

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man  
at HMP Cardiff in March 2014**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Cardiff in March 2014. He was 28 years old. I offer my condolences to his family.

A clinical review of the care that the man received at the prison was undertaken. The prison cooperated fully with the investigation.

The man was remanded to HMP Cardiff on 27 January 2014, charged with a violent offence against his partner. When he arrived at the prison, reception staff failed to identify that this and other factors which increased his risk of suicide and self-harm. He was from the Slovak Republic and spoke little English, but the reception staff did not use an interpreting service. His personal officer said he saw him often, but there is no written record of any staff interaction with him for the next six weeks. In early March, he became distressed and staff supported him using suicide and self-harm prevention procedures until 21 March. He hanged himself three days later.

I am concerned that, as in a number of previous cases at Cardiff, reception staff did not identify factors which increased the man's risk of suicide and self-harm. It is also difficult to understand how they could have made an informed decision about his risk without using an interpreting service. Subsequently, there was too much reliance on another prisoner to interpret, even for confidential and sensitive matters.

Once the man's risk had been identified, he received some good, practical support. His mood appeared to improve, so the case manager ended the suicide and self-harm monitoring measures. This could have been a reasonable decision at the time, but I am concerned that the lack of professional interpretation meant that his risk factors might not have been fully identified. None of the case reviews were multidisciplinary and there was no healthcare involvement. A doctor prescribed him antidepressants, but his mental health was never fully assessed. Finally, although it was too late to save him, there were deficiencies in the emergency response which need to be remedied.

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**  
**Prisons and Probation Ombudsman**

**November 2014**

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## SUMMARY

1. The man was charged with a violent offence against his partner and remanded to HMP Cardiff on 27 January. He was a citizen of Slovakia and spoke and understood very little English. Despite this, no one in reception at Cardiff used a telephone interpreting service to communicate with him for their assessments. The reception officer did not use the local suicide and self-harm screening tool correctly and did not identify that he was charged with an offence against a family member (a factor which can increase the risk of suicide) or that this was his first time in prison. Contrary to the prison's foreign national policy, no one referred him for help with his English language skills during his induction period.
2. There is no written evidence in the records of any staff interaction with the man for the next six weeks. However, his personal officer told the investigator that he used a prisoner from the Czech Republic to interpret for him and help him with daily life on the wing. After six weeks in prison, he told the Czech prisoner that he had thoughts of hanging himself. The Czech prisoner told the wing staff and, on 8 March, they began Prison Service suicide and self-harm prevention procedures (known as ACCT). A mental health nurse saw him and arranged for a GP to prescribe an antidepressant. A mental health referral meeting discussed him and decided that the mental health nurse should review him a month later.
3. There were three ACCT case reviews over the next two weeks, none of which had a member of healthcare staff present. The Czech prisoner attended to interpret for the man, who was offered some practical help and began attending English classes full-time. On 17 March, at the second case review, he said he would take his own life if he had the opportunity. Despite this, his assessed risk of suicide and self-harm was reduced from raised to low based on his overall mood. At the third case review four days later, on 21 March, his mood seemed further improved and the ACCT was closed. The ACCT case manager was satisfied that the identified goals on his care map had been completed. Officers checked him each day after that, but identified no concerns about him.
4. Several days later the man's cellmate woke and found that he had hanged himself using a torn blanket attached to the bed frame. He raised the alarm and staff attended and cut the ligature. They did not use an emergency response code and there was a delay of four minutes until they asked the control room to call an ambulance. The staff did not attempt resuscitation as it was apparent to both them and the nurse who attended that he had died. Paramedics arrived and pronounced his death.
5. We are concerned that reception staff did not identify all the man's risk factors when he first arrived, something we have criticised in previous investigations into deaths at Cardiff. We are also concerned that reception staff did not use a telephone interpreting service to make sure he understood what he was being asked. Similarly, another prisoner interpreted during ACCT reviews and healthcare interviews, which is inappropriate for sensitive and confidential matters. While some sensible practical support was provided to him when he was on an ACCT, reviews were not multidisciplinary and we question some of the risk assessment. Finally, although it did not affect the outcome in his

case, there were weaknesses in the emergency response which could be crucial in a future emergency. We make six recommendations.

## THE INVESTIGATION PROCESS

6. We issued notices to staff and prisoners at HMP Cardiff about the investigation. No one responded. The investigator visited Cardiff on 27 March and collected copies of the man's clinical and prison records. On 8 and 9 April and 8 May, he interviewed members of staff and prisoners. He gave verbal feedback to the Head of Safer Custody and written feedback to the Governor about the initial findings of the investigation.
7. Healthcare Inspectorate Wales reviewed the man's clinical care at the prison.
8. We informed HM Coroner for Cardiff and The Vale of Glamorgan of our investigation, who provided a copy of the post-mortem report. We have sent the Coroner a copy of this report.
9. After NOMS received the draft report, they pointed out that the man's antidepressant medication was appropriately prescribed and that a follow-up appointment had been arranged. We therefore agreed to remove the recommendation relating to antidepressant medication and this final version of the report only has six recommendations instead of seven.

