



**Investigation into the death of a man  
at HMP Cardiff in June 2012**

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

**February 2013**

This is the report of an investigation into the death of a man in June 2012, while a prisoner at HMP Cardiff. He was found hanging in his cell three days after he arrived at the prison. He was 40 years old. I offer my condolences to his family and friends.

An investigator conducted the investigation. The local PCT conducted a review of the medical care given to the man in custody. The prison cooperated fully with the investigation.

The man had a history of self-harm, which court staff had drawn attention to in a self-harm warning form and by telephone. He was assessed on reception at Cardiff and was judged not to be at risk of self-harm despite the warning form and the fact he was withdrawing from alcohol, which increased his risk. During his short time at the prison, staff recorded no concerns about him. At the end of June, an officer found him hanging in his cell. Resuscitation attempts by officers, nurses and paramedics were unsuccessful.

The investigation found that prison staff either did not see or act on a self-harm warning form completed by court staff before the man's arrival at Cardiff. Assessing the risk a prisoner poses to himself involves balancing the prisoner's demeanour and behaviour against known risk factors and it is a concern that staff seem to have relied too much on subjective assessments of his personal presentation. Even without seeing the self-harm warning form, on the evidence available, greater weight should have been given to his known static risk factors including his history of self-harm, mental health problems, the circumstances of his offence and his withdrawal from alcohol.

I am concerned that the man's risk was not adequately assessed and there was insufficient guidance on managing his detoxification from alcohol. However, the PCT consider that his death was neither foreseeable nor preventable. His actions at the end of June do indeed appear to have been impulsive and we cannot know whether the outcome would have been any different had these aspects of his treatment been better managed.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

**Nigel Newcomen CBE**  
**Prison and Probation Ombudsman**

**February 2013**

## **CONTENTS**

Summary

The investigation process

HMP Cardiff

Key events

Issues

Conclusion

Recommendations

## SUMMARY

1. The man arrived at HMP Cardiff as a remand prisoner on 27 June 2012. This was not his first time in prison and he had been released from Cardiff the previous January. He was 40 years old.
2. A court officer telephoned the prison to alert staff to concerns that the man seemed depressed and had tried to hang himself in 2010. The officer also completed a self-harm warning form, which was sent to Cardiff.
3. The nurse who carried out the man's reception health screen did not see the court self-harm warning form, so she did not know about the attempts to self-harm in 2010. He told her that he had tried to hang himself in 2006, but he did not mention the 2010 incident. He said he had no existing thoughts of self-harm and, although he was noted to be at "increased risk," he was given a single cell on the induction wing. His induction officer also did not see the warning form from court. It was recognised that he was withdrawing from alcohol but this does not appear to have been taken into account as a factor which increased his vulnerability. He was not assessed as needing monitoring as a risk of suicide and self-harm.
4. A member of the chaplaincy team spoke to the man as part of his induction. He was concerned about his relationship with his girlfriend, but he expressed no thoughts or intentions of self-harm. He telephoned his mother briefly the day after his arrival and also spoke to a friend an hour before he was found in his cell but gave no indication to either of them that he felt depressed or intended to harm himself.
5. One afternoon at the end of June, the man was found hanging in his cell. Efforts by prison staff and paramedics to resuscitate him were unsuccessful and he was pronounced dead at 3.15pm. Prison staff notified his mother promptly of his death and contributed to his funeral costs.
6. The investigation found that prison staff did not properly follow the prison's reception procedures that require reception officers to pass self-harm warning forms to the reception nurse for action before the initial health screen and to other staff who assessed risk. Despite the reception manager saying that she would regularly attach the form in a way that would make it easily identifiable, it is evident that this did not happen on this occasion. The fact that the man was withdrawing from alcohol does not appear to have been given sufficient weight in assessing his risk of suicide and self-harm and Cardiff's guidance to staff about alcohol detoxification does not comply with national guidelines. In addition, his cell sharing risk assessment was not updated, when his perceived needs changed and concerns noted on the form were not discussed.
7. We make four recommendations for improvements in the operation of Cardiff's reception and alcohol detoxification procedures.

