

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Jeffrey Griffiths a prisoner at HMP Parc on 11 February 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Jeffrey Griffiths was found hanged at HMP Parc on 11 February 2016. He was 35 years old. I offer my condolences to Mr Griffiths' family and friends.

Mr Griffiths was subject to Prison Service suicide and self-harm prevention monitoring at the time of his death. Unfortunately, we found weaknesses in the management of these arrangements – as we have in previous investigations at Parc, particularly that the prison did not properly identify or address all Mr Griffiths known risk factors. However, I do not, consider that his behaviour was so concerning immediately prior to his death that the level of checking to which he was subject should have been higher.

The investigation also identified Mr Griffiths' probable use of new psychoactive substances at Parc and their possible impact on his mental health. I echo the concerns raised by HM Inspectorate of Prisons and the Independent Monitoring Board about the need for more effort to address both supply and demand for illicit drugs at the prison.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**October 2016**

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# Summary

## Events

1. In February 2013, Mr Jeffrey Griffiths was remanded to HMP Swansea. This was not his first time in prison. He was later convicted of robbery and sentenced to seven years. On 28 August 2015, Mr Griffiths was transferred to HMP Parc. Mr Griffiths had a history of substance misuse and self-harm. He was anxious about ongoing custody proceedings involving two of his children, who were due to be adopted. He had a history of depression but stopped taking his antidepressant medication in September.
2. In September, Mr Griffiths told staff he had tried to hang himself with a shoe lace because he had problems with other prisoners on his wing. He was monitored under Prison Service suicide and self-harm prevention procedures, known as ACCT for a week.
3. On 31 December, Mr Griffiths tried to hang himself again and staff began ACCT procedures. Mr Griffiths said he was depressed about the custody issues concerning his children, felt paranoid and wanted to die. He was referred for mental health support. Over the next four days, Mr Griffiths harmed himself twice and was moved to the Safer Custody Unit for closer monitoring. On 5 January, a nurse referred Mr Griffiths to the mental health in-reach team for assessment. Mr Griffiths said he had smoked a lot of 'Spice', a synthetic cannabinoid known as a new psychoactive substance, over Christmas.
4. Mr Griffiths remained paranoid and anxious and seriously harmed himself again on 8 January by running into a toilet brush, which he held against a wall. On 21 January, when his mental health seemed to have settled, the mental health in-reach team nurse decided that Mr Griffiths could be supported by the primary care mental health team. On 26 January, a prison doctor diagnosed Mr Griffiths with drug induced delirium caused by NPS use. The doctor did not prescribe any medication and Mr Griffiths was not referred for substance misuse support.
5. On 10 February, Mr Griffiths cut his wrist with a piece of broken plastic. At the ACCT case review held later that day, the nurse attending noted that Mr Griffiths had said that if he had a blade he would cut his throat. The other staff at the review did not remember Mr Griffiths saying this. At this time, Mr Griffiths was subject to five ACCT checks an hour.
6. During 11 February, Mr Griffiths was quiet and a little withdrawn but staff were not particularly concerned about him. At about 6.10pm, Mr Griffiths spoke to his sister said he could not cope anymore. At around 6.25pm, Mr Griffiths went to the unit shower room and, at about 6.40pm, an officer found Mr Griffiths hanged by a ligature made from bedding. Staff and paramedics tried unsuccessfully to resuscitate Mr Griffiths and at 7.35pm, paramedics recorded that he had died.

## Findings

7. Mr Griffiths had a number of risk factors, which increased his risk of suicide and he was subject to ACCT monitoring on two occasions, including at the time of his death. We have identified some shortcomings in the management of these

procedures. We found that, although staff appropriately began ACCT procedures in response to Mr Griffiths' suicide attempt, there was no evidence that they had considered the range of his risk factors. The ACCT caremap also did not reflect the range of Mr Griffiths' concerns, including his substance misuse. There was no evidence that staff had considered involving Mr Griffiths' family, despite ongoing custody issues with his children. The day before Mr Griffiths died, he apparently said that he would kill himself if he could, but this was not recorded in the ACCT plan.

8. However, at the time of his death he was subject to five ACCT checks an hour, and we do not think that this demeanour or behaviour on the day of his death was so concerning that staff should have considered placing him under constant supervision.
9. Mr Griffiths' mental health problems appear to have been linked to his heavy use of NPS over the Christmas period. However, we were concerned that he was not referred to substance misuse services until 8 February. We are satisfied that Mr Griffiths received appropriate mental health care, although we were concerned that the referral to the mental health in-reach team was delayed.

