FINAL REPORT

ARTICLE TWO COMPLIANT INVESTIGATION

IN THE CASE OF 'CR'

JANUARY 2020

The young man at the heart of this investigation suffered severe brain injury as a result of attempting to hang himself in a cell in the induction unit at Swansea Prison. After some four years in a nursing home, the young man died in October 2019. I offer my condolences to his family.

To protect the privacy of the young man and his relatives, he is known in this report by the pseudonym 'CR'.

Barbara Stow
Lead Investigator

COMMISSION AND TERMS OF REFERENCE

I am commissioned by the Secretary of State for Justice to conduct an investigation with the following terms of reference:

- to examine the management of CR by HMP Swansea from the date of his reception on 21 November 2015 until his life-threatening self-harm on 3 December 2015, and in light of the policies and procedures applicable to CR at the relevant time;

- to examine relevant health issues during the period spent in custody at HMP Swansea from 21 November 2015 until 3 December 2015, including mental health assessments and CR's clinical care up to the point of his life-threatening self-harm on 3 December 2015;

- to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved;

- to provide a draft and final report of my findings including the relevant supporting documents as annexes;

- to provide my views, as part of the draft report, on what I consider to be an appropriate element of public scrutiny in all the circumstances of the case. The Secretary of State will take my views into account and consider any recommendation made on this point when deciding what steps will be necessary to satisfy this aspect of the investigative obligation under Article 2 of the ECHR.

The Interested Parties to the investigation are:

CR. The Lead Investigator has met CR's sister and had some further correspondence with her but she has chosen not to take an active part in the investigation.

The Ministry of Justice, through Mr Andy Rogers, Deputy Director, Safety Group, HM Prison and Probation Service.

Abertawe Bro Morgannwg University Health Board, through Ms Hazel Lloyd, Head of Legal Service. The Health Board is the current provider of healthcare at HMP Swansea but at the time of the events with which this report is concerned the Prison Service was responsible for healthcare at the prison.

The investigators are:

Barbara Stow, Lead Investigator
Andy Barber, Assistant Investigator
The Clinical Reviewer is Anthony Pritchard.

I now present my report.

Barbara Stow
BA (Hons), MSt (Cantab) Applied Criminology and Management, FRSA

January 2020

THE STRUCTURE OF THE REPORT

A full index to the Contents of the report is provided at pages 7 to 14 but broadly the report is structured as follows:

- Part One of the report contains:
  - A note on the reason for the investigation
  - A note on a sufficient element of public scrutiny
  - A summary of the investigation's findings
- Part Two of the report contains a detailed account of the evidence we have considered and which is the basis for our conclusions and recommendations.
- Part Three contains the findings of the clinical review by Mr Anthony Pritchard.
- Part Four examines general issues emerging from the investigation.
- Annex One is a note of the procedure that the investigation has followed.
- The Confidential Annexes, which were available to the Interested Parties but will not be published with the report.
  - Confidential Annex One is a key to the pseudonyms used in the report.
  - Confidential Annex Two is the clinical review in full, which contains detailed personal data from CR's clinical history which it is not necessary to include in the public report.

- Confidential Annex Three lists the contents of the documents referred to by the investigation.

- Confidential Annex Four is a list of documents seen but not relied on by the investigation or referred to in the report.

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PART ONE

BACKGROUND, SUMMARY AND RECOMMENDATIONS

THE REASON FOR THE INVESTIGATION

CR was arrested in November 2015 and remanded in custody. He was aged 32 at the time. He had attempted to set fire to himself at his home in a block of 11 flats. The Fire Brigade and the police attended. CR was pulled from the fire and taken to hospital suffering the effects of smoke inhalation. He was charged with arson with intent to endanger life. He is said to have set fire to his bed and is reported to have told a police officer that his partner had recently died, that he had liver failure, and that he wanted to end his life.

CR was remanded to HMP Swansea. Thirteen days later, at about 9pm on 3 December 2015, CR was found hanging in his cell. His cell mate raised the alarm. Prison staff gave first aid, an emergency ambulance attended and CR was taken to hospital. He suffered severe cognitive impairment with no capacity for independent movement or communication. CR was cared for in a nursing home for the rest of his life. He died in October 2019.

Article 2 of the European Convention on Human Rights says that everyone has an absolute right to life. The European Convention has been incorporated into UK law through the Human Rights Act 1998. Case law has established that when someone who is in the custody of the State dies or suffers life-threatening self-harm there must be an investigation that is impartial, independent and open to public scrutiny.

The purpose of an investigation of this kind is to ensure as far as possible:

- that the full facts are brought to light
- that any culpable and discreditable conduct is brought to light
- that suspicion of deliberate wrongdoing is allayed if it is unjustified
- that dangerous practices and procedures are changed

- and that those whose relative has been harmed may at least have the satisfaction that lessons learned may save others.

The investigation report examines the circumstances in which these events occurred, and importantly whether there are lessons to be learned to prevent something similar happening in future.

SUFFICIENT ELEMENT OF PUBLIC SCRUTINY

I am asked to provide my views as to what I consider to be an appropriate element of public scrutiny in all the circumstances of CR's act of self-harm.

My objectives for the investigation have been:

- to bring to light, as far as is possible, all the relevant facts
- to find answers to questions posed by CR's family
- to discover any shortcomings in systems, or in the conduct of individuals, that adversely affected CR's care
- to draw from what happened any lessons that may help to save others, in future, from suicide or catastrophic self-harm

In conducting the investigation, I and my colleagues received full and prompt cooperation from the Interested Parties, and from South Wales Police and the Welsh Ambulance Service. We were able to interview all the current members of staff from Swansea Prison and the Health Board whom we identified as able to contribute. I am grateful for the assistance of all the witnesses. Where there are questions that we have not been able to answer, I believe that they have occurred because of the passage of time since the events and not through any wilful obstruction.

