received a tour of the prison, including the cell in which the man died. She also met with members of the local committee of the Prison Officers' Association (POA).

Notices were issued to both prisoners and staff inviting anyone who might have information relating to the man to make themselves known to the inquiry.

The lead investigator and one of my family liaison officers visited members of the man's family and made a number of phone calls to discuss the investigation and ascertain any particular family concerns and questions. The family were shocked by the man's death. During his sentence there had been other times when he had appeared more vulnerable than in the days before his death. His family are trying to understand his actions and would welcome any information that will help them to do so. They were convinced that he was being bullied by some other prisoners, as he had written to them about this. They also asked if the apparent delay in his move to a category C prison had any noticeable affect on his mood. These issues are explored further in this report.

My investigators interviewed staff and prisoners, both formally and informally. They examined the man's prison record, medical records and a series of prison documents.

A clinical review of the man's healthcare in custody was undertaken by a doctor appointed by Healthcare Inspectorate Wales.

HMP CARDIFF

HMP Cardiff is a category B local/training prison, holding up to 754 male adult prisoners drawn predominantly from the surrounding court catchment area in South Wales. E wing is a dedicated wing for those serving life sentences and can hold 96 prisoners.

The healthcare centre at Cardiff provides 24 hour primary care and has 16 in-patient beds. Clinical care is provided by doctors and nurses employed by the Prison Service. The latest staffing profile is a team comprising two general practitioners (supported by locums from a local general practice), a senior nurse, practice manager, three supervisory grade nurse/senior healthcare officers and 16 healthcare staff (nurses and healthcare officers). Specialist mental health services – the mental health in-reach team (MHIRT) – are provided by Cardiff and Vale NHS Trust.

HM Chief Inspector of Prisons last inspected HMP Cardiff in February 2005. The inspection found there were mutually respectful relationships between staff and prisoners and it was a generally safe environment. The Chief Inspector was impressed by the suicide prevention arrangements but less so by the anti-bullying work. My investigators felt this was improving.

The Chief Inspector also found that the good healthcare observed on their previous full inspection in 2003 had been maintained. However, she was very disappointed that a new build healthcare centre promised in 2004 had not materialised. The Chief Inspector found the current two storey building 'unfit for purpose'. It was also disappointing that the Chief Inspector's previous recommendation that 'a primary care-compatible' information technology system should be installed had not been achieved. While praising the work of the MHIRT, the Chief Inspector said that the team was small and lacked capacity to meet the needs of the prisoners at Cardiff.

KEY EVENTS

The man was remanded into HMP Nottingham in December 1998, accused of murder. He had attempted suicide immediately after the alleged offence. He found it hard to cope with prison life and the enormity of the crime. He frequently expressed his intention to end his life. The man was under the care of a psychiatrist and received regular assessments. He was subject to the F2052SH procedure, a system in which prison staff supported and monitored those at risk of suicide or self-harm. (This has since been replaced by ACCT (Assessment, Care in Custody and Teamwork).)

In October 1999, the man was convicted and sentenced to life imprisonment with a tariff (minimum period to serve) of 12 years. He moved to Long Lartin prison a month later. Whilst at Long Lartin, he was regularly reviewed by the mental health in-reach team. It was noted that the man felt worse, and more suicidal, around significant dates such as the anniversary of his offence and his victims birthday. He felt he should be punished for what he had done.

In spite of receiving psychiatric help, his depressive illness worsened as the anniversary of his index offence approached in late 2002. He was assessed by a mental health nurse because of his low mood, and was placed on a F2052SH. He refused food and was admitted to the healthcare centre. On 8 December, the man wrote to the Governor alleging threats by other prisoners to kill him and he requested protection. A psychiatric assessment was performed on 11 December and it was noted that the man was still refusing food. On 20 and 24 December, he was assessed by forensic psychiatrists who thought that he had 'psychotic depression'. He was 'very paranoid' and deemed detainable under the Mental Health Act, should transfer to hospital be required for treatment. At the beginning of January 2003, he was sectioned under the Mental Health Act and the transfer papers were prepared. However, this transfer was not effected as he took medication and responded to the treatment while located in prison healthcare.