## Recommendations

- The Director should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
  - Case reviews should record and take into account all the known risk factors and triggers when considering the risk of suicide or self-harm.
  - Setting effective caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk and which identify who is responsible for them.
  - Involving the prisoner's family when that would be beneficial.
  - All staff, including healthcare staff, record relevant information about risk, observations and interactions with prisoners in ACCT documents, and any action taken.
- The Director and Head of Healthcare should ensure that there is a clear pathway for mental health services, which ensures that prisoners identified as at risk of suicide and self-harm have an urgent mental health assessment within three days.
- The Director should ensure there is an effective substance misuse strategy to help reduce the availability and demand for new psychoactive substances, that staff are vigilant for signs of its use and are briefed about how to respond when prisoners appear to be under the influence of such substances.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Parc on 16 February. He obtained copies of relevant extracts from Mr Griffiths' prison and medical records and interviewed two prisoners. At the initial report stage, the National Offender Management Service (NOMS) responded to the recommendations.
12. Healthcare Inspectorate Wales (HIW) commissioned a review of the clinical care Mr Griffiths received at the prison.
13. The investigator interviewed 14 members of staff and one prisoner at Parc. HIW was present for interviews with healthcare staff.
14. We informed HM Coroner for Bridgend and Glamorgan Valleys District of the investigation who gave us the results of the post-mortem examination. The coroner commissioned additional toxicology tests in the light of information from our investigation. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Griffiths' father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Griffiths' father said that his other son, who had also been at Parc at the same time as Mr Griffiths, had asked to see Mr Griffiths on a number of occasions after Mr Griffiths moved to the Safer Custody Unit, but had not been able to. The family liaison officer and the investigator interviewed Mr Griffiths' brother at HMP Swansea.

## Background Information

### HMP Parc

16. HMP Parc is a medium security private prison run by G4S, which holds around 1,600 convicted men and young adults on remand or convicted. It also has a unit for around 60 young people under 18.
17. Integrated Services, a branch of G4S, provides 24-hour primary general and mental healthcare services at Parc and St John's Medical Practice provides 24-hour GP cover.

### HM Inspectorate of Prisons

18. The most recent inspection of Parc was in January 2016. Although inspectors noted there were a high number of incidents of self-harm, ACCT documents were completed to a good standard. Inspectors found that mental health provision was inadequate. Prisoners with mental health problems received limited support from the primary mental health team and referrals to the secondary mental health in-reach team were subject to a restrictive acceptance criteria. In their survey of prisoners, more prisoners than in comparator prisons said it was easy or very easy to get drugs in the prison. Inspectors noted that Parc was working with the local police to disrupt the supply of drugs to the prison but their efforts to tackle the availability of drugs were not sufficiently effective.

### Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2016, the IMB expressed concern about the increasing numbers of prisoners with mental health problems placing a growing demand on the limited resources. The Board was concerned about the level of substance use at Parc, and particularly of New Psychoactive Substances (NPS), such as 'Spice' – a synthetic cannabinoid.

### Previous deaths at HMP Parc

20. Mr Griffiths' was the third apparently self-inflicted death at Parc since 2014, and there has been one since. We have previously raised concerns about the management of the ACCT process.

### Assessment, Care in Custody and Teamwork

21. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
22. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As

part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

23. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

### **New Psychoactive Substances (NPS)**

24. NPS are an increasing problem across the prison and immigration detention estates. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Psychological effects can include psychosis and hallucinations, depression and suicidal thoughts, antisocial or paranoid behaviour and emotional and erratic behaviour.
25. As well as emerging evidence of dangers to both physical and mental health, there are other links to suicide or self-harm. Trading in these substances, while in custodial settings, can lead to debt, violence and intimidation.
26. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

## Key Events

27. On 7 February 2013, Mr Griffiths was remanded to HMP Swansea, charged with burglary and possession of a weapon. This was not his first time in prison. On 3 September, Mr Griffiths was sentenced to seven years in prison for robbery. He was moved to several prisons over the next two years. His brother, who was one of the co-defendants in the offences, also received a custodial sentence, and they were often held at the same prisons. There was significant security intelligence indicating that Mr Griffiths was involved in trafficking and using drugs in prison. Mr Griffiths had been briefly monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT) in 2012 and had self-harmed in the community some years earlier. Mr Griffiths had a history of drug and alcohol misuse.
28. On 28 August 2015, Mr Griffiths transferred to HMP Parc. At his routine health screen in reception, a nurse recorded in Mr Griffiths' medical record that he had depression and that he wanted to be prescribed mirtazapine (an antidepressant). She recorded that Mr Griffiths' current mood was stable, and that she had no concerns about his mental health, risk of suicide and self-harm or substance use.
29. On 7 September, Mr Griffiths' offender supervisor carried out the post-induction offender management assessment. Mr Griffiths told her that two of his children were due to be adopted and asked for a final visit with them. She contacted Parc Supporting Families, who said they could arrange a visit for him. She offered to arrange bereavement counselling to help Mr Griffiths but he declined. He said he had stopped taking his antidepressants medication while at HMP Swansea, wanted to restart and had a GP appointment to discuss this.
30. On 8 September, Mr Griffiths saw a prison GP who prescribed sertraline (an antidepressant) at a dose of 50mg a day. Mr Griffiths told the GP that he had never tried to kill himself and said he had no current thoughts of suicide or self-harm.
31. At 12.20am on 15 September, Mr Griffiths told an officer, via his cell intercom, that he had tried to hang himself with a shoe lace but it had snapped. The officer and the night manager immediately started ACCT procedures. Mr Griffiths told the staff that he had tried to hang himself because he did not feel safe on B Wing and had thought killing himself was the only way out. He said that he had a problem with two other prisoners on B Wing, but would not name them. He asked to move to D Wing where his brother was. That night, staff moved Mr Griffiths to the Safer Custody Unit (a 15 cell unit holding vulnerable prisoners on their first night, and other vulnerable prisoners in crisis) and staff checked him twice an hour until the first ACCT case review had taken place.
32. Later on the morning of 15 September, an officer assessed Mr Griffiths as part of the ACCT procedures. Mr Griffiths repeated that he had problems with two prisoners, who were violent, but would not name them. He said he was glad he was alive. Mr Griffiths said he had also been an enhanced prisoner at Swansea but was standard at Parc. He said he had no previous history of suicide attempts or self-harm and felt safer now he had moved to the Safer Custody Unit. He said he was no longer feeling suicidal and had support from his mother and sister.