### **The man's family**

10. One of our family liaison officers contacted the man's family in Slovakia to explain the investigation process. They asked for more information about:
  - His court dates and remand status;
  - The physical and mental healthcare he received;
  - Monitoring of his welfare;
  - The medication he was prescribed;
  - His cellmate;
  - The exact circumstances of his death.
11. We provided the family with a copy of our draft report translated into Slovakian. They responded with comments that do not impact on the factual accuracy of this report. We have replied in a separate letter thanking them for their involvement in the investigation process.

## **HMP CARDIFF**

12. HMP Cardiff is a city centre prison holding around 800 men mostly from South East Wales. Many of the prisoners come from the local courts on remand. Cardiff and Vale University Health Board is responsible for delivering primary physical and mental health services in the prison.

### **Her Majesty's Inspectorate of Prisons**

13. HM Inspectorate of Prisons (HMIP) last carried out an inspection of Cardiff in March 2013 and noted that the prison was busy and overcrowded. The population was very transient and many prisoners served short sentences. They noted that action plans resulting from the Prisons and Probation Ombudsman's investigations were good and that some changes in practice were evident. Inspectors found that the quality of ACCT documents was variable and post-closure checks were not done well. Too few prisoner records had entries from their personal officer. HMIP found that few foreign national prisoners were offered a free monthly telephone call home.

### **Independent Monitoring Board**

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. The IMB most recently published an annual report in 2012. They noted that the prison had made changes to its reception and induction processes. The IMB was saddened at the number of deaths at the prison and reported that information about lessons to be learnt from previous deaths had been circulated, including the need for better identification of risks for newly arrived prisoners. The Board commented that the education department was buoyant and well-led.

### **Previous deaths**

15. There have been 12 deaths at Cardiff since the start of 2012. Like a number of other prisoners who have taken their own lives at Cardiff, the man was alleged to have assaulted a family member or partner. While his death was not in the very early days of custody, it is a concern that reception staff again did not identify this risk factor. After a previous death in November 2012, a new suicide and self-harm screening form was introduced. As with the death of another prisoner in September 2013, his reception officer did not complete this correctly.

### **Assessment, Care in Custody and Teamwork (ACCT)**

16. Assessment, Care in Custody and Teamwork (ACCT) is a Prison Service-wide process for supporting and monitoring prisoners thought to be at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary review meetings involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## KEY EVENTS

17. The man was arrested on 25 January 2014 after allegedly assaulting his partner while under the influence of alcohol. He was also charged with possessing a stun gun. He lived in Newport, Wales. He was from the Slovak Republic and spoke and understood very little English. He had no previous convictions in this country.
18. On 27 January, the man appeared at Magistrates' Court and was remanded into custody. He was taken to HMP Cardiff and arrived at 6.20pm. His Person Escort Record (the document which accompanies all prisoners when they transfer between police stations, courts and prisons) noted that he required a Czech interpreter (although he was a Slovak).
19. A nurse assessed the man in reception. The nurse noted that he reported no concerns about mental and physical health and did not report any drug or alcohol misuse. The nurse told the investigator that he could not remember him, but he noted on the reception template in the clinical record that he had not had any previous or current suicidal thoughts. As he had raised no concerns and did not mention any outstanding hospital appointments or medication, the nurse did not request his community health records. The nurse did not use an interpreter or a telephone interpreting service and it is not clear how he obtained accurate information from him.
20. An officer noted on the reception records that the man spoke little to no English. Despite this, the officer did not use a telephone interpreting service to speak to him. The officer and nurse each completed the relevant sections of his first night suicide / self-harm screening tool (a document designed by Cardiff's safer custody team to help to identify risk factors for suicide and self-harm). In the healthcare section of the form, the nurse recorded that there were no concerns about detoxification or mental health. In the section to be completed by the induction officer, the officer incorrectly recorded that this was not his first time in prison. He also noted that the man had not been charged with a violent offence against a family member, although the alleged offence was against his partner. The officer noted that he fully understood how to access a Listener if he needed to. (A Listener is a prisoner trained by the Samaritans to support other prisoners in distress.) It is not clear how a Listener would have been expected to communicate with him.
21. The nurse and officer also completed the man's cell sharing risk assessment (which helps determine whether a prisoner will be a risk to anybody he might share a cell with). The nurse assessed that he could share a cell and was a standard risk. The officer provisionally assessed him as a standard cell sharing risk until his risk could be further assessed using his police national computer record, which would detail any previous offences.
22. During the reception process, the records indicate that the man declined an offer by staff to make a telephone call to a friend or family member on his behalf. He would not give details of his next of kin.
23. The man was located in a shared cell 5-08 on C wing, the induction unit, with a British prisoner. An officer recorded that he had not been to prison before, spoke very little English, would need assistance with reading and writing and

that his cellmate would explain to him how things worked. It is unclear how his cellmate was supposed to do this as there is no indication that he spoke either Slovak or Czech.