An entry in the clinical record dated 9 January 2003 notes that the man was very concerned that other prisoners would kill him if he was released from healthcare. A letter from the psychiatrist on 14 February 2003 noted that the man had improved, and no longer needed a bed at the secure hospital. He was therefore taken off the waiting list. The Governor and staff discussed his continuing fear about his fellow prisoners and decided he should remain in the healthcare centre. Following an improvement in his condition, he was transferred to HMP Cardiff on 22 April 2003.

The man remained at Cardiff except for a brief return to Nottingham in July 2003 to receive accumulated visits. Continuous psychiatric support was offered and although he sustained the improvement he had shown, he remained on medication.

On 18 May 2004, the man attempted suicide during the night by cutting his wrists. He had written a note, but had not told anyone of his intentions. After attending hospital, he returned to Cardiff where he was again subject to F2052SH monitoring and kept in the healthcare centre in a cell with a camera. An emergency psychiatric review was carried out. It was noted that periods of heightened risk were around his index offence, and the birthdays of his wife and children.

The man was held in the healthcare unit for some months and regularly reviewed by a multidisciplinary team. He briefly returned to a normal wing in August 2004. During this time, he struggled to cope with the crime he had committed and his need for punishment. He was angry with himself, and staff described him as guilt ridden. Occasionally, he would begin to improve, but would then deteriorate. During spells of despair he often did not eat. He did not self-harm, but had suicidal thoughts.

Towards the end of 2004 and beginning of 2005, the man made significant progress. His mental health improved slowly and on 10 January 2005, as part of a structured reintegration plan, he was discharged from the healthcare centre to a shared cell in E wing (the lifer unit). After a period of assessment he returned to a single cell. The F2052SH was closed on 18 March 2005. The man attended drama therapy and CALM (Controlling Anger and Learning to Manage it) courses and worked in the tailors workshop.

After a period of apparent mental stability, the man underwent a medication review on 20 March 2006. His Olanzapine (anti-psychotic medication) was reduced to 5mg a day, and then stopped entirely on 5 June. Venflaxine (an anti-depressant) was also reduced and stopped on 6 July. From that point on, he received no mood-altering medication.

During the following few months, the man had other health concerns. He attended an appointment with the prison doctor on 31 July 2006, explaining that he had a persistent cough, with blood and sputum. The doctor referred him for a chest x ray which was performed on 7 August. She also advised an urgent CT (computerised tomography) scan which took place on 24 August. Due to the persistent cough and a possible diagnosis of sarcoidosis, a further referral was made to a chest clinic at the local hospital on 11 September 2006. He attended this clinic on 22 September and more tests were arranged to allow for an accurate diagnosis. After discussion with the prison doctor, the man agreed to have a bronchoscopy and bronchial biopsy. This was performed on 23 November and no cancer was found. A lung biopsy was needed to confirm sarcoidosis, and on 18 December 2006 a referral to a cardiothoracic surgeon was made.

The hospital postponed the initial consultation appointment, which was due to take place on 9 January 2007, and rescheduled it for 23 January. The man was anxious about the procedure, but he did not request any medication. The biopsy, performed on 9 March, confirmed that the man was suffering from sarcoidosis. Steroid treatment was given for the condition. (The clinical reviewer describes sarcoidosis in the following terms: "a multisystem chronic inflammatory condition of unknown cause. It appears likely that a genetic susceptibility is combined with a triggering infection to cause the disease. After the thorax, the skin and eyes are most commonly affected, followed by the liver, heart, joints and nervous system.")

There is a significant entry in the medical record dated 24 October 2006. It notes that the man's psychologist referred him for a nurse review as she felt that he was feeling low in mood. The nurse, who saw him on the same day, clearly asked him if he wished to kill himself and was told 'no'. This entry also notes that he was

'amused that anyone thought the contrary.' It appears, with hindsight, that the man might have been feeling depressed, but did not admit it to anyone.

For some time, the man had been working towards reducing his tariff. In March 2007, it was reduced to 10 years. Staff and prisoners said he was pleased about this. He was anxious to move to a category C prison to progress through his sentence as soon as possible. Various staff were preparing reports to facilitate this.

The man had developed a good relationship with his personal officer whom he had met frequently. The man had been open with her when he had concerns and had told her about his health. The personal officer described him as a polite man, who worked hard and was a good role model for other prisoners. He helped others who found prison difficult. The man's personal officer moved to another wing at the end of April 2007, and was no longer his personal officer. She assured him that she would liaise with his new personal officer to help complete his parole paperwork. However, to be a personal officer to life sentenced prisoners requires training. No other trained officers were available so the man did not have another personal officer allocated after his personal officer left the wing.