33. Shortly after, an operational manager chaired the first ACCT case review with Mr Griffiths, an officer and a mental health nurse. Mr Griffiths repeated his concerns about living on B Wing and said he wanted to move to D Wing with his brother and other friends. The staff assessed him as at a low risk of suicide and self-harm (from the options of high, raised and low). They reviewed the frequency of observations and reduced them to one observation per hour, two conversations per day and one conversation at night.
34. The operational manager made three entries on the ACCT caremap (the plan of care, support and intervention), two of which related to moving Mr Griffiths off B Wing and possibly to D Wing; and to look into his Incentives and Earned Privileges (IEP) status. After the review, staff checked Mr Griffiths' IEP status and he was made enhanced level. There is no record that the staff considered referring Mr Griffiths for a full mental health assessment, despite his attempted suicide.
35. The mental health nurse recorded in Mr Griffiths' medical record that he no longer wanted to take his antidepressant medication because it made him feel unwell. It is not clear whether he continued to take antidepressants after this date.
36. On 22 September, an operational manager chaired the second case review with Mr Griffiths and a nurse. Mr Griffiths said he had no thoughts of suicide and self-harm and wanted to stay on D Wing, as he had support from his brother and other prisoners. The manager reviewed the caremap and recorded that all of the actions had been completed. The staff decided to end the ACCT monitoring. The post-closure review took place on 29 September, and Mr Griffiths raised no further concerns. Over the next two months, Mr Griffiths spoke to his personal officer once a month, generally attended work as required and seemed settled.
37. On 25 November, Mr Griffiths appeared via video link at the family court, in relation to the custody of his two daughters. On 5 December, he told his personal officer he was 'going through a rough patch' fighting for his children. He appeared at the family court again on 8 December, and the case was adjourned for 21 days.
38. During the morning of 31 December, Mr Griffiths told his personal officer that he had tried to hang himself earlier, but, again, the shoe laces he had used had snapped. Mr Griffiths was rocking backwards and forwards, crying and told him there was radiation coming into his cell. Mr Griffiths told him there was nothing staff could do to help him. The officer started ACCT procedures.
39. Staff moved Mr Griffiths into a cell with CCTV on D Wing and completed the ACCT immediate action plan, noting that a mental health nurse needed to see Mr Griffiths as soon as possible. Staff were instructed to check Mr Griffiths twice an hour and record two conversations with him each day. It is not clear whether staff were also constantly supervising him via the in-cell CCTV. Mr Griffiths said he had regular contact with his family, and would speak to a Listener if he needed to. (Listeners are prisoners trained by the Samaritans to support other prisoners.)