The report makes recommendations for changes that I hope will improve the identification and care of prisoners at risk of self-harm. The Health Board has already considered these recommendations and formed an action plan. HMPPS will respond to my recommendations to them in due course. The response of the Health Board and HMPPS will be published alongside this report.

It is for others to judge how far the investigation has succeeded in achieving its objectives, but in my view, attention to the recommendations and the publication of the report without delay will best serve to meet the proper requirements for public scrutiny, by enabling those

who have an interest in the care of people in custody, and the power to affect what happens there, to learn from what happened to CR.

EXECUTIVE SUMMARY

In brief

1. CR was remanded to HMP Swansea after setting a fire with the intention of ending his life. Documents accompanying him to prison gave details and warned that he was at risk of suicide. In Reception at the prison he explained the fire to a nurse as an impulsive act when he was drunk. He was not considered at risk of suicide and no protection plan was opened. No information about a risk of suicide was passed to the wing. CR was in poor health and detoxing from alcohol. He became ill and was in hospital for some days.

2. Shortly after discharge from hospital, CR made superficial cuts to his arms and a suicide prevention plan (ACCT Plan) was opened. Staff responsible for the plan were not aware of his previous self-harm. He was considered to be at low risk. Measures to protect him were mainly formulaic.

3. There was no staff member from CR's wing on the first ACCT case review panel. On the same day as the first case review CR attempted to hang himself with a prison sheet from the window bars of his cell. Staff gave timely and appropriate assistance until paramedics arrived. CR was taken to hospital. As a result of lack of oxygen to the brain, he had no independent functioning and was unable to communicate. CR died in October 2019.

4. The investigation found several instances of failure to comply with Prison Service policies. These were not all directly related to CR's risk of self-harm but indicated lack of attention to procedures. Most significant is the failure to pass information about his risk of suicide to the wing. It is also hard to understand why no precautionary ACCT Plan was opened in Reception.

5. When CR was placed on an ACCT Plan, there was little evidence of active steps to enable him to access sources of support. Policies on safer custody repeatedly

emphasise the importance of engaging prisoners' families where possible. CR identified family members as important to him but this was not reflected in the plans to keep him safe.

6. There was no reference to the ACCT Plan in CR's clinical record, and the investigation's Clinical Reviewer found that communications between the outside hospital and healthcare in the prison were often unclear.

7. Contrary to Prison Service requirements, Swansea Prison did not conduct an investigation into the circumstances of CR's self-harm to examine whether lessons could be learned. Staff were not asked to provide statements at the time. This has meant that our investigation required staff whom we interviewed to rely largely on their memories of events that occurred some three years earlier.

The investigation's findings and observations

Preventing suicide and self-harm in prison - Assessment, Care in Custody and Teamwork (ACCT) (see Chapter 1)

8. ACCT is the Prison Service strategy to protect prisoners from self-harm. CR ligatured in his shared cell on the induction wing despite being supported by an ACCT Plan. Chapter 1 gives a brief outline of the ACCT scheme.

About CR (see Chapter 2)

9. CR was 32 in November 2015. He was gay. CR's partner died early in 2015. CR was distressed by his partner's death. CR drank alcohol prolifically and his liver was - damaged by alcohol abuse. CR was much loved by close relatives, who described him as warm, generous, sociable, but changeable and sometimes depressed. At one time the family had tried to get help for CR from a psychiatric hospital but they say he was late for an appointment, the staff would not see him, and he ended up being arrested.

CR's sister was aware of a suicide attempt in the past but she had not been aware at the time that CR had tried to set fire to himself.

10. Family members continued to visit CR several times a week in his nursing home until his death but they did not know whether he was aware of their presence.

Arrest, police custody and remand to Swansea Prison (see Chapter 3)

11. CR attempted to set fire to himself and was rescued by the Fire Service. He told the police, a nurse and a custody officer at the court he had intended to kill himself and that he had tried before, a week or so previously. He was distressed by the death of his partner and by his physical condition. He also spoke of having tried to throw himself from an eighth floor flat three years earlier.

12. The prison would not have seen the police custody record, or the grounds for continued detention, or the assessment of CR's risk made by the hospital nurse whom he told he had also set another fire the previous week.

13. The documents that accompanied CR to prison included the Person Escort Record, a Suicide and Self-Harm Warning Form and the warrant from the Magistrates' Court. These all recorded a risk of suicide on the basis of CR's deliberate attempt to take his own life by setting himself on fire.

14. The Person Escort Record noted that there were also previous incidents which they did not specify, and CR's depression and poor physical health. The Suicide and Self-Harm Warning Form completed by the escort service referred to the fire-setting and a previous suicide attempt in 2012. The warrant said that CR was charged with arson with intent or reckless as to whether life was endangered. The Magistrates' Court recorded that CR wished to take his own life. A note on the warrant said CR appeared vulnerable, with suicidal tendencies.

Induction at HMP Swansea (see Chapter 4)

15. The staff who saw CR in Reception knew he had tried to kill himself two days earlier and that the police, the escort service and the court considered him to be at risk. We do not know what factors influenced the Reception Officer, but the nurse was reassured by CR's manner and his explanation that the fire, and a similar attempt two weeks previously, were impulsive acts committed when he was drunk. Neither member of staff opened an ACCT.