One of the psychologists worked with the man throughout his time at Cardiff. She told my investigators that when the man arrived he had been deemed unsuitable for a number of offending behaviour programmes and had considerable guilt about his offence. She conducted one to one work with him to be able to better assess what help could be given. However, after the first session in May 2004, the man self-harmed. The psychologist was involved in his care whilst he was subject to the F2052SH procedures, but they stopped offending behaviour work as he had not been able to cope at that stage. When the man began to improve they continued some work. He completed a motivational course aimed at vulnerable prisoners and, as mentioned above, the CALM course.

The psychologist said that during a review meeting several staff had expressed the concern that the man had never been able to give a full and open account of his offence, partly due to the risk to himself. It was decided that before his move to a category C prison, the psychologist would work with him one to one, exploring his offence in more detail.

This work began in April 2007, and they met about five times for two hours at a time. The man participated well. He found it difficult, and he sometimes became tearful when discussing his offence. Whilst this work was taking place, the psychologist was asked for her contribution to his lifer progress report. She felt that he was now ready for progression to a category C prison. She told my investigators that she had informed him of this, although he did not see the official paperwork before his death.

The last appointment between the psychologist and the man was on 15 May 2007. The psychologist told him she would be preparing her report and it would take two to three weeks. In their last meeting, the psychologist felt the man had been preoccupied with his physical illness, and looked unwell. The man told her about the physical pain he was experiencing and that he had been waking up at night. He had made it clear to both his personal officer and his psychologist that his condition was treatable, but could not be cured.

The man's condition caused considerable pain for which he was given dihydrocodeine (a painkiller). Prisoners told my investigators that they heard his "hacking cough" at night and he would often complain about the pain. The prison doctor, who had established a good relationship with the man, discussed and altered the level of pain relief at various times as necessary. On 5 May 2007, the man wrote to the prison doctor explaining that he was in a lot of pain and felt the regular painkillers were no longer adequate. The doctor re-prescribed and dispensed 50mg Diclofenac (a different painkiller) three times a day. The Diclofenac prescription was changed to Naproxen (maximum dose of 500mg twice a day) on 25 May, after the man reported that he was still experiencing great pain. (This is considered in detail in the issues section of this report.)

On 22 May, the man submitted a formal complaint about food in the wing complaints box. He was not someone who complained regularly; his previous use of the complaints system had been in 2005.

In Cardiff, prisoners select their meals from a menu a day in advance to ensure, as far as possible, that everyone's preference from the options available is met. The man said that almost every other day his landing (3's) was unlocked last for lunch, and that by the time he got to the servery there was either no food left or the meal he had pre-selected had run out. He had suggested that the staff supervising the hotplate check on prisoners' orders so that they did not change their mind at the servery. He wrote, "this would avoid favouritism between mates." He went on to say that he had gone without food on numerous occasions because his order was not available and he did not want different food.

The senior officer replied to the complaint on the same day saying that all prisoners were unlocked at the same time, that he was not aware of "favouritism" and that all prisoners should receive a meal. He added that a new ordering system was due to be implemented and urged the man to give this a chance.

Prisoners told my investigators that a sign was put up in the servery saying "one prisoner one meal". The senior officer said the sign had not been prompted by the complaint. However, it would appear that some prisoners thought the sign had been placed as a result of the complaint and the man began to feel intimidated by some prisoners.

The man regularly wrote and received letters from family and friends. Many of them were disclosed to my investigator. The man wrote about his medical condition, and the progress of his sentence. In April 2007, he had been concerned about his sentence progression and his work with the psychology team. The letters often made reference to the future, and his plans for moving prison and working towards his release.

Towards the end of May 2007, he mentioned in several letters that he had been in "tremendous pain ... twisted up and bent double in agony," and that this had been the case for much of the month. He added that he had a good relationship with the prison doctor; she had recently changed his tablets, and he was beginning to get more sleep.

The man also wrote to several people saying that he had received trouble from some prisoners. He felt that this was a consequence of having made the complaint about the food. He said some prisoners had begun calling him a “grass and a nonce” and spread rumours about him. The man felt he could not do anything about this as he did not want to jeopardise his parole. He said he had therefore stopped going down to collect his food from the servery to prevent any conflict. The steroid medication increased the man’s appetite, and he said he was largely reliant on food from the canteen (prison shop).