## THE INVESTIGATION PROCESS

8. When we were notified of the man's death, notices were issued informing staff and prisoners at HMP Cardiff of the investigation. The investigator contacted the prison and visited Cardiff on 4 July 2012, to speak to prison staff and collect his prison and medical records.
9. Healthcare Inspectorate Wales commissioned a review of the medical care given to the man in custody and the report was received on 9 November.
10. One of our family liaison officers contacted the man's family on 16 July, to find out if they had any concerns about his care and to provide information on the investigation process. His family raised three questions, which are addressed in the report:
  - Were telephone calls made by him recorded?
  - Did he leave a suicide note?
  - Were any illicit drugs found in his system after his death?
11. The family liaison officer attempted to contact the family to ask if they wish to provide feedback to the draft report, but received no reply. He followed this in writing explaining that if no response was received by the deadline the final report would be issued. No response was received. A copy of the final report will be made available to the family.
12. The investigator contacted HM Coroner, to inform her of the investigation and request a copy of the post-mortem and toxicology reports.
13. On 5 September, the investigator returned to Cardiff to conduct interviews with prison staff. He subsequently gave both verbal and written feedback to the Governor.

## **HMP CARDIFF**

14. HMP Cardiff is a local prison, predominantly serving the Welsh courts and the South West of England. It holds up to 784 adult convicted and remand prisoners.
15. The local health board commissions healthcare, but all nurses and other healthcare staff are employed by the Prison Service. The general practitioner service is delivered by the local health board, which also employs a consultant psychiatrist for seven sessions a week. A 22 bed inpatient facility in the healthcare centre provides 24-hour nursing and medical cover.
16. Prisoners dependent on opiates who arrive at Cardiff without a community prescription of methadone or Subutex (used to treat addiction), undertake a 14 day detoxification programme. Where necessary this takes place in the healthcare wing. Once the prisoner is regarded as stable, he is moved to a residential wing. The Counselling, Assessment, Referral, Advice and Throughcare service (CARATs) provides longer-term support for alcohol and drug users.
17. Since 2011, there have been nine deaths at Cardiff. Recommendations from previous investigations are not repeated in this report.

## **HM Inspectorate of Prisons**

18. An unannounced follow-up inspection of Cardiff took place in June 2010. HM Chief Inspector of Prisons, commented that:

“...Despite a tragic spate of deaths in custody, Cardiff continued to provide an essentially safe environment. An appropriately heightened focus had been given to suicide prevention work and to learning lessons that might prevent future fatalities. Early days in custody were satisfactorily managed, although reception staff struggled to deal with the churn of prisoners that they faced. Anti-bullying work was sound and levels of assault were low ...”

Inspectors noted that only 43% of staff had received assessment, care in detention and teamwork (ACCT) refresher training in the previous three years.

## **Independent Monitoring Board**

19. Every prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who monitor standards to help ensure prisoners are treated fairly and decently. In the last published IMB report for the period 1 September 2010 to 31 August 2011, the Board described the suicide and self-harm procedures as “well used”. They also noted the dispersal of substance misusers from a dedicated wing to the healthcare centre and residential wings. They considered that this has improved the conditions of prisoners undergoing detoxification.

## KEY EVENTS

20. The man was arrested on 26 June 2012, following a domestic dispute and remanded into police custody. He was 40 years old. He had been released from an earlier sentence at Cardiff, in January 2012
21. The police recorded that the man was intoxicated on arrest. The duty doctor noted on the 'Detained Person Medical Form' that he was an alcoholic in good general condition. He considered him fit to be detained and prescribed diazepam, widely used in the treatment of alcohol withdrawal, to be taken every 8 hours.
22. The man told the police duty doctor that he might have undiagnosed bi-polar disorder, formerly known as 'manic depression'. (Those with the disorder experience swings in mood, from over-excitement to deep depression.) He had claimed to have this disorder during previous arrests. It was also recorded that he had attempted suicide in 2010.
23. The man appeared at Magistrates' Court on 27 June, and was remanded into custody, charged with wounding with intent. At court, a custody officer was concerned about him as he appeared depressed. In view of this and medical information about a history of self-harm, including an attempted hanging in 2010, he completed a self-harm warning form. The court officer noted that he had telephoned a Senior Officer (SO) at Cardiff to alert him.
24. The investigator asked the SO if he recalled the conversation, and what action he is required to take on receiving such information. The SO said he had been on duty at the time but he could not specifically recall the telephone conversation. The SO said that he recorded the man's name in the reception book, but he did not record that a self-harm warning had been opened as this would be handed to reception staff when he arrived.
25. After the man's details were recorded by the reception SO, a nurse carried out an initial health screen. Before completing the health screen, the reception nurse collects the medical record from the reception staff. This should contain any information received from outside agencies, including the police, and self-harm warning forms. The record should also contain a cell sharing risk assessment (CSRA) which nurses are also required to complete. The CSRA is used to identify prisoners at risk of seriously assaulting or killing a cell mate in a locked cell. She noted 'detox' and mental health issues on the CSRA form as she believed this information was relevant to the process.
26. Cardiff's suicide and self-harm prevention policy at Cardiff, requires all self-harm warning forms to be passed to the reception nurse, for action and signature. The man's form was signed by the SO in reception but was not signed by the nurse.
27. The nurse recorded that the man had been diagnosed with depression for which he had been prescribed mirtazapine. (The clinical reviewer notes that it is not uncommon for the dosage given to him to be prescribed when patients