24. The next day, 28 January, a healthcare assistant completed the man's second day health screen without using any interpreter. Again, he noted that he did not raise any concerns and did not report any thoughts of suicide or self-harm. An officer completed his cell sharing risk assessment that day. He assessed him as a standard cell sharing risk based on his police national computer record, which was now available.
25. On 4 February, the man moved from the cell he shared with his cellmate on C wing to cell 14 on the fourth landing of A wing, which he shared with another prisoner. As he spoke very little English, the staff on A wing used a Czech prisoner who worked as a wing cleaner, to help interpret. (The Czech and Slovak languages are mutually intelligible.) The Czech prisoner told the investigator that the officers used him all the time to communicate with the man. He estimated that the man understood only 50 percent of what was said to him in English and he rated his spoken English as two out of ten.
26. An officer was the man's personal officer between 4 February and 5 March while he lived on the fourth landing of A wing. (Personal officers are expected to get to know the prisoners they are responsible for, act as a first point of contact for any problems and help with resettlement issues.) He told the investigator that the man was very quiet and polite and caused no problems. He said he kept himself to himself and spent a lot of time in his cell. The officer said that he had never mentioned any concerns. The officer said that he had frequent contact with him, but as he understood very little English, he used the Czech prisoner to interpret. He did not make any entries in his prison record.
27. On 13 February, the man appeared at Crown Court by video link. There is no record that anyone reviewed him afterwards. The Czech prisoner said that sometime that month, the man told him that he would hang himself if the Czech prisoner were to be released, because he was his only source of support. He did not inform staff of this at the time.
28. On 5 March, the man and his cellmate moved into cell 15 on the third landing of A wing and continued to share. On 6 March, a friend visited him. On Saturday 8 March, he told the Czech prisoner that he wanted to hang himself. The prisoner was now very worried and told an officer what he had said. At 3.30pm, the officer began Assessment, Care in Custody and Teamwork (ACCT) suicide and self-harm prevention and support procedures. The officer and a Supervising Officer (SO) (the wing manager) completed the ACCT concern and keep safe form with the help of the Czech prisoner. He said that he was very low in mood due to family issues and he felt that he had lost everything.
29. The SO completed an ACCT immediate action plan. It was agreed that the man should remain in a shared cell with his existing cellmate. He said that he was not thinking of harming himself at the time. Initially, staff were required to check him at least once every half hour and record four quality conversations

with him during the day. The SO noted that there were problems offering access to the Listeners because the man spoke such little English.

30. Wing staff asked a nurse from the primary care mental health team to speak to the man. An officer was present and the Czech prisoner interpreted. He said that he was having fleeting thoughts of deliberate self-harm, but not of suicide, and said he would speak to staff if he did. He said he was having difficulty coming to terms with being in prison, but he was grateful for the Czech prisoner's support and said that he would welcome any help available. He said that he had not assaulted his partner and that she was lying. He did not show signs of hopelessness or helplessness and indicated that he understood the nurse. The nurse advised him on how to keep himself occupied in his cell and suggested that he be provided with books in his own language. (Apart from a translation book, there is no evidence that other books were provided.) She suggested to staff that they find him a job on the wing. (He began attending education full time rather than working.)
31. The nurse referred the man to the GP to be assessed for antidepressant medication. She added him to the primary care mental health team waiting list, but not as a priority because the urgency of assessment is decided at a weekly referral meeting held on Wednesdays. She discussed with prison officers the possibility of moving him to a safer cell. (These are specially designed to have fewer ligature points to help prevent prisoners hanging themselves.) As safer cells cannot be shared, they decided that this would be unhelpful, as he would only be further isolated and would have too much time to think. He told staff that he got on well with his existing cellmate, despite the language barrier, so they were kept together.
32. At 11.20am the next day, 9 March, an officer interviewed the man for an ACCT assessment. He used the Czech prisoner to interpret. The man said that he had found it difficult since arriving in prison and had become low and depressed. He was not eating or sleeping properly. He said that he had been sitting in his cell all day thinking about what had happened with his partner. He said that he had not tried to harm himself either in prison or previously and was not currently having suicidal thoughts. He said that he wanted to be kept busy and wanted his friends to visit him. The officer said that staff could try to help him arrange this. They spoke about him enrolling on an English for Speakers of Other Languages (ESOL) course and obtaining a Czech-English vocabulary book (As Czech and Slovak are derivations of the same language.) The Czech prisoner agreed to act as liaison between the man and the staff to ensure that he was able to tell them how he was feeling.
33. After the assessment interview, a SO held the man's first ACCT case review. The Czech prisoner and an officer attended, but there was no healthcare representation, which is a mandatory requirement for first ACCT case reviews. The SO offered to use a telephone interpreting service, but he declined and said he preferred to use the prisoner. The SO noted that he made little eye contact and did not fully engage with the review. She recorded that he was frustrated and depressed because he was unable to communicate with others. She referred him to the ESOL course and planned to arrange a visit from a friend and book a doctor's appointment. She also planned to provide him with a Czech-English dictionary. The ACCT review panel assessed his risk of suicide as raised and instructed staff to check him

at least once an hour during the day and night and record four quality conversations with him during the day. (It is not clear how that was to be achieved without an interpreter.)