Another feature of the letters was that the man distrusted some staff. He crossed out names of staff and prisoners he mentioned. He wrote that the complaint he made was meant to be confidential but staff had been indiscreet. However, the letters to friends and family still had messages of hope. He said he was not letting the problems bother him. He was expecting a move to a category C prison and looking forward to his release on licence. He also said it was the newer people on the wing who had been causing him trouble and he did have some very good friends.

In a letter to his sister on 29 May 2007, the man wrote about the trouble with the other prisoners, “they are spreading malicious rumours about me saying I’m a nonce and want kicking in.” He went on to say that he had decided to stop going to the hotplate for food, and asked that his sister should send him some money to buy food from the canteen. The man said that he was fed up and was hoping for a transfer as soon as possible. He said, “I just cannot believe how someone can have the conscience to thief off another inmate.”

The man had some savings that his sister looked after. At the end of the letter on 29 May, he wrote another page in which he said he wanted to “treat himself and buy some nice things.” He asked his sister if she could send him £2,000. He said he could only spend £40 per week, but would rather have the money as a lump sum than gradually.

The following day, the man wrote to his sister again. He said he had rethought and did not want her to send him the money after all. He thanked her for all her help. He asked his sister to see if she had any of his certificates that might help when he came up for parole. The man also told her what should be done with his money if anything happened to him. He said he hoped he would get out and use the money to help start a new life. He asked if she had his current will, and said that he would be writing another one in the coming months. He was uncertain about his health and “how far this thing is going to go”. He told her he was in pain and living on painkillers, and it was really getting him down: “I keep smiling but as soon as I’m behind my door and alone after bang up, I feel absolutely sh*t.”

The man received a letter from his sister expressing her concern for him. He replied on 2 June. He asked her to send £50 to a friend in the prison. He said this was a good friend who had really been helping him a lot. The man also said he was eating lots of food from the canteen. He said he did not want her to worry; no one was pressurising him, he just felt sorry for himself and would not get involved in anything as he did not want to jeopardise getting out. However, now she had written about it he thought he would be under observation. He was concerned someone would be

reading his mail and would think he had said he was being bullied. He assured his sister he was not being bullied and could handle himself with words not violence. He asked his sister not to make such remarks in her letters again as, "it's having adverse effects and causing waves."

Several prisoners told my investigators that the man had been asked to store "hooch" (illicitly brewed alcohol) in his cell in the weeks prior to his death. One prisoner said that on the day of a cell search he saw a bag being passed between the man and another prisoner.

On 29 May 2007, the man wrote to request a visit from an official prison visitor, as he was feeling down and they had previously helped him. An official prison visitor arranged to see him on 4 June. He would not have known this had been arranged when he died.

The suicide prevention coordinator knew the man well from his involvement during the time the man had been deemed at immediate risk. The suicide prevention coordinator told my investigators that he knew December, May and June were times of year that the man had found harder. For this reason, he decided he would speak with the man to see how he was. On Friday 1 June, he spoke with the man in his cell for about 40 minutes. The man was very pleased that his tariff had been reduced on appeal to 10 years, and was due for a parole hearing in 2008. He was hoping to be moved to a category C prison in the near future. The only concern was his health: "he had been diagnosed with a lung condition, which was, in his words ... incurable but not terminal." The suicide prevention coordinator said that the man really wanted to complete all the programmes to guarantee his release before he died of his incurable illness:

"He wanted to do this because he felt that explaining to his two children what had happened ... was his prime motive in life now. He was very focused on that issue and I left the man that day, thinking that, you know he's got something to look forward to, he wants to do something. He's looking to get out of prison ... I didn't feel there was any risk, he didn't portray any thoughts of self-harm, he didn't show any risk in his body language, he was calm in manner and I think I left him that day thinking he was more upbeat than I've seen him for a long, long time, even with his illness."

Several prisoners told my investigators that the man could be heard coughing at night. Prisoner A was in the cell next door to the man's cell. He said the coughing was worse on the night of 3 June, and he could tell that the man was also out of breath.