are beginning to feel well.) They discussed his previous self-harm and he told her that he had attempted to hang himself in 2006, but was found by a friend and regretted his actions. He did not refer to the 2010 incident on the court warning form. He said he had not attempted to harm himself during previous periods in prison and had not been treated by a psychiatrist. The nurse recorded that he made good conversation and eye contact and said he had no thoughts of self-harm.

28. The man and the nurse also spoke about his previous drug and alcohol use. He disclosed that he was an alcoholic, and that he used cannabis, as well as benzodiazepines when he could not afford alcohol. (Benzodiazepines are used to treat anxiety, sleeping problems and other disorders.) She recorded that she referred him to the prison GP due to his substance misuse problems and to the prison's mental health team.
29. Prisons in Wales are required to have a local policy and procedures to identify and treat prisoners with substance misuse problems, who may require detoxification treatment. At interview, the nurse explained that reception nurses at Cardiff screen for various substances and some symptoms, such as tremors, can be assessed visually. The prisoner is then seen by the GP, who decides on the appropriate length of treatment.
30. During the health screen, the nurse completed an alcohol assessment, which asks a series of questions about current feelings in order to identify signs or symptoms of withdrawal. The man had moderate tremors but he was not sweating. When asked whether he was anxious or nervous, he replied that he was moderately to severely anxious. At the end of the assessment, a final score indicates the level of withdrawal and detoxification and the treatment required. He had an overall score of 17, which indicated a requirement for a standard alcohol detoxification programme of seven days, using diazepam.
31. The investigator asked the nurse about additional care for those detoxifying, for example, whether they went to a particular wing or were observed more frequently. She replied that in addition to observations by wing staff, nurses also see the prisoners twice a day to dispense medication. At that point, the nurses would discuss progress with them and ask how they were feeling so they would be alert to any deterioration in symptoms. She explained that 'rescue medication' would also be prescribed by the nurses, as required. These are medicines to treat symptoms of withdrawal such as stomach cramps, diarrhoea, nausea and general aches and pains. She added that some prisoners take this additional medication for the duration of their detoxification and others choose not to.
32. Cardiff's suicide and self-harm policy instructs staff to pass the self-harm warning forms to the reception nurse. The nurse could not recall seeing the self-harm warning form or any medical information that had arrived with the man from court. She said he had volunteered the information about his previous self-harm and alcohol use during the assessment. The investigator showed her the form and police information but she said that, even if she had seen this during her assessment, she would not have done anything differently

as she had covered self-harm issues and his demeanour was appropriate. She added that he was keen to work with the Counselling, Assessment, Advice and Throughcare service (CARATs) team to address his substance misuse problems. CARATs teams address the non-clinical drug treatment needs of prisoners, such as advice and counselling.