16. CR had a history of attempted suicide, and he was known to have mental health problems and alcohol dependency. These are all factors indicating an enhanced risk of self-harm. Coupled with the warnings from other agencies, there should, in our view, have been a presumption in favour of opening a precautionary ACCT. We are not persuaded that CR's assurances and demeanour were sufficient reason to overturn that presumption.

17. Suicide prevention is everyone's responsibility in prison. It is important that healthcare staff are appropriately trained in the ACCT ethos and procedures, and that they do not leave it to the discipline staff to take the initiative.

18. The wing staff who completed CR's induction and were responsible for his first days in prison were not aware of the warnings that accompanied CR to prison and they did not know he had tried to kill himself. Contrary to Prison Service Instruction PSI 07/2015 the Suicide and Self-Harm Warning Form and the warrant were not passed to the wing.

19. The electronic Case Note History was accessible to staff on the wing but there was no entry about the warnings that accompanied CR to prison.

20. The personal details form in the Core Record was not completed properly in Reception. The officer did not sign the form and it was not clear whether CR gave consent for his next of kin to be contacted in an emergency.

21. The Reception Officer knew that CR was charged with arson, but contrary to Prison Service Instruction PSI 20/2015 he did not refer the Cell-Sharing Risk Assessment for consideration by a manager. Risk of self-harm is not necessarily an impediment to cell-sharing but it is possible that consideration by a manager might have led to another view as to CR's suicide risk.

Tuesday 24 November to Tuesday 1 December - CR becomes ill and spends five days in hospital (see Chapter 5)

22. CR was dependent on alcohol, and healthcare supervised a detox regime. He was known to have liver damage. He became ill and was admitted to hospital. At first, CR was agitated and irrational for much of the time and unwilling to cooperate with treatment. This appears to have been in large part due to his illness.

23. Arrangements were made to notify CR's next of kin of his illness on his third day in hospital, at his request. He was by then more rational and the family visits went well. One of the bedwatch officers who knew CR from the wing observed that he belonged to a close and loving family.

24. CR was discharged by the hospital three days later. He had been keen to leave the hospital but, contrary to some entries in the prison records, he did not discharge himself against medical advice.

CR cuts himself; an ACCT Plan is opened; later CR becomes unwell and goes back to hospital (see Chapter 6)

25. In the evening after his discharge from hospital, CR inflicted superficial cuts to his arms. A nurse attended and an ACCT Plan was opened. There was no reference to either event in the clinical record.

26. The officer who opened the ACCT Plan had no knowledge of CR's prior history of self-harm or the circumstances of his arrest. Apart from a requirement to record hourly observations and for CR to remain in shared accommodation, the provisions of the Immediate Action Plan were non-specific, with no timescales or allocated responsibility for actions.

27. CR became unwell and was taken back to the hospital. He was in A&E overnight. His condition was related to his withdrawal from alcohol, not the cuts to his arms. The electronic record and the clinical record said wrongly that he had discharged himself from hospital the previous day against medical advice. This erroneous information may have originated from the hospital records.

28. CR returned to the prison on Wednesday morning. There is no reference in the record of events to the provisions in the Immediate Action Plan for CR to have access to Listeners and to make phone calls, and to see the medical officer as soon as possible. He appears to have slept for much of the day and entries in the ACCT record of events are uninformative as to his state of mind.

29. Whilst we see no connection with CR's mood or his self-harm, we note that CR's cellmate was a convicted prisoner. Contrary to the Prison Rules there is no record that CR, as an unconvicted prisoner, was asked to agree to share with someone who was convicted.

Thursday 3 December - the ACCT Plan (Chapter 7)

30. There is no indication in any of the ACCT documentation or from our interviews that the discipline staff responsible for CR's risk assessment and care plan on 3 December knew how he came to be in prison. The trigger for the ACCT Plan was CR's superficial self-harm in his cell two days earlier.

31. We cannot know whether CR believed that the ACCT assessor and the review panel knew about the fire-setting but there is nothing in any of the ACCT documents to indicate that they did. The only reference to previous self-harm in the assessment interview is that CR had tried to jump from a building some months before.

32. Nurse 1, who attended the case review, had spoken with CR about the fire-setting when she met him in Reception, but when we spoke to her during the investigation she was unable to recall whether at the time of the review she linked CR in her mind with having met him during his reception and induction into the prison.

33. This confirms our concern that the significant evidence of risk that accompanied CR on his admission to prison was not passed on to the staff responsible for his management on the wing. This vests too much authority in the judgments that were made at admission. The information should have been passed on, to be taken into account if circumstances changed or there were other indications of risk.

34. Not only were the panel not aware of the extent of CR's recent history of attempted suicide, only Nurse 1 had had any prior contact with him before the assessment interview. None of the panel members could be said to have known CR, nor would they have any continuing relationship with him on the wing. This is contrary to the provisions on preventing self-harm in Prison Service Instruction PSI 64/2011. There were officers who knew something of CR. Several had spent time on bedwatch when he was in hospital. Some had met members of CR's family.

35. The assessment interview and review were held some 42-hours after the ACCT Plan was opened. This was not an undue delay given that CR had spent part of that time in hospital. But there was little evidence of active engagement with him until the assessment interview. Except for a requirement for CR to remain in shared accommodation and to record hourly observations, the provisions of the immediate action plan were generalised, with no timescales or allocated responsibility, and there is no indication of any measures to implement the action plan, other than hourly observations, which appear cursory.