On 4 June, the man came out of his cell when he was first unlocked. A wing officer saw him at about 7.35am and they acknowledged each other with a nod of the head. Another prisoner on the wing, went to the man's cell at about 8.00am. This was because he had heard him coughing again and thought it was "worse than ever". The prisoner asked the man if he was okay and wanted anything. The man said he was going to spend the morning in bed. The prisoner thought this was very unusual as the man could normally be counted on to be up at 8.00am and ready for work.

The man did not collect his medication. Staff called him to attend, and he went to the medical hatch on the wing soon after 8.30am. He told the staff nurse he did not need his medication and had not taken it for two days. He did not show any signs of agitation or cause for concern. As he returned to his cell he passed a prisoner, prisoner. This prisoner told the man he had written to an old friend. The man simply replied "alright". In interview, the prisoner said that the man seemed his normal self and did not show any outward emotion. My investigators were told that the man gave some sweets to another prisoner to give to one of the tutors in the tailors' workshop.

At about 10.30am, a prison officer collected a prisoner from the library and brought him back to his cell on E3 landing. The officer also began to distribute the mail and newspapers for the wing. The letter for the man was too thick to push through the side of the door as usual, so he opened the cell door. He found the man on the floor. Approaching him, he saw that a ligature made from a torn bed sheet around his neck had snapped. The remaining section of sheeting was attached to the cupboard. The officer shouted for staff and shouted "code blue" (a code indicating that a prisoner is not breathing). This was radioed through to the control room at 10.41am. The prison officer knelt next to him and used his ligature knife to remove the ligature from around the man's neck. There were no signs of life. The wing principal officer and two officers quickly arrived to help. The wing officer used the radio to alert the control room. At first he said "code white" (code for an unconscious prisoner). Within a minute or two he corrected it to a "code blue" to signify the man was not breathing. The first and the second prison officers attempted resuscitation.

Two nurses arrived within minutes. They detected no life signs. A further nurse then arrived with an emergency bag. They continued cardiopulmonary resuscitation (CPR) in rotation, along with another nurse.

The first paramedic arrived at 10.47am, followed by an ambulance at 10.55am. They continued CPR and attempted defibrillation, but the defibrillator instructed not to shock. The doctor pronounced the man's death at 11.15am.

The same day, a friend of the man, another prisoner, received a birthday card from the man. This must have been put in the internal post in the preceding days. In the card, the man wrote something to the effect of 'see you when you're released', and that he would write to the prisoner.

That afternoon, a hot debrief was conducted with staff and they were all offered support from the prison's care team.

ISSUES

Continuity of care

The man had been in HMP Cardiff since April 2003. He had continued contact with a number of key staff. For example, the psychologist was his psychologist from the beginning of his time there. The man had also worked in the tailors' workshop for most of his time at Cardiff, and had a trusted relationship with staff, who spoke highly of him. Furthermore, although the doctors changed in his four years at Cardiff, he regularly saw the prison doctor who oversaw his care.

The care and management the man received under the F2052SH procedures, following his suicide attempt, was of high quality. The man was fully involved. There were regular reviews involving multi-disciplinary teams. There was a good support plan put in place, with referrals and regular reviews by the in-reach psychiatrists. The man received medication, counselling and throughcare support to help resolve his depression. Case conferences were held to discuss his progress. There was also a comprehensive reintegration plan to help him settle back on the lifer wing.

The man's personal officer was his personal officer for nearly three years. I have been impressed by her knowledge and level of involvement with the man. To be a personal officer on a lifer wing, an officer must complete training to enable them to perform the appropriate assessments and reports. It is evident that the officer engaged with the man regularly and often (sometimes weekly) wrote in his wing file. The entries showed she had spoken with him in some depth.

The completing of reports on prisoners is one aspect of the lifer personal officer role. It is self-evident that better ongoing interaction leads to a better quality report. The personal officer is generally the 'first port of call' for any concerns. As was the case with the man who died, the personal officer will have a better understanding and knowledge of the prisoner involved than most staff. In turn, again as was the case with the man, the prisoner tends to trust their personal officer more than others in uniform.

The man was at an important part of his sentence, where a number of assessments and reports needed completion to enable him to move to a category C prison. However, for perfectly standard operational reasons, his personal officer left his wing at the end of April. It is impossible to determine whether he would have mentioned any concerns to his personal officer. Indeed, there were others with whom he had worked for a long time. It would also have taken time to build up a relationship with a new personal officer. However, it was an important time in his sentence. The man himself wrote and asked when a new personal officer was to be appointed.