33. On the medical section of the CSRA, the nurse recorded 'increased risk, mental health issues, requesting B1 landing. Awaiting mental health assessment, states that he is a poor copier'. The investigator asked the nurse about the CSRA and her comments on the form.
34. The nurse said that the man's previous history of depression and self-harm, as well as his detoxification, were relevant to the risk assessment. The investigator asked why she had ticked the increased risk box and recorded that he was awaiting a mental health referral. The nurse explained that she had initially considered a mental health referral, but after a further conversation with him it became clear that his priority was to address his alcohol use as he linked this to his mental health and felt this was the cause of his depression. She advised him that he could request a mental health referral if he needed this later but did not amend the form. She had designated him as 'increased risk' as he had described himself as a poor copier, not because of concerns about his mental health or self-harm
35. The man told the nurse that he had previously lived on B1 landing and believed he would cope much better if he returned there. B1 landing at Cardiff provides accommodation for vulnerable prisoners (those at risk of threats and intimidation from other prisoners usually because of the nature of their offence). She explained to him that she would recommend this but the decision would be made by operational prison staff.
36. The investigator asked the nurse whether she would consider a prisoner detoxifying from alcohol or other substance, with a history of mental health problems and a documented history of self-harm to be at greater risk. She replied that every prisoner is assessed as an individual and she attempts to build a rapport in the short time that she spends with them. She said that, if she had had any concerns or felt that he needed additional support or monitoring, she would have started the suicide and self-harm monitoring procedures and opened an Assessment, Care in Custody and Teamwork (ACCT) document. The ACCT process is used to provide additional support and monitoring for prisoners considered to be at risk of self-harm.
37. After the initial health assessment, an officer saw the man. The officer's duties were to interview newly received prisoners and complete the remainder of the CSRA, as well as induction paperwork. HMP Cardiff's CSRA policy says that where healthcare staff indicate there is evidence of increased risk, they are to discuss their concerns with the reception officer or manager. The nurse and officer both agreed that it would be usual for the nurse to speak to the reception officer if concerns were indicated on the CSRA but neither recalled speaking to each other about the man.

38. The officer said that he reads the escort record and CSRA, as well as any other information that arrives with the prisoner, but he could not recall whether he had seen the self-harm warning form or information from the police. He explained that the SO on the reception desk usually staples it to the CSRA and places it inside the front cover of the record, which is then passed to nurses and induction officers. He said the man seemed very quiet and nervous, but answered all his questions. In his case, the self-harm warning form was not stapled to the CSRA but was placed inside his personal file.
39. The man declined to take part in the full induction programme. The officer explained that it was not unusual for those who had been in the prison previously to decline the full induction. The man had recently been released from Cardiff. The officer recorded on the CSRA that he was a standard risk for cell sharing which meant that he was not regarded as a risk of violence to someone he might share a cell with. After the reception procedures, he was given a single cell on the induction wing (C wing), where most of the cells are single.
40. The next day, 28 June, a Staff Nurse completed the man's secondary health screen, including discussion of his alcohol detoxification. (The purpose of this is to gather more information about a prisoner's medical history, as well as offering advice on immunisations and other available clinics.) The investigator asked the nurse whether he had discussed self-harm issues with him. He explained that this would not normally be part of the health screen and he would not have access to information such as the self-harm warning form or police information, but if a prisoner mentioned self-harm it would be recorded and discussed. The nurse was unable to recall him, but said that as he had not recorded anything significant he could only assume that he had been 'quite ordinary'.
41. Although he had not seen the self-harm warning form, the nurse explained the administrative process. He said that the information should be placed in the prisoner's record and during the initial health screen, the nurse should record any information received from an outside source. There is also a section on the warning form for the nurse to sign, to indicate that they have seen it and the action taken.
42. As part of the normal induction process, a part-time prison chaplain saw the man later that morning. He had not met him during his previous periods in custody. He recalled that he was concerned about his girlfriend and the breakdown of their relationship. He disclosed to him that his current offence was against his girlfriend and that a restraining order was in place. He also wished to attend chapel and discuss his relationship. He did not appear unduly upset or distressed. The chaplain had only worked at the prison a short time, but said he was fully aware of the actions to take if he had concerns about a prisoner's welfare.
43. During the afternoon on 28 June, the man had a brief telephone conversation with his mother. The investigator listened to a recording of the call. He sounded upbeat and did not mention any concerns.