36. We are satisfied that the assessor and the case manager undertook their tasks with sensitivity and diligence in light of the information they had. However, we have reservations about the adequacy of the CAREMAP. The three actions identified were appropriate, though without timescales, but two of them, the referrals to mental health in-reach and CARATs, were already in place with initial assessments awaited.

37. The only personalised intervention for CR's particular circumstances was the plan for CR to meet the Chaplaincy and light a candle for his late partner.

38. Needs identified in the list of factors for consideration, to encourage family contact and engagement in activities, were not carried over into the CAREMAP, so no responsibility was allocated for them. We have expressed a similar concern about the Immediate Action Plan accompanying the Concern and Keep Safe Form.

39. There was no entry in the clinical record that an ACCT Plan had been opened in the evening of 1 December. Nor was there any entry for the ACCT review, even though a member of the healthcare staff attended. There was no red flag on the clinical record alerting healthcare staff to the risk of self-harm.

40. In the ACCT review, CR's relationship with his current cellmate was identified as a protective factor. He was assured that he would be able to stay in his current cell with the current cellmate. However, the cellmate was moved, at his own request, almost

immediately after the case review. From the record and the staff's memories some three years after the event, we cannot be precisely sure of the circumstances of Prisoner 1's request to move. Nor can staff place on other prisoners the responsibility to take care of prisoners at risk of self-harm. But Prisoner 1's move, coming so quickly after the assurance CR was given, may well have seemed a breach of trust, and it needed careful management.

41. From what we have been told, staff were aware of the sensitivity of the cell move, at least in part. A wing officer placed another prisoner with CR as soon as she could. The Case Manager visited him. Conversations with CR about the new cellmate were noted in the record of events. Some of the entries indicate that CR continued to be bothered about the move.

CR's act of self-harm and the staff's response (see Chapter 8)

42. The case review was held in the afternoon of Thursday 3 December. At about 9pm that evening, CR was found to have ligatured with a twisted prison sheet attached to the bars of the window to his cell. His cellmate rang the cell bell to alert staff. Officers and a nurse attended. They removed the ligature and attempted to resuscitate CR. An ambulance was called. Paramedics arrived first and took over CR's care, with the help of the prison nurse and an officer. The ambulance crew arrived soon afterwards and continued resuscitation attempts.

43. At about 10.20pm. CR was taken to hospital. At the hospital, a scan showed hypoxic brain injury through oxygen starvation. The clinical prognosis was that if he did not die, he would be seriously disabled and not make any form of recovery.

44. On 18 December 2015, the police were informed that charges had been dropped against CR. He was formally released from custody and prison staff ceased attendance at the hospital. CR's condition remained unchanged. He was moved to a nursing home. It was thought unlikely his condition would improve. CR died in October 2019.

45. We have not been able to obtain exact timings for when Prisoner 2 raised the alarm but, from the evidence available, we were satisfied that there was no delay in opening CR's cell and providing assistance. That is partly due to the compact nature of Swansea Prison. Both the nurse and the Night Operational Manager were located close to the wing.

46. The investigation's Clinical Reviewer concludes that the staff who attended to CR acted in line with national standards. They should be commended for their diligence in delivering timely and appropriate emergency care.

47. Despite the best efforts of the staff who attended to him, CR's injuries caused severe and life-changing harm which left him unable to move or communicate and wholly dependent on institutional care.

The Police inquiry (see Chapter 9)

48. The police took the lead in investigating the immediate circumstances of CR's hanging. Concerns were raised by a letter written by CR's new cellmate, Prisoner 2, and found in the cell. It referred harshly to CR as being someone who self-harmed by cutting and, disgruntled at being in prison, Prisoner 2 wrote of tying his own sheet to the window bars to end his life.

49. We cannot know if Prisoner 2's conversations with CR had any effect on CR's state of mind. Prisoner 2 undoubtedly had his own problems and he was not responsible for CR's welfare. He acted appropriately in supporting CR's weight and calling for staff. The police were satisfied that there were no suspicious circumstances.

50. We note the reference in Prisoner 2's letter to tying his sheet to the window bars. The cell offered obvious ligature points to occupants feeling despair.

Part Three: Clinical Advice to the Investigation

The Findings of the Clinical Review pertaining to the standard of care offered to CR (see Chapter 10)

Physical health needs

51. The clinical review finds that CR's physical health needs were appropriately assessed on his reception to HMP Swansea and second health screening appropriately undertaken the following day.

52. Prison staff alerted the healthcare team when there were changes in CR's condition and there was ongoing liaison, monitoring, and observation of him whilst awaiting transfer to secondary care, though no evidence of suitable discharge information when he initially returned to prison from hospital.

53. Healthcare staff were alerted and provided appropriate treatment when CR self-harmed on 1 December, though this was not documented in the clinical record.

54. Hospital discharge information following CR's A&E attendance was poor. Once CR was hospitalised following his attempted hanging, there was evidence of regular communication and liaison between prison and hospital healthcare teams.

Mental health needs

55. Clear concerns about CR's risk of suicide/self-harm were documented by other agencies prior to CR's reception at HMP Swansea. It is not clear if this information was taken into account at the time of the initial health assessment and this is not explicitly referred to in the clinical record. However, CR presented with a number of factors that would alert to an increased risk of suicide/self-harm and would indicate the need for an ACCT to be opened. It appears that clinical assessment was based on the

perception of CR's presentation and the responses that he gave in relation to any thoughts or intention of suicide or self-harm.

56. At the later initiation of the ACCT process on 1 December 2015, these earlier concerns were not referred to, which indicates that they were not considered in the management of CR's risk to himself.