I recommend that the Governor appoints and trains an appropriate number of officers in the lifer personal officer role, to ensure there are no avoidable gaps in continuity of care. Where there is an unavoidable gap, a nominated officer should ensure the normal personal officer role is covered until a suitably trained person can take over.

Clinical care

The clinical reviewer has found that the primary healthcare the man received was good and comparable to that delivered in the community:

“Healthcare staff were willing to investigate and refer both mental and physical illnesses promptly. There is some evidence that outpatient appointments were cancelled once or twice, but this was by the hospital and they were eventually kept. This would not have affected the man’s physical disease progression.”

The clinical reviewer says in addition:

“Secondary healthcare was good, timely and comparable to that delivered in the community. For example, forensic psychiatric and CPN reviews were carried out in a timely manner upon request. Treatment was appropriate and adequate.”

On several occasions the man asked for a reduction in medication, and there were times when he refused it altogether. The clinical reviewer feels that the man may have disguised some of his feelings at times, or said he was feeling better than he was.

Sarcoidosis and pain relief

Sarcoidosis is an uncommon disease that can affect various organs and systems in the body. Often it affects the lungs, but it can affect all the internal organs as well as other parts of the body such as the eyes and skin. The prison doctor said that it can manifest itself in different ways and be present for many years, undiagnosed. In some cases, it can resolve by itself but for a significant proportion of patients, including the man who died, it is a chronic condition. It can be disabling, particularly if the lungs are affected.

The prison doctor told my investigators that the man had been suffering chronic pain for a number of years. When asked if he was on a high level of pain relief, the prison doctor said it was not excessively high, and she thought it appropriate. As a comparison, she said:

“I would have a lot of elderly arthritic patients on co-codamol medication, which contains 30 milligrams of codeine per tablet and they might be on a many as eight a day of those, which is 240 milligrams of codeine. Or people can buy over the counter co-codamol. Which contains eight milligrams of codeine and they can take up to eight of those a day and so that’s 64 milligrams of codeine. So the man was on dihydrocodeine 120 milligrams a day so it was a middle sort of range of the doses that I would expect.”

As the prison doctor and the man communicated well with each other, when the man was in more pain she would increase the medication or change the prescription. The

man would let her know when he was feeling better, and they would reduce the medication accordingly.

The clinical reviewer examined the pain relief in her clinical review. From the prescription charts in 2007, the man was given dihydrocodeine (an opioid pain reliever given for moderate to severe pain) at maximum dose of 60mg twice a day from December 2006. This was changed to DHC Continus (a modified release form of dihydrocodeine), maximum dose of 60mg twice a day, from February 2007 until he died. In-possession pain relieving medications were paracetamol 1g. Following the man's letter of 5 May in which he said he was in pain, he was re-prescribed and dispensed 50mg Diclofenac (an anti-inflammatory pain reliever) three times a day. His Diclofenac prescription was changed to Naproxen (a pain reliever), maximum dose of 500mg twice a day, on 25 May. This was the last time the prison doctor saw the man: "he said he felt a lot better and certainly his breathing and physical demeanour appeared much more comfortable to me since he had been on the steroids."

Indeed, in the man's letters to family and friends at the end of May 2007, he had described the pain he had been in. He said he had spoken with the prison doctor and she had changed the medication and he was finding it easier to sleep. It is therefore interesting that the man did not take his medication for the last two days of his life, and was heard coughing "worse than ever" during the night of 3-4 June.

In her clinical review, the doctor comments that the pain relief prescriptions were:

"... effective doses of very good pain killers: it is surprising that they did not relieve the man's pain. From later events, we could hypothesise that the physical pain the man was feeling was psychosomatic i.e. he was in a lot of mental pain as a significant anniversary approached, his mood was low and he felt more comfortable addressing it through physical symptoms."

Food complaint

The man rarely submitted formal complaints. However, on 22 May 2007 he submitted a complaint form in which he said that his landing was almost always unlocked last for lunch, and that there was either no food left or the meals selected had run out. The man suggested that the staff supervising the hotplate should monitor the orders so that prisoners did not change their minds at the servery. The man went on to say that he had gone without food on numerous occasions because his choice was not available and he did not want different food.