44. The next morning, 29 June, the man collected his medication at around 8.00pm. It is not recorded whether he chose to spend time in the open air with other prisoners in the exercise yard between 9.00am and 9.30. In the afternoon, all prisoners on C wing had association (social time when prisoners are able to mix with each other, shower and make telephone calls) between 2.00pm and 3.00pm. Nothing was recorded about him. Prisoners were then locked in their cells until they collected their evening meal at 5.00pm. Afterwards, they were locked up again for the remainder of the evening. There were no recorded concerns raised by or about him that day.
45. On Saturday prisoners followed the same routine. At around 1.50pm, Officer A was on C wing unlocking prisoners for afternoon association. He said in a statement to police, that he unlocked the cell and shouted 'association'. The man, who was sitting on his bed, acknowledged him by saying 'okay'. The officer saw nothing that gave him cause for concern.
46. The man made a four-minute telephone call to a family friend at 1.55pm. The investigator listened to the call. His voice sounded slurred but he made no reference to feeling depressed or any thoughts of harming himself.
47. Three prisoners in cells close to the man's, said that they had seen him wandering around the landing just after being unlocked that afternoon, but they had not spoken to him. They described him as someone who kept himself to himself. One prisoner said that, during the association period, he had walked back past his cell and noticed his door was closed. He assumed he had closed it himself, as there was no one else on the landing. During association, no officers are based on the upper landings and most prisoners congregate on the ground floor to play pool or talk to friends.
48. At approximately 2.50pm, two officers began to lock prisoners back in their cells on C4 at the end of association. When Officer B reached the man's cell, he noticed the door and outer observation hatch were already closed. He opened the hatch to look in, and saw him at the back of the cell with something tied around his neck (later found to be a prison issue t-shirt), attached to the window bars. He immediately called to Officer C for assistance.
49. The officers went into the cell. Officer C said in a statement to police, that the man was 'slumped' against the back wall facing into the cell. He lifted him while Officer B cut the t-shirt from his neck using his anti-ligature knife. The officers then laid him on the floor and Officer B began chest compressions. Officer C used his radio to request medical assistance.
50. An officer, trained in first aid, responded to the emergency call as the first responder and assisted the resuscitation attempts. He took an emergency bag containing an automated defibrillator. He used his radio to request an emergency ambulance to be called.
51. Two nurses were treating prisoners when they heard a code blue emergency call. (Prisons generally use a coding system for medical emergencies, usually

red for bleeding and blue for respiratory problems. The codes help notify the nurses and other staff of the type of emergency and what equipment might be required.) Nurse A said that she collected the emergency equipment from the office on C wing and they reached the cell at around 3.00pm. The nurses took over the resuscitation attempts from the officers. They set up the equipment and placed an oxygen mask on the man. They also checked for a pulse and breathing but neither was evident. Nurse A said one of the officers had attached a defibrillator but there was no response.

52. Paramedics arrived at 3.12pm and assessed the man while the nurses continued CPR. They found no cardiac rhythm or spontaneous breathing and he was pronounced him dead at 3.15pm.

### **Events after the man's death**

53. An officer was appointed as the prison's family liaison officer (FLO). At about 5pm, he, the Governor and the prison chaplain went to see the man's mother to break the news of her son's death. A follow up visit was arranged.
54. The day after the man's death a debrief was held with the staff involved in the emergency. The nurses said that they were offered the opportunity to attend and all staff said that they had been suitably supported. Prisoners on C-wing were also offered support by wing staff and the investigator was told that prisoners subject to ACCT monitoring were reviewed.
55. On 1 July, the FLO visited the family again and, in line with national Prison Service guidance, offered a contribution to funeral costs. He remained in regular contact and attended the funeral with the chaplain on 11 July.

## ISSUES

### Assessment of risk

56. As the man was at Cardiff only a very short time before his death, there were few entries in his prison record. A self-harm warning form detailing concerns by a member of the court staff and police documents about previous self-harm attempts were given to reception staff. Cardiff's local guidance says that self-harm warning forms should be passed to the reception nurse in all cases, but the investigation found that neither the nurse nor the first night officer had sight of the documents during their subsequent assessments.
57. His mental state and risk of self-harm or suicide were assessed by healthcare staff on his arrival at the prison. All those who met him described him as seeming calm and he said he was "fine". An officer carried out both the relevant part of the CSRA and first night assessment. During the latter, he said he had no current thoughts of self-harm or suicide.
58. A nurse said that although she had not seen the self-harm warning form she had asked him about past and current actions or thoughts of self-harm. He said that he had no such thoughts and she did not notice any signs of vulnerability in relation to self-harm. He had a history of mental health problems and initially she intended to make a mental health referral. However, after speaking to him again, she changed her mind as he wished to engage with the CARATs staff to address his alcohol misuse, which he considered to be the catalyst for his mental health problems.
59. We have considered whether staff should have opened an ACCT plan on the man's arrival, particularly as we have been critical in the past when prison staff place too much reliance on what the prisoner tells them and ignore the weight of other risk related information. The PER that accompanied him to prison made reference to his history of self-harm behaviour as did the self-harm warning form. He also had a history of alcohol misuse, as well as mental health problems. In addition, he had been convicted of an offence against a family member and placed on an alcohol detoxification programme. All these factors are significant indicators of risk of self-harm and suicide. Set against these, he consistently said he had no thoughts of self-harm or suicide when asked directly. His behaviour and demeanour gave no indications otherwise.
60. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. However, we are concerned that staff relied so heavily on the man's presentation, when he had a number of known risk factors when he arrived at Cardiff. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We