40. On 1 January 2016, an officer carried out the ACCT assessment interview. Mr Griffiths said that he was feeling depressed about the custody of his children. Mr Griffiths seemed very paranoid and said he wanted to spend time alone in his cell. He said he was having trouble eating and sleeping. Mr Griffiths said he had been thinking of hanging himself for the past 48 hours, and wanted to die. He said he intended to barricade his cell so that staff could not stop him. He said he had smoked two cigarettes other prisoners had given him. The officer asked him if he thought the cigarettes might have had an illicit substance in them, but Mr Griffiths did not know. Mr Griffiths told him about his previous history of substance misuse.
41. The mental health nurse noted in Mr Griffiths' medical record that she had talked to him on the wing and he said he had not actually tried to hang himself, but knew he was behaving oddly so had told officers he had tied the shoe laces around his neck. Mr Griffiths said he felt very paranoid and guilty that two of his children were being adopted. He told her that he had not used any drugs recently. He reported hearing voices, but could not really describe them or what they said. She recorded that there was some evidence of thought disorder and placed him on the list for short term mental health support.
42. Later that day, an operational manager chaired the first ACCT case review with Mr Griffiths, an officer and the mental health nurse. Mr Griffiths said he was feeling down, perhaps because he was not sleeping well. The nurse suggested Mr Griffiths arrange an appointment with the GP to discuss medication. Mr Griffiths said he would think about this. He said he would talk to staff before doing anything 'stupid'. The case review agreed that the nurse would support Mr Griffiths. The review assessed Mr Griffiths as at a raised risk of suicide and self-harm and instructed staff to check Mr Griffiths twice an hour, and record two conversations per day and one conversation at night. The manager made one entry on the caremap: for Mr Griffiths to make an appointment with the GP. He did not make any entries relating to Mr Griffiths' children being adopted or possible substance use.
43. During the evening of 2 January, Mr Griffiths cuts his wrists with a nail clipper. A nurse cleaned the cuts and applied a dressing. Mr Griffiths told him that he could not cope with the 'noise in his head' and that he wanted to move to a different wing. The nurse recorded that Mr Griffiths was due to be allocated to a mental health nurse. Later that day, Mr Griffiths was placed on the mental health nurse's caseload.
44. At 9.35am on 3 January, an operational manager held a case review with Mr Griffiths, a mental health nurse and an officer. He recorded that Mr Griffiths had initially stopped staff from unlocking his cell by putting a plastic fork in the door. Mr Griffiths said he was having difficulty sleeping and had problems on the wing, because other prisoners thought he was a 'grass'. Mr Griffiths refused to name any of the prisoners or answer whether he was in debt on the wing. Mr Griffiths wanted to move to the Safer Custody Unit but there was no space, and he did not want to move to either A or B Wing. The staff assessed Mr Griffiths as at a raised risk of suicide and self-harm and did not change the frequency of observations. He reviewed the caremap and recorded that Mr Griffiths was still awaiting medication to help with his mood, although he did not record whether Mr

Griffiths had actually made a GP appointment yet. He made no entries on the caremap about Mr Griffiths' perceived problems on the wing.

45. At 12.15pm, an officer noted in the ACCT ongoing record of observations that Mr Griffiths had asked to speak to the police about a sexual matter, but would not give any further information. The officer noted that he had passed Mr Griffiths' request to the duty manager. At 1.45pm, an officer radioed a code red emergency (which indicates a life threatening incident, normally when a prisoner is bleeding and alerts other staff to bring emergency equipment and the control room to call an ambulance) after Mr Griffiths stabbed himself in the neck with a pen. A nurse treated the wound and Mr Griffiths did not require any hospital treatment. At 2.10pm, Mr Griffiths was moved to the Safer Custody Unit.
46. On 4 January, a first line manager chaired an ACCT case review with Mr Griffiths, a nurse, a complex case manager and a Safer Custody Unit interventions officer. He recorded that Mr Griffiths was nervous and anxious. Mr Griffiths said he had hallucinated about being bed with his sister and had mistakenly told another prisoner, who had spread it around the wing. Mr Griffiths then expressed some confused thoughts about his brother.
47. The first line manager recorded that Mr Griffiths needed reassurance throughout the review, because he believed he was at risk from someone. He reassured Mr Griffiths that staff would monitor him via the CCTV in his cell. Mr Griffiths said he was happy to engage with the mental health in-reach team. He reviewed Mr Griffiths' level of risk and frequency of observations and left them unchanged.
48. The nurse recorded in Mr Griffiths' medical record that he had appeared very distracted, looked tired and displayed paranoid behaviour. She recorded that, during the review, Mr Griffiths had said that his head was in "a bad place, it's gone". She noted that she had urgently referred him for a mental health assessment.
49. On 5 January, a mental health nurse assessed Mr Griffiths and noted that she had referred him to the mental health in-reach team for assessment. (The in-reach team treat prisoners with severe and enduring mental health problems.) She recorded that Mr Griffiths had agreed to make a GP appointment to discuss medication.
50. Later that day, an operational manager held a case review with Mr Griffiths, the first line manager and a nurse. Mr Griffiths continued to demonstrate signs of paranoia and anxiety and believed that people were out to get him and would torture him in his cell. The nurse recorded in Mr Griffiths' medical record that he had said he had used large amounts of Spice recently, and particularly over Christmas. The case review considered that his level of risk remained raised, and did not alter the frequency of checks. The operational manager made no further entries on the caremap. The review did not refer Mr Griffiths for any substance misuse support.
51. The operational manager told the investigator that when she returned to D Wing after the case review, she spoke to Mr Griffiths' brother and explained that Mr Griffiths had moved to the Safer Custody Unit as he had self-harmed. Mr Griffiths' brother told the investigator that he asked to visit his brother and she