57. In addition, the involvement of healthcare staff in the ACCT process was not recorded in the clinical record and there was no evidence of an ACCT flag within the clinical record.

58. The intended referral to Primary Care Mental Health Services was indicated in the clinical record and ACCT documents and the need for this was also indicated in his hospital discharge information. However, there is no evidence that CR was seen by the service.

Management of alcohol dependence

59. CR was appropriately assessed in relation to his alcohol dependency and was provided with suitable medication to support detoxification. CR was appropriately observed by members of the healthcare team during the first three nights of detoxification and this was noted in the clinical record.

60. As CR was received into prison on a Saturday, he was seen by the CARAT service on the following Monday and there was evidence of subsequent attempts to follow-up on this initial contact.

61. A referral titled 'alcohol abuse' appears to relate to a clinic provided by the Primary Care Mental Health Service, though there was no evidence of an appointment having been made and referral records relating to this were not available.

Decisions about the most suitable location for CR

62. Appropriate decisions were made about the most appropriate location for CR. Staff recognized and responded to the deterioration in CR's condition on 25 November 2015 prior to his transfer to hospital. He was again appropriately transferred to A&E on 1 December 2015.

63. The hospital notes and discharge communications indicate that CR was suitable for discharge back to primary care at the time of discharge. A concern is noted, however, in relation to documentation relating to the transfer/discharge of CR between prison and hospital services. Prison transfer information did not note the location and was not dated, timed or signed. Discharge summaries from the hospital service were not always comprehensive, whilst required actions following discharge were not noted in the clinical record.

The emergency treatment of CR

64. CR received appropriate and timely emergency care. There was prompt recognition and appropriate action following CR's attempted hanging. Prison staff appear to have initiated CPR whilst an ambulance was called. A nurse responded promptly and the required equipment to support resuscitation was available. The nurse undertook a suitable assessment of CR's status and continued attempts at resuscitation in line with guidance whilst awaiting paramedical support.

65. A concern was identified during investigation about the completion of annual resuscitation training updates by healthcare staff as there appeared to be no clear process for monitoring the completion of this training.

Was CR's care equal to what he could have expected in the community?

66. CR was able to access healthcare services whilst in prison, and he was appropriately referred to secondary healthcare services when this was indicated. There is evidence that CR's concerns about his sexuality within a prison environment were discussed with him and that he was offered reassurance in this respect. There is evidence of appropriate liaison between healthcare teams and hospital services, though the documentation to support handover and communication between services was not always robust.

67. The Clinical Reviewer concludes that CR received healthcare which was equitable to that which he could have expected to receive within the community.

Were events leading to CR's condition foreseeable and preventable?

68. There is evidence that a range of risk factors were present when CR was initially detained at HMP Swansea and that these would have indicated a significant risk of suicide/self-harm. These relate to the preceding events and the alleged offence along with CR's existing depression, bereavement, alcohol dependence and long-term health issues. It is therefore concluded that the risk of suicide/self-harm was foreseeable.

69. However, as CR was under an ACCT which included 60-minute observations at the time of his attempted hanging, it is not possible to conclude for certainty that the incident was preventable.

70. The Clinical Reviewer makes seven recommendations, and comments on the desirability of standard templates for hospital discharge summaries.

Part Four: General issues arising from the investigation

Engagement with prisoners' families (see Chapter 11)

71. The disclosure of information declaration on CR's personal summary sheet form was not completed properly on his admission to the prison so it was not clear whether CR had expressed a view about whether his family should be informed in an emergency.

72. It was only on his third day in hospital that, at CR's request, his family were informed he was in hospital. CR had asked before, when he was in an agitated state, for his family to be allowed to visit. The risk assessment should have been reviewed on his first day in hospital, and, subject to that, contact with his family encouraged and facilitated. As an un-convicted prisoner CR was entitled to unrestricted family contact so long as this was consistent with security.

73. It was not unreasonable that the family were not informed overnight on 1 - 2 December when CR was in A&E, but family contact was part of the ACCT Immediate Action Plan. There is no evidence that any consideration was given to this.

74. There was nothing in CR's behaviour or demeanour to suggest that he should have been placed in an unfurnished cell or in restrictive clothing to prevent him hurting himself. These are emergency measures used briefly in crisis and liable to cause additional distress.

75. However, the cramped and dingy cell with an only partly screened toilet and conspicuous window bars is not in our view a decent environment, especially for new prisoners. It is known that self-harm is particularly prevalent in prisoners' first days in custody.

76. Prison Service policy recognizes the importance of families in protecting prisoners from self-harm. Wing officers had seen CR's interaction with his family when he was

in hospital and knew them to be supportive. CR told the ACCT assessor that family members were a resource and a reason for living.

77. The Immediate Action Plan and the ACCT document referred to telephone access to family but with no measures in place to encourage or facilitate it. The plans were too passive. It is not safe to assume that if a prisoner wants something they will take the initiative and ask for it. Many prisoners have low expectations of staff's willingness to help them, and left to themselves, will not ask for facilities but just keep their heads down. This is especially likely if the prisoner is in poor health, or contemplating self-harm.

78. Prison Service policy explicitly requires that ACCT review panels should always consider whether there is scope for actively involving families, must facilitate family contact wherever appropriate, and must document what arrangements are made for the prisoner to have contact with family. There is no evidence that this was done.

79. CR's family asked the investigation about the emergency care provided to CR. The investigation's Clinical Reviewer has confirmed that prison staff provided appropriate and timely emergency care in compliance with professional standards.