To submit a formal complaint, the prisoner places it in the complaints box on the wing. At Cardiff, keys to the box are held only by the complaints clerk. Every morning the boxes are emptied by the complaints clerk, who then notes the detail of the complaints and directs them to the most appropriate person to respond. The outcome of the complaint is communicated either by the complaints clerk, or directly by the person who has responded.

The senior officer told my investigators that sometimes there were problems with portion sizes of the meals. In the event of shortfalls, he would ensure everyone

receives a meal, although it was not always what the individual had pre-ordered. This potentially posed a problem for the man who was careful about his diet as he had put on weight.

The man felt that some prisoners who worked on the servery showed favouritism to their friends. The senior officer explained that a senior officer must stand at the hotplate whilst the meals are served, and he was not aware of favouritism being shown.

At meal times all prisoners are unlocked at the same time. It may be that those on the higher landings have further to walk and are therefore last to the servery. The man mentioned two occasions when his landing was the last to be unlocked. These appear to have been isolated occasions.

The senior officer was not aware that the man was going without his meals. He explained that he has a sheet with everyone's name on, and when they come down he ticks them off. If someone does not come to collect their meal, he asks an officer to shout their name. He did not recall having cause to do so for the man.

There were no other complaints regarding the availability of food around this time. My investigators observed the meals being served on several occasions. The process appeared to go well, and at those times there was enough food for everyone. However, my investigators spoke to a number of prisoners who said this was not always the case. Prisoners also said that they had little to look forward to, and therefore meals were a significant part of the day. The senior officer did not recall discussing the man's complaint with anyone else. He said the complaint was put into a folder for an officer to return to the man.

Prisoners told my investigators they were not confident in the complaints process, and were concerned about the confidentiality of the system. They believed that the man's complaint had been inadvertently and carelessly mentioned in conversation. Furthermore, they said they did not want to complain in case it could be used against them. As lifers, they had to consider their future more than most.

The Governor should review the effectiveness of the complaints system, particularly on the lifer wing.

Bullying

The man clearly felt he was being bullied by some prisoners. He wrote the names he was being called, and threats he had received, in his letters to friends and family. Some of the man's friends on the wing were aware that he was being called names. One also said he had seen the man and another prisoner pass a bag during a cell search, suggesting the man had hidden it for the other prisoner. The fact he asked his sister to send in a large amount of money is worrying and gives rise to suspicion as to its purpose.

However, I am satisfied that the man did not disclose any of this to staff. My investigators spoke to a number of staff. The psychologist said that the man was not streetwise. He was mindful of whom he could trust, and had a small close group of

friends. She said they had recently spoken about him trying to be more assertive. The man had told her that there had been “hooch” on the wing and that people had approached him to store it in his cell. He said he had assertively dealt with that, and knew that the consequences would be serious for him if he was caught hiding hooch.

The suicide prevention coordinator said that the man was quite passive, “I doubt very much if he would retaliate. I suppose he would be one of those people who could be a victim, most definitely yes.” The man did not mention that he was having problems to the suicide prevention coordinator, the tutor in the tailor workshop, any other officers, the healthcare staff, or his psychologist.

Cardiff has well organised anti-bullying policies and measures. A dedicated violence reduction coordinator examines a range of collated information to ascertain if there are problems with bullying, as well as investigating allegations. No one alerted the violence reduction coordinator or any other staff, or raised any concerns. Information is clearly displayed on E wing about what prisoners should do if they are being bullied.

I conclude that there can be no criticism of staff for not knowing that the man was experiencing bullying; they did not witness anything or have it brought to their attention. However, I was concerned that several prisoners said they knew that the man was experiencing problems but did not feel able to raise the matter with staff.

Similarly, prisoners felt distrusting of some staff, and suspected their mail was being improperly read. They were concerned about potential repercussions if they complained. The man was also concerned by this, and crossed out the names of those he accused in his letters to friends and family.

The Governor, together with the safer custody team, should consider how best to increase prisoners’ trust in reporting allegations of bullying.

Crisis management

When the man was found, staff acted professionally and quickly in their attempts to resuscitate him. Paramedics arrived quickly and took over the management of the situation.

Cardiff uses a code system to alert staff to emergencies. Code red indicates self-harm by cutting, code blue signifies use of a ligature, and code white indicates that someone is fitting or unconscious.