consider that more weight should have been given to the known risk factors in comparison to his presentation.

**The Governor should ensure that, when staff receive a self-harm warning form during the reception process, it is given to the reception nurse and induction officer for consideration and action if necessary.**

**The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of self-harm or suicide.**

## **Detoxification**

61. Prison Service Order (PSO) 3550, 'Clinical Services for Substance Misusers' provides guidance on services for those with drug or alcohol issues. This sets out what a prison should provide in their substance misuse treatment service and a framework for their local policy. The investigation found that Cardiff has clear assessment tools for prisoners with alcohol or drug dependency. Links to services such as CARATs were evident during the initial health screening process, with onward referrals as appropriate.
62. However, the PSO also specifies a requirement for each prison to have written, evidence-based guidelines for the management of alcohol misusers, with a mandatory task list including the frequency and nature of physical observations and guidelines for admission to healthcare. Cardiff's alcohol detoxification policy provides background for staff to consider when assessing a prisoner's medical history and the detoxification regime but omits several of the mandatory tasks such as observations and location. There is a requirement in the PSO for 'treatment managed and supervised, where possible in health care centre by trained and experienced staff.' The only provision at Cardiff for a prisoner identified as detoxifying from alcohol to be admitted to healthcare is if there is a need for them to undergo IV medication. Other than this, the majority of prisoners, like the man, are located in the first night wing supervised by prison officers. The nurse indicated that the nurses carried out a form of general observation when such prisoners collected their medication. No regular basic clinical observations such as checking pulse, temperature and blood pressure were taken for prisoners withdrawing from alcohol on the wings. We note that the requirement for prisons in England is that 'all drug and alcohol dependent prisoners arriving in reception must always be offered immediate admission to a stabilisation unit' which has 24 hours health cover.
63. The man was assessed and considered to require a standard alcohol detoxification and displayed some physical signs of withdrawal. There is no evidence that he was observed more regularly than any other prisoner on the wing. We believe that the Cardiff guidance on the management of alcohol detoxification is inadequate and make the following recommendation:

**The Governor and Head of Healthcare revise their local policy for managing prisoners withdrawing from alcohol to meet the requirements**

**specified in PS0 3550 'Clinical Services for Substance Misusers' and ensure that all relevant staff understand it and are trained and competent in their roles.**

### **Clinical care**

64. The man had a full health assessment when he arrived at Cardiff. This included questions about previous and current thoughts of self-harm and substance use. It was evident from the investigation that Nurse Richards, who carried out the assessment, had not had sight of the self-harm warning form relating to him, and this issue is dealt with below. However, the nurse discussed with him his current and previous self-harm issues, and recorded this clearly on his medical record. She said at interview, that she had no concerns about his well-being during the assessment and having subsequently read the information on the self-harm warning form, she would not have done anything differently.
65. The PCT point out that the current medical IT system (SystmOne) does not allow a full printout of patients' notes and they make a recommendation on this issue. There are four further recommendations in their report, including clinical input on CSRAs and self-harm warning forms. However, they conclude that on the information available and on the balance of probability, the man's death was neither preventable nor foreseeable and the emergency response was prompt and equipment was working and readily available.