34. The SO recorded the four issues identified on the man's care map. These were his inability to communicate (with an action to obtain a translation book from the education department), his lack of visits (the action was to contact the visits booking department to finalise arrangements for a visit), the need to see the doctor (the action was to book a new appointment for him, but a GP later prescribed antidepressants without seeing him) and the need to stay busy (the action was to ask the education department to enrol him in ESOL classes). On 10 March, the SO marked each of the issues on the care map as completed (although he had not actually seen a GP and had not been prescribed any medication).
35. On Tuesday 11 March, on the basis of a nurse's entry in his clinical record, a doctor prescribed the man 50mg daily of Sertraline, an antidepressant.
36. The man was not allowed to keep his medication in possession so that the nurses could monitor him for at least a month when he came to collect it each day from the medication hatch. A nurse issued medication on A wing as part of her daily duties and said that he collected his medication regularly. He never raised any further concerns with her.
37. The same day, 11 March, a SO reviewed the ACCT document and made an entry in the ACCT ongoing record to remind wing staff to have four interactions with the man during the day and to ensure that these were recorded in the ongoing record. He had a second visit from his friend that day.
38. On Wednesday 12 March, the weekly mental health referral meeting discussed the man and other cases referred in the previous seven days to decide what level of intervention was needed. The meeting was attended by a consultant psychiatrist the in-reach team leader, an administrator, a psychotherapist, an occupational therapist, a nurse and the healthcare inpatient manager. He was allocated to a nurse's caseload and was to be reviewed a month later.
39. The same day, the man attended a foreign national clinic to discuss his case with a solicitor and someone from the immigration authorities. He also attended his first ESOL class. Prisoners of all nationalities and abilities attend the ESOL class together and there are eight sessions a week, every morning and afternoon from Monday to Thursday. The class teacher made regular entries in his ACCT document when he attended classes. Prisoners normally only attend either a morning or afternoon session. However, the SO was keen to keep him busy and to improve his English quickly, so she arranged for him to attend the morning and afternoon sessions which occupied him for up to six hours each day.
40. As the man was attending the ESOL class full time, the class teacher was the member of staff who spent the most time with him over the next week or two. She had a chat with him when he first started because she knew he was being managed under ACCT procedures. She showed him the ACCT folder

and explained that the staff were worried about him and that she would be writing in the document while he was at ESOL classes to help support him. He said that he was worried that he would be deported to Slovakia, where he said that he faced possible imprisonment.

41. The class teacher assessed the man as entry level 2, meaning that he had a basic grasp of English. Entry level 1 is the lowest. She told the investigator that he was quick to learn, very keen and the ideal class member. He joined in and got on well with his classmates. Because he was subject to ACCT monitoring, she said she had been a little surprised to see him apparently consistently happy when he was at the class. He never showed any distress or mentioned any thoughts of suicide or self-harm. He said he enjoyed the class. His English improved over the next couple of weeks and he started to help other learners.
42. On Thursday 13 March, the man attended the ESOL class. There were no classes on Friday 14, Saturday 15 and Sunday 16 March.
43. On the morning of Monday 17 March, the man saw his solicitor. That morning, the SO again wrote in the ACCT document a reminder to wing staff to have four conversations with him during the day and record this in the ACCT document. In the afternoon, he went to the ESOL class. The class teacher wrote in an ACCT entry that he seemed happy and interacted well with the other prisoners. His cellmate transferred to another prison that day and another prisoner moved in to share the cell with him.
44. At 5.40pm, the SO held the man's second ACCT case review which an officer and the Czech prisoner attended. There was no member of healthcare staff present. He said that he lay awake at night thinking about his partner, his court appearance and his possible deportation. He said that he would speak to staff or the Czech prisoner if he felt down, but that if he had the opportunity, he would attempt to kill himself. However, he also said that he did not want to be dead. He said that he did not feel that his medication was so far having an effect.
45. The review noted that the man's English had begun to improve as a result of ESOL lessons. (He had by then attended classes for 2,5 days.) The SO recorded that the four actions on his care map had been done and that there was nothing else that he wanted staff to do for him. He said that he was not thinking so much about his problems with his partner and was feeling slightly better. The panel and he agreed that ACCT support should continue until at least the next review, when the document might be closed. H said that he continued to need support because of his inability to sleep and his changeable mood at night. The review reduced his assessed level of risk of suicide and self-harm from raised to low because the SO felt that his overall mood and presentation had improved. Staff were still required to check him at least once an hour during the day and night and record four conversations during the day.
46. The SO told the investigator that, at some point during the ACCT process, she had planned a cell transfer to allow the man to share with a prisoner who spoke his own language. (The proposed transfer is not recorded in the ACCT

document.) However, he said that he preferred to remain in a cell with his current cellmate, as he had become friends with him.

47. The man spent the morning and afternoon of Tuesday 18, Wednesday 19 and Thursday 20 March in the ESOL class. The class teacher recorded in the ACCT document that he was friendly, helpful and smiling.
48. At 8.00am on Friday 21 March, the SO held the man's third ACCT case review with an officer and the Czech prisoner attending, but still no one from healthcare or any other department. He said that he was feeling really good. He said that he did not want to kill himself and felt happy. His English was improving and he was keeping busy in the ESOL class. He said that he was coping well on the wing and would talk to staff or prisoners if he felt low again. The SO considered that the caremap goals had been achieved. He said that he did not feel that he required the support of the ACCT procedures any longer. The review assessed his risk of suicide as low and ended ACCT monitoring. The SO told him that she would begin the ACCT procedures again if he asked her to and she reminded him that staff were still there to support him if he felt low again. He thanked her for her help. She told the investigator that she had noticed a massive difference in his mood by the third and final review. The Czech prisoner also thought that his mood had improved considerably.
49. Staff checked the man once a day on Friday 21, Saturday 22 and Sunday 23 March after the ACCT was closed, to check that there were no further concerns. None were identified. As the ACCT document was now closed, there was no other monitoring of him during the day or night. There were no ESOL classes on those days.
50. On the evening of Sunday 23 March, an officer completed a roll check on the wing at 6.30pm and checked all cells. Another rofficer did an evening roll count at 8.45pm and a colleague completed a further routine check at the start of the night patrol at about 9.00pm. None of the officers noted any concerns about the man. The officer who worked on A wing overnight told the investigator that he checked him a couple of times at the start of his shift before he went to sleep. He did this because he knew that his ACCT document had only recently been closed. The officer had no concerns either.