- told him he needed to complete an inter-wing visit application. She told the investigator that she did not remember Mr Griffiths' brother asking about visiting Mr Griffiths.
52. Mr Griffiths' brother told the investigator that Mr Griffiths was happy when he first arrived at Parc. He said Mr Griffiths had used amphetamines for a long time in the community and that, around Christmas, Mr Griffiths had smoked a lot of Spice and after that, he became difficult to talk to.
  53. Mr Griffiths' brother said he had received no information about Mr Griffiths after he had moved to the Safer Custody Unit. He said that he had asked every day to visit Mr Griffiths, but nothing happened. Mr Griffiths' brother said he did not complete an inter-wing visit application. Staff did not record in either Mr Griffiths' brother's prison file or the wing observation book that he wanted to visit his brother on the Safer Custody Unit.
  54. Mr Griffiths wrote to his brother after he had moved to the Safer Custody Unit. The letter was undated but the contents suggest he wrote it after 5 January. Mr Griffiths wrote that he had struggled to cope with the voices in his head but that he was hopeful that the right medication could help him. Mr Griffiths asked his brother to come and visit him.
  55. At around 8.00pm on 8 January, Mr Griffiths deliberately injured his eye, by running into his cell wall holding a toilet brush. A nurse treated a small, deep cut on Mr Griffiths' right upper eyelid. Staff took Mr Griffiths to the local hospital, but he did not need any treatment, and he returned to Parc later that night.
  56. During the morning of 9 January, staff noted that Mr Griffiths was in a very low mood and was convinced that people were out to get him. At 11.00am, an operational manager held a case review in Mr Griffiths' cell with Mr Griffiths, an officer and a nurse.
  57. Mr Griffiths seemed agitated and paranoid and said he was experiencing flashbacks of being sexually abused as a child and wanted to report this to the police. Mr Griffiths said he heard people shouting at him, but it was not clear if this was real or imagined. Mr Griffiths refused to be unlocked at the same time as other prisoners as he thought they might harm him. Mr Griffiths said he had not smoked any Spice in the last seven days. He could not say that he would not harm himself or attempt suicide. The review assessed Mr Griffiths as at a high risk of suicide and self-harm and increased the frequency of checks to five an hour, with four recorded conversations a day and one at night. The operational manager added three actions to the caremap: that Mr Griffiths should receive smoking cessation support, be seen by a mental health nurse every day, and speak to the police about his experience of abuse (Mr Griffiths later decided not to pursue the matter).
  58. On 12 January, a manager held an ACCT case review with Mr Griffiths, a nurse, a mental health nurse from the in-reach team, an officer, the complex case manager, the interventions officer and an operational manager. Mr Griffiths was tearful and said he felt depressed and paranoid. The case review agreed that Mr Griffiths appeared to be displaying signs of drug induced paranoia. The nurse noted in Mr Griffiths' medical record that Mr Griffiths was scared that other

prisoners planned to murder him and wanted to kill himself before they could do so. The review agreed that, at night, staff should remove from Mr Griffiths' possession items such as pens, the toilet brush and his tooth brush because of his recent self-harm. Despite Mr Griffiths' concerns and presentation, the review assessed him as at a low risk of suicide and self-harm but left the frequency of checks unchanged at five an hour. The manager recorded two additional actions on the caremap. The interventions officer was to work closely with Mr Griffiths to help with distraction techniques, and that he needed more smoking cessation support. (It was recorded that these actions were completed on 12 and 15 January.)

59. During the afternoon on 12 January, the mental health in-reach team reviewed Mr Griffiths' referral (made on 5 January) at their weekly single pathway access meeting and arranged for a nurse to assess Mr Griffiths the next day. At the assessment, the nurse recorded that Mr Griffiths was suffering from low mood and anxiety with signs of psychosis, probably due to substance misuse. The nurse decided that Mr Griffiths should be assessed by a psychiatrist.
60. On 20 January, the operations manager chaired an ACCT case review with Mr Griffiths, a manager, a nurse and the complex case manager. A nurse gave a telephone contribution to the case review beforehand. Mr Griffiths said he had no current thoughts of suicide or self-harm and felt better than at his last review, but was still hearing voices. Mr Griffiths said he felt comfortable in the Safer Custody Unit and got on with staff and prisoners there. The operations manager did not record Mr Griffiths' assessed level of risk, but the frequency of checks remained at five an hour. She recorded one additional action on the caremap, for a nurse to arrange a GP appointment to review Mr Griffiths' eye wound.
61. On 21 January, a nurse saw Mr Griffiths. He recorded that Mr Griffiths' mental health had improved and he seemed settled with no signs of psychosis, although he suffered from low mood and anxiety. He decided that Mr Griffiths did not need to see the psychiatrist, could be managed by the primary care team and discharged Mr Griffiths from the mental health in-reach team's caseload. He told the investigator that Mr Griffiths did not fit the criteria to continue on the mental health in-reach team's caseload. He thought Mr Griffiths could be prescribed antidepressants to help him to cope with his low mood. He said that if Mr Griffiths' mental health deteriorated, he could be referred to the in-reach team again.
62. On 26 January, a prison GP saw Mr Griffiths and diagnosed him with drug induced delirium caused by heavy use of Spice. The GP recorded that he thought Mr Griffiths could be managed by the primary care team but that if his mental health worsened, he might need to see the mental health in-reach team for treatment. The GP prescribed eye drops for Mr Griffiths' eye wound, but did not prescribe any other medication. He did not refer Mr Griffiths to the substance misuse service.
63. On 27 January, a manager chaired an ACCT case review with Mr Griffiths, a nurse and the interventions officer. Mr Griffiths said he had good and bad days, and that his head was 'messed up'. He said he had phoned the Samaritans the day before and found this a good source of support. Mr Griffiths said he had

been hearing 'crazy' things and a voice which he did not recognise. He still thought that other prisoners were talking about him and said he turned up his television, did word searches or colouring to distract himself. He said that his mother-in-law was due to visit at the end of the week and was worried about this. The group encouraged him to attend the visit and Mr Griffiths said he would as he wanted his children to visit him next time. The review assessed Mr Griffiths as at a raised risk of suicide and self-harm and left the frequency of checks unchanged at five an hour.