### **Cell Sharing Risk Assessments (CSRA)**

66. A Cell Sharing Risk Assessment (CSRA) is completed for all prisoners on reception into custody. The purpose is to identify prisoners at risk of seriously assaulting or killing a cell mate in a locked cell.
67. The nurse recorded on the CSRA form that the man was awaiting a mental health assessment, but later clarified at interview that the referral had not been sent. She explained that she had initial concerns about his history of depression. However, after a later discussion in which he told her that it was caused by his alcohol consumption and he would prefer to work with the CARATs team, she decided against the mental health referral. She therefore made a referral to CARATs and told him that he could ask one of the nurses if he felt that he required support from the mental health team. She did not re-write the CSRA following the later discussion with him. This gave the impression to staff who read the form in the days following his reception that a mental health assessment was pending. At a review of his CSRA the day after he arrived, it was recorded that he should remain as an 'increased' risk as he was awaiting a mental health assessment.
68. The nurse indicated that the man was an 'increased' risk, whereas an officer recorded that he was a 'standard' risk. They did not discuss the assessment with each other and it seems that she might not have fully understood the purpose of the CSRA. It is not explained why a history of depression would increase the risk that he would assault a cell mate and it seems that this related

to vulnerability. The increased risk box on the healthcare assessment part of the CSRA refers to a “clear indication of increased level or risk that prisoners might assault cell mate”. Where there is an indication of increased risk this should be discussed with the reception officer. HMP Cardiff’s policy on CSRAs says, ... “Where HCC [healthcare centre] staff indicate there is evidence of increased risk, they are to discuss their concerns with the reception officer or manager ...” While there is no evidence that the handling of the CSRA had a direct impact on his circumstances, the CSRA is an important document and it is essential that staff fully understand and comply with the assessment process.

**The Governor and Head of Healthcare should ensure that staff are fully aware of the purpose of CSRAs, complete the forms accurately and update them promptly if there are changes to a prisoner’s circumstances. Healthcare staff should discuss concerns about prisoners considered to be at increased risk of harm to another prisoner with the appropriate reception staff.**

## **CONCLUSION**

69. When the man was sent to Cardiff court staff completed a self-harm warning form that highlighted his risk. The form was not considered during his reception to the prison and staff relied too much on his personal presentation rather than objective risk factors when assessing his risk of suicide and self-harm. He was prescribed medication for alcohol detoxification but was not fully supervised by healthcare staff. The appropriate cell sharing risk assessment procedures were not followed.
70. Although we conclude that his actions at the end of June could not reasonably have been foreseen nor prevented by staff, we are concerned that his risk was not rigorously assessed and there was insufficient guidance on managing his detoxification from alcohol.

## RECOMMENDATIONS

1. The Governor should ensure that, when staff receive a self-harm warning form during the reception process, it is given to the reception nurse and induction officer for consideration and action if necessary.

The Prison Service accepted this recommendation and said:

Governor's Order (GO) 53/2012. The Person Escort Record (PER form) & Self-Harm/Suicidal Documentation was issued on the 13<sup>th</sup> December 2012. This reminds staff that all SH warning forms and other documentation from the police or other external agencies must be passed to all staff carrying out assessments/reviews on prisoners.

2. The Governor should ensure that all the known risk factors of a newly arrived prisoner are fully considered when determining their risk of self-harm or suicide.

The Prison Service accepted this recommendation and said:

A "Suicide & Self-Harm screening tool" has been created, this will be used in reception and any prisoner who has a number of "Trigger" points will automatically have an ACCT document opened on them.

3. The Governor and Head of Healthcare revise their local policy for managing prisoners withdrawing from alcohol to meet the requirements specified in PSO 3550 'Clinical Services for Substance Misusers' and ensure that all relevant staff understand it and are trained and competent in their roles.

The Prison Service accepted this recommendation and said:

Not all nurses working within HMP Cardiff have completed specific training in substance misuse, but have a basic understanding when dealing with prisoners with substance misuse issues.

Specific substance misuse/alcohol training is due to be implemented, with Public Health Wales and the Royal College of General Practitioners.

Plans are also in place for a Drug Treatment Wing, where prisoners will be monitored. Policies are currently under review in preparation of the opening of this wing.

A copy of PSO 3550 will be e-mailed to all staff.

4. The Governor and Head of Healthcare should ensure that staff are fully aware of the purpose of CSRAs, complete the forms accurately and update them promptly if there are changes to a prisoner's circumstances. Healthcare staff should discuss concerns about prisoners considered to be at increased risk of harm to another prisoner with the appropriate reception staff.

The Prison Service accepted this recommendation and said:

The establishment's Cell Sharing Risk Assessment (CSRA) Policy will be re-issued under a Governor's Notice to Staff (GNTS), reminding staff of their individual responsibilities.

A CSRA training plan is being formulated for Health Care Centre staff to ensure compliance with local policy.