### **Day of the incident**

51. Shortly after 5.00am on the cellmate woke and got down from the top bunk to use the toilet. As his eyes adjusted to the darkness, he wondered where the man was. He then noticed him slumped on the floor. He had hanged himself from the bottom bunk. He switched the light on and shook him. His tongue was protruding and he was very cold. He was in a seated position on the floor with a piece of torn blanket tied around his neck. The other end of the torn blanket was attached to the frame of the bunk bed.
52. At about 5.05am, the cellmate pressed the in-cell emergency bell. (The electronic cell bell recording shows 5.03am, but the investigation found that the system timings are approximately two minutes slow.) He tried to bite through the end of the torn piece of blanket which was attached to the bed frame to release the ligature, but was unable to do so.

53. Two officers were the A wing night patrol officers. Officer A was just coming back from the first landing of A wing (the segregation unit). The night orderly officer in charge of the prison that night was in the centre of the prison at the time and came to A wing when he heard the cell bell. He and the officer identified which cell bell had been pressed and headed to the third landing. On the way, they could hear the cellmate banging and shouting.
54. At 5.07am, two minutes after the cellmate had pressed the cell bell, the officers reached the cell. (Again, the cell bell recording shows 5.05am.) The officer looked through the cell door observation panel and saw the man hanging. The night orderly officer unlocked the cell door, went in and cut the torn blanket from around his neck using his anti-ligature knife. He checked him and found no signs of life. He remained in a rigid seated position and he was very cold and pale. His tongue was swollen and blood had pooled in his hands. The night orderly officer believed that he had been dead for a while. While he checked him, the officer looked after the cellmate on the landing.
55. Officer B had continued to work in the A2 landing office while his colleagues answered the cell bell. Officer A shouted to him, asking him to come up to the A3 landing. He walked upstairs to the cell. All three staff agreed that the man had already died. The night orderly officer then temporarily located the cellmate in a shared cell with a Listener.
56. The control room incident log states that, at 5.11am, the night orderly officer radioed to ask healthcare staff to attend A3 landing as a prisoner had been found hanging. He did not use the correct medical emergency response code (code blue) and nobody else called a code blue during the emergency. Also at 5.11am according to the incident log, Officer B went to the A3 landing office and telephoned the control room staff, telling them that there was a casualty on A3 landing and asking for an ambulance. The prison's incident log and the ambulance service's own log show that the control room staff telephoned for an ambulance at 5.12am. There was a four minute delay between the officers reaching the cell and asking the control room staff for an ambulance.
57. A nurse, who was working in the healthcare unit with a healthcare assistant, heard the officer's radio message asking healthcare staff to come to A3 landing. She collected the emergency response bag containing a defibrillator and oxygen and hurried to the wing, where she found the officers waiting outside the cell. They told her that they had already requested an ambulance. She went into the cell with the night orderly officer and found the man seated on the floor by the bed. He was stiff and cold. She noted that there were clear signs that he had died and therefore did not attempt resuscitation.
58. According to the incident log, an ambulance arrived at the prison at 5.18am. The paramedics arrived on the wing and attached a monitor to the man. They pronounced his death and estimated that he had died approximately two hours earlier. A doctor came to prison and certified his death at 6.15am. The police found a suicide note in the cell written in Slovak. In it, he expressed remorse to his partner for his actions.

59. Staff began ACCT procedures to support the cellmate after the incident. At about 8.00am, managers held a debrief meeting for staff involved in the incident to check on their welfare.
60. As the man had not provided details of his next of kin, the prison's family liaison officer contacted the Consul for the Slovak Republic in Wales, the man's solicitor and the police. On 25 March, the Slovak embassy confirmed that the Slovak police had informed his parents of his death. The prison did not manage to locate his partner in this country. Members of his family travelled to Cardiff. They visited the prison and spoke to the staff using the telephone interpreting service. They then attended his cremation service on 4 April, paid for by the prison, and took his ashes back to Slovakia.
61. The man's death was a profound shock for the class teacher and the members of his ESOL class. After he died, other prisoners provided information to the investigator and the class teacher. The Czech prisoner told the investigator that a few days before he died, the man had said to him that he still wanted to hang himself. He said that he had mimed hanging himself using the privacy curtain in his cell. The prisoner said that the man had been smiling when he said this, so he had thought that he was joking and had not told officers. He also said that, on Sunday 23 March, another prisoner had mentioned to him that the man was writing a letter (which was presumably the note he left behind).
62. Another prisoner from the ESOL class told the investigator that the man had been upset about the end of his relationship with his partner. Another prisoner, also in the ESOL class, told the investigator that, on 23 March, he had seen him in his cell with red marks around his neck. When he asked him about them, he had explained that the marks had been caused by an allergy and he had indicated that he did not wish to discuss the matter any further. None of this information was reported to wing staff before he died.
63. The post-mortem examination found that the man died as a result of hanging.