80. The family say that the Family Liaison Officer whom they met the day after CR's self-harm was unable to answer their questions. When a prisoner dies in custody, Prison Service policy requires a Family Liaison Officer to be nominated, and before meeting the family the liaison officer must be familiar with the circumstances and the prisoner's history. It should be made clear that similar considerations apply where a prisoner suffers life-threatening self-harm.

81. We recommend the selection, training and appointment of a Family Liaison Officer in the Safer Custody Team to promote and monitor measures to engage families in supporting prisoners at risk of self-harm, and possibly to work in conjunction with the

Resettlement Unit in promoting the maintenance of family links across the prison population.

The prison's investigation (see Chapter 12)

82. The prison knew from the hospital on 4 December that the prognosis for CR was grave and he was unlikely to recover. Contrary to Prison Service Instruction PSI 15/2014 there was no follow-up to CR's self-harm to see whether there were lessons to be learned. There was no examination of CR's management before his self-harm and no consideration of why the ACCT Plan was insufficient to protect him. No staff were asked to make statements. There was no examination of what was known about CR's history of self-harm. Healthcare staff were not consulted.

83. A Senior Manager should have commissioned a systematic inquiry by someone who was not involved in CR's care or the incident, including an examination of his care and management before his self-harm, and with input from healthcare, to advise on any lessons to be learned. Prison Service Order 1300 requires that this should have been a formal investigation, registered with the Investigations Support Section at HMPPS Headquarters.

84. The police investigation may have inhibited the prison from investigating immediately, although there is no evidence that this was considered. However, the police investigation would not cover wider questions about preventing self-harm and the prison should have liaised with the police to progress its own investigation without compromising the police enquiries.

85. Advice from Prison Service Headquarters in August 2016 came too late for the prison to remedy the failure to take statements from staff immediately after CR's self-harm.

Safer custody at Swansea Prison (see Chapter 13)

86. Some of the concerns identified by Her Majesty's Inspector of Prisons (HMIP) reflect concerns that we have expressed about the management of CR's risk of self-harm in Swansea Prison. The 2014 inspection identified inadequate investigation of incidents of self-harm and inadequate interrogation of data by the safer custody meeting to identify any patterns and trends. Initial assessments did not always take place promptly. Self-harm history was not always taken into account. CAREMAPS did not always reflect need. Staff entries in ACCT records were often uninformative. In 2017, deficiencies identified in the previous inspection had not been remedied and initial risk assessment was weak.

87. In CR's case, the staff responsible for his management on the wing, and the ACCT assessor and review panel, were ignorant of his recent attempts to kill himself. The support identified in the CAREMAP was limited and mainly formulaic. After CR's life-threatening self-harm there was no examination of the surrounding circumstances, and the safer custody meeting showed no curiosity. We also know that there was poor communication between healthcare and discipline: CR's self-harm two days before his attempted hanging, and the opening of an ACCT Plan at that time, were not noted in the clinical record.

88. We have been assured that action has now been taken on all the recommendations of the Inspectorate about safer custody. It is beyond the scope of this investigation to verify how effective those changes are but it may be a useful exercise under the direction of the Governor for appropriate managers to consider each of the deficiencies we have identified in the case of CR, and to test whether there are now robust arrangements in place that will prevent similar shortcomings in future.

89. We note HMIP's comments in the 2014 and 2017 reports on Equality and Diversity. As part of our investigation, we spoke to CR's sister and to all the staff who were interviewed, about CR's reported concern about being a gay man in prison. This was

identified as a concern by the ACCT assessor and the case review panel. CR's sister told us that CR was comfortable and open about his sexuality. Most of the staff we spoke to said they had no recollection of CR being gay. We have not found any evidence that CR's sexuality or any adverse treatment by staff or other prisoners was a factor in his self-harm.

90. We note the observation of the POA representatives that because of workload and logistics ACCT case managers may have no prior knowledge of the men whose ACCT plans they manage and no routine involvement with their daily life. In this case, the assessor and the case manager both worked in the Offender Management Unit. The only other member of the panel was a nurse. We have noted elsewhere that none of the staff who knew CR from his wing or from the bedwatch took part in the review.

91. We understand the pressures on prison staffing levels, and we were impressed with the diligence and sensitivity of the case manager and the assessor, but, in our view, the case review should include at least one member of staff from the prisoner's wing with whom the prisoner is familiar, who knows something of the prisoner's daily life and who can provide continuity between reviews. We refer to the guidance on First Case Review in Prison Service Instruction PSI 64/2011.

92. We note that it is for Governors to determine on the basis of a local risk assessment the number and deployment of staff accredited to administer emergency first aid. We think it important that adequate and up-to-date provision is maintained and that this is regularly reviewed.

Recommendations

93. Our general recommendations and recommendations arising from the clinical review follow directly after this summary.

THE INVESTIGATION'S RECOMMENDATIONS

1. This section of the report contains general recommendations which are addressed to HMPPS, and healthcare recommendations arising from the clinical review, which are addressed to the local health board.

RECOMMENDATIONS TO HM PRISON AND PROBATION SERVICE

2. The recommendations to HMPPS are primarily matters for the Governor of HMP Swansea. However, we ask that HMPPS considers in each case whether they are matters that have more general application and whether they require any changes to national instructions or guidance.

Recommendation 1

Non-compliance with Prison Service policies

3. The investigation has identified the following clear breaches of requirements in Prison Service policies:

- The CSRA should have been authorised by a manager as CR was charged with arson
- The warrant, PER and Suicide and Self-Harm Warning Form were not passed to the wing
- The Personal Details Form was not completed properly so it was not clear whether CR wished his next of kin to be informed in the event of illness or transfer
- The opening of an ACCT document was apparently not notified to healthcare. In any event it was not recorded on the clinical record so healthcare staff responsible for CR's care and treatment were not alerted to it

- CR, an unconvicted prisoner, was located with a convicted prisoner, apparently without having given his express consent
- No investigation was commissioned into the circumstances of CR's self-harm.