On his arrival at the cell, the wing officer saw that the man was unconscious and called “code white”. He quickly rectified this to “code blue”. The wing officer was confused about the codes. Many other prisons operate a coding system that is simply red or blue, depending on whether the emergency is related to blood or breathing.

Whilst I do not believe that the confusion affected the man's care, it is important that staff are fully aware of the codes and confident in the definitions.

The Governor should consider whether to simplify the emergency code system, and should remind staff of the definitions.

Family care

When the man died, the prison appointed a family liaison officer (FLO). She made attempts to locate the man's next of kin who lived a considerable distance from Cardiff. The FLO then contacted a prison closer to the family's home to ask if they could send someone to break the news in person. Unfortunately, this was not possible.

The FLO was properly concerned that the man's family needed to be informed quickly, and that they should not learn of his death by other means. She therefore telephoned them.

A visit in person is always best practice. However, I am satisfied that efforts were made to conduct such visit and careful consideration was given to the balance of giving the news in person and doing so in a timely manner.

The FLO subsequently kept in regular contact with the family. She visited to meet them in person and to return the man's belongings. Several matters arose after the man's death in terms of friends trying to contact him. The FLO liaised with the man's family to decide how best to deal with the situations. One of the man's brothers described the FLO as "brilliant".

The FLO has performed her role with diligence and compassion. The man's family have been grateful for her help.

The FLO should be recognised for her actions in her role as the prison's family liaison officer.

Conclusion

The man had a number of opportunities to speak with people about his feelings. The suicide prevention coordinator, who is experienced in identifying, assessing and caring for those at risk of suicide and self-harm, saw no indication that the man was feeling low when he spoke with him a few days before his death. A birthday card to the man's friend, which must have been posted only a day or two before his death, said he would write.

The man was exceptionally organised. Everything in his cell had a place, and he had a number of cards for various occasions in his cell. My investigators found a Christmas card, addressed "To my family". Inside the card, it said it was no one's fault and "sorry I wasn't stronger". The card was not dated, unlike virtually all other correspondence. His family felt strongly that this was not meant as a suicide note at this time.

There is no doubt that at various times the man was in considerable pain. It is unclear whether, in the last two days of his life, he had rejected any medication, and if so, what type of medication. Certainly, prisoners described the man's coughing the night before his death as "worse than ever" and that he was struggling to breathe. Lack of sleep and pain can affect the state of mind.

On many occasions when the man spoke to others about sarcoidosis, he told how it was incurable and was going to get worse. His psychologist said:

"The man never actually told me what was wrong with him but from what he was telling me, it sounded like he had some kind of terminal illness and he wasn't expected to recover from it but it was a long-term thing that was being managed through medication. That's what he said so he was quite preoccupied with that and I'm not sure. He didn't talk so much about, in the past when he had his last incident of self-harm but in the months, the months afterwards like I said he talked a lot about feeling the need to be punished for what he'd done and he still referred to that relatively recently, saying that he didn't think that prison was enough for him, enough of a punishment for him for what he had done. But I did, I often asked him about suicidal thoughts and self-harm given his history and he said that even though he still felt the need to punish himself he'd never do anything to himself because of his family, he didn't want to put his family through that."

Several years earlier, when the man had felt threatened in Long Lartin, he self-harmed. It is evident from his letters that he felt under threat in Cardiff, although he was at pains to stress he was coping. My investigators asked the psychologist how well the man coped with challenges. She felt that the man was not particularly emotionally robust but was stronger than he had been.

My investigators found there was a sense of shock and bewilderment from both staff and prisoners at the man's passing. They had thought that he had a positive future with a progressive move coming up.

RECOMMENDATIONS

I recommend that the Governor appoints and trains an appropriate number of officers in the lifer personal officer role, to ensure there are no avoidable gaps in continuity of care. Where there is an unavoidable gap, a nominated officer should ensure the normal personal officer role is covered until a suitably trained person can take over.

The Governor should review the effectiveness of the complaints system, particularly on the lifer wing.

The Governor, together with the safer custody team, should consider how best to increase prisoners' trust in reporting allegations of bullying.

The Governor should consider whether to simplify the emergency code system, and should remind staff of the definitions.

GOOD PRACTICE

The prison family liaison officer should be recognised for her role following the man's death.