## ISSUES

### Communication with prisoners who speak little or no English

64. Prison Service Instruction (PSI) 64/2011 about safer custody states:

‘All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and / or during the risk management process.’

65. Cardiff’s policy about foreign national prisoners states:

‘Language barriers obviously make all other problems worse. Staff should not assume that prisoners with some comprehension of English have completely understood what is being said to them. Poor communication between staff and prisoners may have implications for things like risk of self-harm and good order and discipline.’

66. It was evident that the man spoke and understood little English and it was noted on his Person Escort Record that he needed a Czech interpreter (although he spoke Slovak). Cardiff has a contract with a professional telephone interpreting service, yet when he arrived at the prison in January, reception staff did not use the service and there is no record that they used anyone else to interpret for them. Neither the officer nor the nurse could remember interviewing him in reception. It seems very unlikely that he would have been able to understand their questions sufficiently well for them to make reliable assessments of his health, state of mind or risk of suicide and self-harm.

67. The prison’s finance department has confirmed that during January, February and March 2014, Cardiff received no invoice for using the telephone interpreting service, which means that no member of staff used it to help communicate with any prisoner. It seems unlikely that all of the foreign national prisoners who passed through Cardiff in those three months spoke and understand English so well that the service was not needed. Recent figures show that there were 62 foreign national prisoners in Cardiff in February, 60 in April and 41 in May. Although there is no record of their proficiency in English, the fact that there is an active and well subscribed ESOL course indicates that a number of the foreign national prisoners do not have a good understanding of English when they arrive.

68. None of the reception, induction or residential wing staff referred the man to the ESOL class during his first six weeks in Cardiff, despite his obvious need to use the Czech prisoner as an interpreter for interactions with them. Cardiff’s foreign national prisoner policy requires staff to make an ESOL referral to the education department during the induction process for any foreign national prisoners with poor or little English. It was only when his mood deteriorated and he was identified as at risk of suicide and self-harm that staff recognised that his inability to communicate had resulted in social isolation and they made an immediate referral to ESOL.

69. Although the Czech prisoner interpreted for the man at his interview with the nurse, the ACCT assessment interview and three subsequent ACCT case reviews, he was not a trained interpreter. Cardiff's foreign national prisoner policy requires staff to use either Applied Language Solutions (the telephone interpreting service) or an accredited interpreter at ACCT reviews. This would have helped staff be confident that they had understood all the nuances of what he was telling them about his risk and protected his privacy. Although he said that he was happy to have the prisoner interpret for him, using another prisoner for ACCT reviews and mental health assessments is usually inappropriate. Many prisoners would be inhibited from disclosing sensitive and personal information about the reasons for their distress in front of another prisoner and this does not adequately protect their right to confidentiality. We consider that the prison should publicise the telephone translation service to prisoners so that they are able to request its use when they have difficulty communicating. We make the following recommendations:

**The Governor and Head of Healthcare should ensure that foreign national prisoners are informed of the availability of the telephone interpreting service and that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.**

**The Governor should ensure that foreign national prisoners who are not fluent in English are referred to the ESOL class at the earliest opportunity.**

### **Managing the risk of suicide and self-harm**

70. The failure to use the telephone interpreting service in reception might have contributed to the officer overlooking two risk factors that can increase the likelihood of suicide when he completed the man's suicide and self-harm screening tool. He did not identify that he had been charged with assault against his partner or that he had never been to prison in the UK before. The screening tool was introduced in response to PPO recommendations in previous investigations into deaths at Cardiff. We are concerned that this is the second recent example of the screening tool being completed incorrectly. No additional training was given to the reception staff to help them to use the screening tool and identify risk factors when it was introduced. We make the following recommendation:

**The Governor should ensure that reception and first night staff have training and guidance to help them identify and record the known risk factors of newly arrived prisoners.**

71. The man appeared at court by video link from the prison on 13 February. Prison Service Order 3050 (PSO) about Continuity of Healthcare indicates that events such as attending court, sentencing at court and being questioned by the police are factors that might increase an individual's risk of suicide and self-harm and such prisoners should be screened afterwards. PSO 74/2011 (Early days in Custody), section 2.18, states that assessments must also be made of prisoners who by-pass some reception processes and those whose status and demeanour might change after a court appearance via video link.