4. **We recommend** that the Governor of HMP Swansea is asked to establish that robust measures are now in place to ensure that these breaches no longer happen.

Other areas for review

5. There are other areas where it is less clear that policy has been breached but where we consider that performance did not reflect best practice in accordance with guidance in Prison Service policies:

Recording warnings on the Case Note History

Recommendation 2

6. The suicide risk warnings received from the police, the escort service, and the court were not recorded on CR's electronic Case Note History which is the primary source of information for those responsible for his management and care. Just as information about self-harm received at admission is required to be passed to the wing, **we recommend** that there should also be a brief but informative entry on the electronic record.

Arrangements when a prisoner is taken to hospital

Recommendation 3

7. When a prisoner is sufficiently unwell to be admitted to outside hospital, a risk assessment should be made promptly to establish arrangements for notifying next of kin and facilitating visits. These arrangements should take into account the special

rights of unconvicted prisoners to unrestricted visits subject to operational and security requirements.

8. **We recommend** that the Governor of HMP Swansea is asked to establish that appropriate arrangements are in place.

ACCT - Family Engagement

9. Prison Service policies repeatedly emphasise that families can be influential in helping to prevent self-harm. It is not sufficient to pay lip service to the principle.

Recommendation 4

10. **We recommend** that Swansea Prison considers the selection, appointment and training of a Family Liaison Officer as a member of the Safer Custody Team, to promote engagement with families as part of the ACCT scheme, to monitor the operation of this in practice, and to report periodically to the safer custody meeting.

11. Maintenance of family ties is a factor in reducing reoffending and in resettlement of prisoners. The Family Liaison Officer in the Safer Custody Team might work in conjunction with appropriate staff in the Offender Management Unit to develop opportunities for prisoners to have constructive involvement with their families during their imprisonment.

Recommendation 5

12. **We recommend** that particular consideration is given to ensuring that CAREMAPs include reference to specific arrangements for engaging with families unless a reason is given elsewhere in the document why this is inappropriate.

ACCT - Case managers and review panels

Recommendation 6

13. Prison Service Instruction PSI 64/2011 says that the first case review should include a member of staff who knows the prisoner. In the case of a new prisoner this may not be possible but, in our view, case review panels should always include an officer from the prisoner's wing who has, wherever possible had some prior contact with him, and preferably will be able to provide continuity between reviews.

14. **We recommend** that this should be a stipulation in the membership of all case review panels and that the Governor should establish that this is now observed at HMP Swansea.

Recommendation 7

15. The staff who attended CR when his self-harm was discovered gave timely and appropriate care.

16. **We recommend** that Prison Officers E and F, Nurse 3 and the Night Orderly Officer, Mr M, should be commended for their diligence in seeking to save CR.

RECOMMENDATIONS TO THE HEALTHCARE PROVIDER

17. The recommendations from the clinical review are addressed to the Abertawe Bro Morgannwg University Local Health Board which took over responsibility for the provision of healthcare services at Swansea Prison in 2016. At the time of CR's self-harm, HMP Swansea was the provider of healthcare services at the prison.

Healthcare Recommendation 1

18. A range of information including that from assessment during custody and from court proceedings should be considered along with the presenting risk factors when undertaking an initial assessment of an individual's risk of suicide/self-harm and the opening of a potential ACCT.

Healthcare Recommendation 2

19. A triaging process should be in place for individuals requiring referral to Primary Care Mental Health Services to ensure that those with significant needs are prioritized for early review, intervention and referral to secondary care mental health services when indicated.

Healthcare Recommendation 3

20. The opening of an ACCT and a summary of key issues and actions from ACCT reviews should be documented in the clinical record to ensure that this information is easily accessible to members of the healthcare team. In addition, the ACCT flag function should be used to ensure that all staff who access the record are aware that an ACCT is in place.

Healthcare Recommendation 4

21. The date and time of an individual's transfer to secondary care and discharge back to prison should be documented in the clinical record. This should include any required actions which are identified on discharge from secondary care.

Healthcare Recommendation 5

22. Paper documentation which is generated and subsequently scanned to the electronic Patient Record should clearly identify the location, date, time and author along with their designation.

Healthcare Recommendation 6

23. Individual staff log-in details should not be shared or used by other members of the healthcare team to make entries to the electronic Patient Record.

Healthcare Recommendation 7

24. An auditable system should be implemented to monitor completion of annual resuscitation training updates for staff within the healthcare team.

Additional considerations

25. Though outside the scope of this review, it is recommended that work is taken forward to develop discharge summary templates within secondary care to ensure that relevant information about diagnosis, condition, treatment and ongoing needs are communicated at discharge. It is also of concern that entries to the hand-written hospital records were not consistently dated or timed on each page and did not routinely identify the designation of the person making the entry, whilst a significant proportion of the records were also illegible.