64. At 9.00pm on 30 January, Mr Griffiths told the night patrol officer that he had cut his left wrist with a small blade he had found on the unit. Mr Griffiths said he had flushed the blade down his toilet. A nurse treated what he described as a superficial scratch on Mr Griffiths' left arm.
65. On 31 January, a manager held a case review with Mr Griffiths and a nurse. Mr Griffiths said his head had gone again and he thought his family were phoning the prison to get him killed. Mr Griffiths said he could hear people outside his cell window talking about him. He said he had spoken to the Samaritans three times already that day, as he found it easier to talk to people he did not know. The manager recorded that Mr Griffiths needed to see the GP to be prescribed anti-anxiety medication. After the review, the nurse recorded that she had referred him for a mental health assessment and to the GP. The manager and nurse assessed Mr Griffiths as remaining at a raised risk of harm and did not change the frequency of checks.
66. On 2 February, Mr Griffiths saw his offender supervisor and a substance misuse offender supervisor. Mr Griffiths told them he had been injecting amphetamines and mephedrone (a synthetic chemical compound) for 15 years and had been smoking Spice for three years. Mr Griffiths said that, since he had last smoked Spice in December 2015, he had become very paranoid and dreamt that he had done something bad to a family member. Mr Griffiths said he wanted support from healthcare and the mental health team. Mr Griffiths' offender supervisor referred him for a GP appointment to review whether to prescribe antidepressants. Mr Griffiths also agreed to be referred for drug counselling. In an email to the investigator, the substance misuse offender supervisor wrote that they had planned to see Mr Griffiths again after he had seen the GP about his low mood.
67. During the morning of 4 February, Mr Griffiths had a mental health review with a mental health nurse. She spoke to Mr Griffiths at his cell door as he refused to come out because he felt in danger. Mr Griffiths continued to express paranoid ideas. When she asked if there was anything healthcare could do to support him, Mr Griffiths asked for a razor to 'slit his throat'. She wrote that unit staff were increasingly concerned about Mr Griffiths' paranoia. She made him a GP appointment for the next day, but as she thought he might not attend the appointment, she asked whether a prison GP could prescribe antidepressant medication without seeing Mr Griffiths herself. Later on 4 February, the GP agreed to prescribe an antidepressant, fluoxetine, at 20mg a day.
68. On 5 February, a manager held a case review with Mr Griffiths, a nurse and the offender supervisor. Mr Griffiths said he was still paranoid and had not spoken to

his family recently, as he did not want to lie about how he was feeling. The manager noted that Mr Griffiths had been referred for substance misuse counselling, which he seemed keen to complete. The nurse referred Mr Griffiths to the in-reach team again, as his mental health seemed to have deteriorated. It is not clear whether this was a routine or urgent referral, but Mr Griffiths did not see anyone from the in-reach team before his death. The review considered that Mr Griffiths was still at a raised risk of harm, made no additions to the caremap and left the frequency of checks unchanged at five an hour.

69. Also on 5 February, the interventions officer emailed a nurse asking him to see Mr Griffiths again. She said that Mr Griffiths wanted to speak to him again as he had not been entirely truthful when they last met. The nurse replied that the primary care team would need to refer Mr Griffiths to the in-reach team again.
70. On 9 February, a mental health nurse assessed Mr Griffiths and recorded that he was very paranoid. He told her that he did not want to speak to her and that his 'head was going'. Mr Griffiths said he was taking his antidepressant medication but he had not yet felt a difference.
71. At around 5.30am on 10 February, the night patrol officer recorded that Mr Griffiths had made a superficial cut to his left wrist with a piece of plastic. A nurse cleaned the wound and put a plaster on it.
72. At 10.20am, a manager held a case review with Mr Griffiths, a nurse and the interventions officer. Mr Griffiths made light of his earlier self-harm. He said he was not eating or sleeping properly, and did not think his medication was working. The nurse explained that it could take some weeks for Mr Griffiths to feel the benefit and advised him to make a GP appointment if he did not feel any better after six weeks. The review assessed Mr Griffiths as at a raised risk of suicide and self-harm and did not change the frequency of checks (which was still five an hour). The manager recorded one additional action on the caremap, for the nurse to see whether the GP would prescribe sleeping tablets.
73. After the case review, the nurse recorded that during the case review, Mr Griffiths had said that if he could get hold of a blade he would cut his throat. This information was not recorded in either the note of the case review or the ACCT ongoing record. Both the interventions officer and the manager told the investigator they did not hear Mr Griffiths make this comment. The nurse told the investigator she did not remember attending the ACCT review, or making the entry in his medical record.