72. We recognise that an assessment after the man's court appearance by video link would not necessarily have led to additional support under ACCT procedures. However this was a missed opportunity to identify any underlying issues that might have been causing him to be stressed. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health or suicide and self-harm issues after events which could involve a change in status, including court appearances by video-link.**

73. Our investigation found a good level of support for the man while he was subject to ACCT monitoring in March. The SO used the care map effectively to help him start ESOL classes, obtain a translation book and arrange visits. She did not close the ACCT document until the issues she had identified with him had been dealt with. She made detailed records of her case reviews. She offered practical help, ensuring that he kept himself busy at the ESOL class, and she ensured that she chaired all three case reviews, providing good continuity of care. The Czech prisoner told the investigator that the SO had helped the man a great deal and had been a brilliant support to him. The ESOL teacher also showed an impressive commitment to her role. It was clear that she had been keenly interested in helping him improve his English and address his difficulties more generally. It would, however, have been appropriate and useful to have invited her to contribute to the ACCT case reviews held after he began to attend the class.
74. None of the three ACCT case reviews were multidisciplinary and no healthcare staff were involved, even though a nurse had been asked to assess the man on the day staff opened the ACCT document. The SO told the investigator that she would normally have invited a nurse to the reviews, but that this had proved difficult because her priority was to ensure that he went to the ESOL class both in the morning and the afternoon to improve his English as quickly as possible. This meant that he was not present on the wing for much of the morning and afternoon from Monday until Thursday. Nurses are normally available to attend ACCT reviews between 9.00am and 5.00pm from Monday to Friday.
75. However, two of the three ACCT case reviews were held when the man was not attending ESOL classes. The first review (at which Prison Service Instruction 64/2011 about safer custody requires there to be a member of healthcare staff) was held before he began attending classes. The third and final ACCT case review was held on a Friday afternoon. There was no reason that a nurse could not have been invited to either review. If attendance by healthcare staff was difficult, the SO could have invited email or telephone contributions from the healthcare staff, an option which is suggested in Prison Service Instruction 64/2011. For the second ACCT case review, it ought to have been possible for him to have left the ESOL class early one morning or afternoon to attend at a time which suited a nurse.
76. The presence of a mental health nurse at the second case review might have improved the assessment of the man's risk of suicide. The review reduced his assessed risk from raised to low, even though he had spoken at the

review about taking his own life if he had the opportunity. The SO explained to the investigator that she had assessed his risk as low because his overall mood had seemed brighter at the second review, in spite of this comment. While this was her individual judgement as the case manager, the comment from him is conspicuous and does not seem to suggest that the risk was low. We would have more confidence in this decision if there had been multidisciplinary attendance.

77. Despite completing a good care map, and speaking to the man at length about his problems, the SO did not record any information in the triggers section of the ACCT document. She felt that his main issues were around language and social isolation. It would have been useful to identify these issues as triggers for his low mood. While these two issues clearly affected him, he also told the ACCT assessor that he was preoccupied with thoughts about his relationship with his partner. This was to be expected as it was an alleged violent offence against her which had brought him to prison. Other prisoners have since suggested that he was very upset about the relationship problems with his partner. More attention could have been paid to this aspect of his low mood at case reviews and this problem could have been added to the triggers section of the ACCT document.
78. While some aspects of the man's ACCT management were positive with consistent and caring case management, some aspects need improvement. We make the following recommendation:

**The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:**

- **Completing the triggers section of the ACCT document**
- **Considering all known risk factors when determining the level of risk of self-harm**
- **Holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care**
- **Inviting contributions from healthcare staff if they cannot attend a case review**

### **Mental health**

79. A nurse saw the man once and referred him to the weekly multidisciplinary meeting. He was discussed at this meeting a few days later and it was decided that the nurse would review him again a month later. The nurse told the investigator that a month for review is the standard timeframe at Cardiff unless serious mental health problems have been identified or the prisoner raises fresh concerns, which he did not. Healthcare Inspectorate Wales was satisfied that there was a strong representation of different staff at the multidisciplinary meeting and that the decision would have been reasonable if there had been involvement from healthcare staff at the subsequent ACCT reviews. However, as we have already discussed, there was not.
80. After the nurse assessed the man, a psychiatrist prescribed antidepressants based on her clinical opinion. HIW were satisfied that the prescription was appropriate, provided that a follow-up appointment was arranged within 14 days. A follow-up appointment was arranged, but was missed because he

was unavailable. However, it was re-booked and was scheduled to take place shortly after he died.

### **Emergency response**

81. There was an unacceptable delay of four minutes between staff finding the man hanging and contacting the control room to ask for an ambulance to be called. Although he had already died, in other circumstances this delay would have been critical. The delay seems to have been caused by several factors:
- The officers did not act with urgency because they decided he had died
  - The night orderly officer and Officer A asked Officer B to come upstairs to the cell before contacting anybody else
  - The night orderly officer relocated the cellmate to another cell before asking his colleagues to contact the control room
  - When he radioed, Officer A did not use the correct medical emergency response code as set out in Prison Service Instruction (PSI) 03/2013, and instead asked for healthcare staff to attend
  - Officer B thinks that he might have dialled the wrong telephone number before he spoke to control room staff
82. Cardiff's most recent Governor's Order GO02-13 about calling an ambulance in an emergency was issued on 5 February 2013. In response to a recommendation we made in the investigation report into a death at Cardiff in September 2013, the prison said that a recent Ministry of Justice internal audit had given them a 'green rating' and that they had reissued the same Governor's Order. However, that order does not clearly state that staff must use a two code system that differentiates between a blood injury and all other injuries (usually code red and code blue) and that the use of one of these emergency codes should automatically result in control room staff calling an ambulance immediately, as the national instruction requires. We do not therefore consider that the local instruction accurately reflects the intended purpose of PSI 03/2013. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Cardiff has a medical emergency response code protocol, based on the PSI, which outlines a two code system and ensures the control room calls an ambulance immediately an emergency code is used.**

## RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that foreign national prisoners are informed of the availability of the telephone interpreting service and that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.
2. The Governor should ensure that foreign national prisoners who are not fluent in English are referred to the ESOL class at the earliest opportunity.
3. The Governor should ensure that reception and first night staff have training and guidance to help them identify and record the known risk factors of newly arrived prisoners.
4. The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health or suicide and self-harm issues after events which could involve a change in status, including court appearances by video-link.
5. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - Completing the triggers section of the ACCT document
  - Considering all known risk factors when determining the level of risk of self-harm
  - Holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care
  - Inviting contributions from healthcare staff if they cannot attend a case review
6. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Cardiff has a medical emergency response code protocol, based on the PSI, which outlines a two code system and ensures the control room calls an ambulance immediately an emergency code is used.

## ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date and function responsible	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that foreign national prisoners are informed of the availability of the telephone interpreting service and that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.	Accepted	<p>An amended Governors Notice to Staff was issued September 2014 (GN81.14) about the provision of Language Services at HMP Cardiff.</p> <p>An additional Governors Notice to Staff will be issued informing staff of the importance of using an accredited interpreting service, including at ACCT case reviews.</p>	<p>14<sup>th</sup> November 2014</p> <p>Head of Residence and Head of Safety</p>	
2	The Governor should ensure that foreign national prisoners who are not fluent in English are referred to the ESOL class at the earliest opportunity	Accepted	<p>The first night documentation will be revised to record the completion of any ESOL referral to the education department, to ensure all residential units are aware of the referral made to address an individual's language abilities.</p> <p>A procedure for referrals to ESOL will be introduced, and this information will be relayed to staff via team briefings and</p>	<p>14<sup>th</sup> November 2014</p> <p>Head of Residence and Safety</p>	

			email.		
3	The Governor should ensure that reception and first night staff have training and guidance to help them identify and record the known risk factors of newly arrived prisoners	Accepted	A self-harm screening tool developed locally was most recently updated in May 2014. The tool is attached to the first night induction booklet and provides specifically trained staff (that is, dedicated induction staff who have received local training on identifying potential risks and triggers), with guidance about known risks and triggers, on which they can record information relevant to the individual prisoner being assessed.	Completed  Head of Residence and Safety	
4	The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health or suicide and self-harm issues after events which could involve a change in status, including court appearances by video-link	Accepted	The senior nurse on duty (Hotel 1) will now be contacted and advised of those prisoners who need to be assessed following a change of circumstance, including those who have attended court by video-link. All such prisoners will be assessed by a member of the Healthcare nursing team, and an entry will be made on SystemOne (the electronic healthcare record) to record the outcome of this assessment, which will be shared with discipline staff as necessary. A log of this contact	Completed  Head of Operations	

			will be recorded in video link diary (occurrences section)		
5	<p>The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <ul style="list-style-type: none"> <li>• Completing the triggers section of the ACCT document</li> <li>• Considering all known risk factors when determining the level of risk of self-harm</li> <li>• Holding multidisciplinary case reviews which include all</li> </ul>	Accepted	<p>The Safer Custody manager and wing managers will remind staff at morning meetings and written correspondence (by email and Governors Notice to Staff) of the importance of identifying triggers and recording them within the ACCT document.</p> <p>Staff will also be reminded that ACCT case reviews must always consist of a multi disciplinary panel of those involved in the prisoner's care, including healthcare and the In-reach team, and written contributions should be invited from relevant staff who are unable to attend. In exceptional circumstances, where a written contribution is unavailable, details of any verbal contributions will be documented in ACCT to be considered at the ACCT case review.</p> <p>Multidisciplinary reviews are now</p>	<p>Completed</p> <p>Action Safer Custody Manager.</p> <p>Action Safer Custody manger will introduce random checks in liaison with the Head of Residence and Safety to provide assurance.</p>	

	<p>relevant people involved in a prisoner's care</p> <ul style="list-style-type: none"> <li>• Inviting contributions from healthcare staff if they cannot attend a case review</li> </ul>		<p>completed and monitored, with daily checks by the wing supervising officer or custodial manager. Weekly Governor checks are also completed on the weekend as part of the Duty Governor reports and distributed to all Governor grades and Band 5's.</p> <p>The Safer Custody manager with the Head of Residence and Safety will be introducing further checks beginning 10<sup>th</sup> Nov 2014 to provide assurance that the checks are being executed effectively.</p>		
6	<p>The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Cardiff has a medical emergency response code protocol, based on the PSI, which outlines a two code system and ensures the control room calls an ambulance immediately an emergency code is used.</p>	Accepted	<p>A Governors Order on Medical Emergency Response Codes (GO08.14) was re-issued to all staff in June 2014, to remind staff of the importance of contacting the control room in a medical emergency to allow an ambulance to be called at the earliest opportunity. The Governors Order outlines the two code system for use to distinguish between the types of injury sustained, and reminds control room staff that an</p>	Completed	<p>Head of Residence and Safety</p>

			ambulance must be called immediately when an emergency code is used.		
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