#### **Thursday 11 February 2016**

74. At 6.00am on 11 February, the night patrol officer recorded that Mr Griffiths had slept all night. At around 8.45am, the chaplain saw Mr Griffiths. Mr Griffiths said he was the Devil and seemed a little withdrawn. At 12.45pm, an officer recorded that Mr Griffiths had been quiet all morning and did not mix with other prisoners.
75. At 3.00pm, an officer recorded that he had spoken to Mr Griffiths while he was out of his cell. Mr Griffiths said that things were the same as usual and there was no change.

76. From around 6.00pm, cell camera footage showed Mr Griffiths pacing up and down his cell. At 6.07pm, shortly after prisoners were unlocked for some free time out of their cells, Mr Griffiths telephoned his sister. He told her that he could not cope anymore and had had enough of the voices and bad thoughts. Mr Griffiths told his sister that he was no longer taking drugs but the damage was already done. He told his sister that he had nominated her as his next of kin and asked her to ensure she got his property from his cell. Mr Griffiths' sister did not alert the prison to the nature of their conversation, and staff did not listen to the call at the time.
77. At 6.10pm, an officer recorded that Mr Griffiths was playing pool and mixing well with other prisoners. Mr Griffiths had been quieter than normal, but told an officer he was okay and just the same as usual. At around 6.25pm, CCTV footage shows Mr Griffiths walking to the unit's shower room, where he waited outside for another prisoner to finish washing. When the prisoner had finished, Mr Griffiths went into the shower room. There is no CCTV coverage inside the shower room.
78. At around 6.40pm, the officer began looking for Mr Griffiths to conduct an ACCT check. He searched the unit and found Mr Griffiths hanging from a piece of bed sheet attached to the partition between the two shower cubicles in the shower room.
79. The officer shouted for help as he did not have a radio. A prisoner was the first to respond and, together, they removed the ligature from around Mr Griffiths' neck, placed him on the floor and started cardiopulmonary resuscitation. Two officers joined them. At 6.43pm, an officer radioed an emergency code blue (which indicates a prisoner is unconscious, not breathing or is having breathing difficulties). Control room staff called an ambulance immediately they received the code blue. (Ambulance service records show they received the call at 6.43pm.) A nurse and other healthcare staff arrived soon after. The nurse attached a defibrillator (a life saving device that gives the heart an electric shock to restart the heart rhythm in some cases of cardiac arrest). The defibrillator did not detect a shockable heart rhythm and advised staff to continue resuscitation efforts.
80. An officer took the prisoner away from the shower room. Paramedics arrived at the shower room at around 6.55pm, and took over Mr Griffiths' care. The paramedics administered adrenaline and the defibrillator delivered two electric shocks but Mr Griffiths could not be resuscitated. The paramedics pronounced Mr Griffiths' death at 7.35pm.

### **Contact with Mr Griffiths' family**

81. At around 10.00pm, the Director of Parc and a manager went to Mr Griffiths' sister's home and told her that he had died. They offered condolences and support. The prison contributed to the cost of Mr Griffiths' funeral, in line with Prison Service instructions.
82. The manager broke the news to Mr Griffiths' brother at 7.45am on 12 February, but Mr Griffiths' brother told the investigator he did not receive much support afterwards. He was moved to another prison a few days after Mr Griffiths' death,

and although this was not for compassionate reasons, said he would not have wanted to stay at Parc.

### **Support for prisoners and staff**

83. After Mr Griffiths' death, the Head of Safer Custody debriefed the staff involved in the emergency response. The prison's care team offered support. The prison posted notices informing prisoners of Mr Griffiths' death and offering support.
84. Officers and members of the chaplaincy team supported prisoners. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Griffiths' death.

### **Post-mortem report**

85. A preliminary post-mortem examination found that the cause of Mr Griffiths' death was pressure on the neck (hanging). A toxicology report found evidence of Mr Griffiths' prescribed medication, fluoxetine, but no evidence of any other drugs, including NPS. We are still awaiting the full post-mortem report.

# Findings

## Assessment and management of risk of suicide and self-harm

86. Mr Griffiths was monitored under ACCT procedures on two occasions at Parc, and was subject to ACCT monitoring at the time of his death. We have some concerns about how effectively the procedures operated to protect him on the second occasion.
87. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and triggers that might increase prisoners' risk of suicide or self-harm. Several of these applied to Mr Griffiths, including previous self-harm and suicidal thoughts, substance misuse, a mental illness diagnosis, relationship difficulties, such as custody issues affecting the prisoners' children, and childhood adversity or maltreatment. Although, Mr Griffiths was identified as at risk of suicide, there is no record that any member of staff considered all of the risk factors that applied to him.
88. The PSI instructs that ACCT caremaps should reflect the prisoner's needs, be aimed at reducing risk and be time bound. The caremap must cover the issues identified in the ACCT assessment interview and subsequent case reviews. It must be clear who is responsible for completing the action within a specified timeframe.
89. Mr Griffith's caremap contained numerous entries, but they were confusing and not all of the issues raised at the assessment interview and later reviews were properly reflected. For example, the caremap did not address Mr Griffiths' mental health needs, possible substance misuse problems or anxieties about the ongoing custody case concerning two of his children. Only two of the caremap actions were time bound. Staff chairing case reviews generally recorded that they had reviewed the caremap but this was not reflected in the actions recorded.
90. Although Mr Griffiths said that family contact was important to him and made regular calls to his sister and mother, no one considered involving his family in the ACCT process. His brother was also a prisoner at Parc and told the investigator he had tried to see his brother on a number of occasions after he was moved to the Safer Custody Unit. PSI 64/11 instructs that staff must consider involving the prisoner's family or next of kin, if that would be beneficial.
91. On 10 February, the nurse who attended the case review that day, recorded in Mr Griffiths' medical record that he had said if he was given a blade he would cut his own throat. This was not recorded in either the note of the ACCT review or the ongoing record. A manager and the interventions officer, who both also attended the case review, did not remember Mr Griffiths making the statement. The nurse did not remember the event. We do not know how the discrepancy occurred, but no specific action was taken to explore this further with Mr Griffiths, or offer any additional support. We make the following recommendation:

**The Director should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:**

- **Case reviews should record and take into account all the known risk factors and triggers when considering the risk of suicide or self-harm.**
- **Setting effective caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk and which identify who is responsible for them.**
- **Involving the prisoner's family when that would be beneficial.**
- **All staff, including healthcare staff, record relevant information about risk, observations and interactions with prisoners in ACCT documents, and any action taken.**

92. However, at the time of his death, Mr Griffiths was subject to five checks an hour, which is a high frequency of observations. During the day of 11 February, while he seemed quiet and a little withdrawn, staff did not have any particular reason to think that his risk of suicide had significantly risen, or that he needed to be subject to constant supervision.

### **Mental health**

93. Mr Griffiths had a history of depression and had previously been prescribed antidepressants. His prescription had lapsed before he moved to Parc in August 2015. On 8 September, Mr Griffiths was seen by a prison GP who prescribed antidepressants for depression. The prescription was for a month, but it seems that Mr Griffiths stopped taking the medication after less than a week, and was not prescribed them again until 4 February 2016 – a week before he died.

94. At the beginning of January 2016, staff noted that Mr Griffiths appeared paranoid and anxious and, over the next six weeks, he had frequent contact with healthcare staff including, primary care mental health nurses, GPs and nurses from the mental health in-reach team. In addition, a nurse attended each of the ACCT case reviews. Healthcare staff considered that Mr Griffiths' mental health problems were the result of his heavy use of New Psychoactive Substances (NPS) over the Christmas period.

95. HIW reviewed the clinical care Mr Griffiths received at Parc and concluded that the mental health care he received was appropriate. HIW noted that Mr Griffiths was referred to the mental health in-reach team when his mental health appeared to have significantly deteriorated. They concluded that when, on 21 January, his mental health appeared to have improved, it was appropriate for a nurse to conclude that Mr Griffiths' mental health needs could be managed by the primary care team.

96. However, on 5 January, a mental health nurse referred Mr Griffiths for assessment by the in-reach team. The in-reach team did not discuss the referral until their weekly single pathway access meeting on 12 January, and a nurse assessed him the next day. We consider that the week long delay in discussing the referral was too long, given his history of suicide attempts, self-harm and deteriorating mental health. We make the following recommendation:

**The Director and Head of Healthcare should ensure that there is a clear pathway for mental health services, which ensures that prisoners identified**

**as at risk of suicide and self-harm have an urgent mental health assessment within three days.**

### **New Psychoactive Substances**

97. Mr Griffiths had a long history of substance misuse before he arrived in custody. When he moved to Parc, Mr Griffiths told staff he did not need support from the substance misuse team. In January 2016, Mr Griffiths told staff he had smoked 'Spice' a new psychoactive substance heavily over Christmas. He said he had not used it again after the first week of January.
98. Staff believed that Mr Griffiths' use of Spice contributed to his mental health decline and self-harming behaviour, yet we found limited evidence of a strategic approach to tackling the problem of NPS. Mr Griffiths was not referred for substance misuse support until 2 February and there were no ACCT caremap actions relating to his disclosed use of Spice.
99. At their recent inspection in January 2016, HM Inspectorate of Prisons reported that illicit drugs were readily available at Parc. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services. It is important that prisons do all they can to eradicate the use of new psychoactive substances and other illegal drugs. We make the following recommendation:

**The Director should ensure there is an effective substance misuse strategy to help reduce the availability and demand for new psychoactive substances, that staff are vigilant for signs of its use and are briefed about how to respond when prisoners appear to be under the influence of such substances.**

**Prisons &  
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