The Health Board's response to the recommendations

26. In response to a draft of this report the Health Board have accepted Healthcare Recommendations 1 to 7 and have prepared an action plan for implementation by March 2020. In particular, in response to Healthcare Recommendation 2, which refers

to the triaging process for mental health needs, the Health Board have stated that HMP Swansea has been successful in securing recurrent funding for additional mental health qualified staff. The new team are expected to commence employment around the end of February 2020. One of the team's specific roles will be to undertake a liaison function between the healthcare core team, secondary mental health care services and the Prison Safer Custody team. Where appropriate and necessary they will make referrals to these established services and also work with men identified as at risk or in crisis until their mental health status improves. The new team will comprise a psychologist, four Band 6 mental health practitioners who will, as noted previously, have a crisis care role, and four Band 3 nursing assistants. A formal review of the current mental health process between the core mental health team, mental health in-reach and the new practitioners will be undertaken, with a specific focus on Triage mechanisms.

PART TWO

THE EVIDENCE CONSIDERED BY THE INVESTIGATION

CHAPTER ONE: INTRODUCTION - PREVENTING SUICIDE AND SELF-HARM IN PRISON - ASSESSMENT, CARE IN CUSTODY AND TEAMWORK (ACCT)

1.1 When CR attempted to hang himself in Swansea Prison he had been identified as at risk of self-harm and a suicide prevention plan was in place that was intended to protect him. One of the main questions for the investigation is to try to discover why the plan did not prevent CR's self-harm and what lessons can be learned.

1.2 Consequently, the investigation report frequently refers to the Prison Service strategy to prevent self-harm, which has the overall title of Assessment, Care in Custody and Teamwork, and is usually called ACCT. So that readers understand the context, this chapter gives a brief explanation of the ACCT scheme. Prison Service policy on the scheme is set out in full in a lengthy Prison Service Instruction, PSI 64/2011 which is about preventing self-harm and violence in prisons. PSI 64/2011 is a public document available on the Prison Service website.

1.3 The instruction aims to '*identify, manage and support'* prisoners who are at risk of self-harm and to *'reduce incidents of self-harm and deaths in custody'*. A key element is *'multi-disciplinary case management and sharing of information to reduce incidents of harm'*.

1.4 Serious incidents of self-harm must be investigated, and prisons must have procedures in place to learn from incidents to prevent future occurrences and improve local delivery of safer custody.

1.5 The instruction contains some mandatory actions that prisons must follow, and some explanation and guidance. Among the mandatory actions are *'Where appropriate,*

procedures must be in place to encourage family engagement in managing and reducing the risk of prisoners who harm themselves and/or others.'

1.6 Chapter 2 on Roles and Responsibilities makes clear that safer custody is everyone's responsibility. All staff in contact with prisoners must be trained in safer custody requirements.

1.7 Chapter 5 of the Prison Service Instruction explains the ACCT scheme. The introduction says:

'ACCT is a prisoner-centred flexible care-planning system which, when used effectively, can reduce risk. The ACCT process is necessarily prescriptive and it is vital that all stages are followed in the timescales prescribed.

The identification and management of prisoners at risk of suicide and/or self-harm is everyone's responsibility. Good staff/prisoner relationships are integral to reducing risk. Other factors which are fundamental to reducing risk are regular participation in regime activities, positive family and peer relationships, and referral to appropriate specialist services such as mental health in-reach.'

1.8 Any member of staff who receives information or observes behavior that may indicate a risk of self-harm must open an ACCT Plan by completing a Concern and Keep Safe form.

1.9 Within an hour of the ACCT being opened, a manager must talk to the prisoner and complete an Immediate Action Plan, register the ACCT Plan, record it on the prisoner's electronic record, inform healthcare so that it can be noted in the clinical record, make arrangements for the prisoner to meet a trained ACCT assessor and for a multi-disciplinary case review, and ensure that the prisoner has been offered an opportunity to talk to a Listener or the Samaritans.

1.10 The First Case Review will draw up a CAREMAP of actions to protect the prisoner and reduce the risk of self-harm. It should preferably be attended, among others, by a member of staff who knows the prisoner, and any other member of staff who has or will have contact with the prisoner and who can contribute to their support and care. Case reviews are to be held periodically, at intervals decided at each review, according to the level of risk. The prisoner is always asked to attend and to be involved in identifying what will help.

1.11 The ACCT Plan document includes the Concern and Keep Safe Form, a note of the Assessment Interview, the record of the Case Review, and an ongoing record of events. In the record of events, staff should record observations or conversations held at intervals set by the Case Review and any other significant events. The ACCT Plan must travel to and from any location that the prisoner moves to when taking part in activities so that all staff with whom he has contact are aware of the risk and able to contribute to the record of events.

1.12 Staff must follow the frequency of observations and conversations stated on the front cover of the Plan and must record these immediately or as soon as practicable.

1.13 Staff must actively engage with the prisoner, encouraging him/her to talk and to take part in activities.

1.14 Prison Governors are responsible for putting in place quality assurance checks for ACCT Plans.

1.15 The investigation has examined how the ACCT scheme operated in the case of CR and we say more about the scheme at various points in this report.

1.16 At the time of our investigation Swansea was one of the prisons testing a new ACCT document as part of a pilot scheme.

CHAPTER TWO: ABOUT CR

What CR's family told the investigation about CR

2.1 CR was 32 in November 2015. CR's sister, Ms R, described him as highly strung but warm, generous, funny and sociable. He was part of a strong and close family and his condition after the self-harm, and the way it came about, continued to be acutely hurtful for them. Family members visited CR at his nursing home several times a week but they did not know whether he was aware of them. CR was always especially close to his mother, and also to Ms R and her twin sister, who were close to CR in age. CR always spent a lot of time with his mother and his sister. Ms R would usually see him at his mother's home every day.

2.2 CR had been with his partner for about two years, before his partner died, early in 2015. CR was gay. His sister says this was not a problem for him. Alcohol was a problem, but CR had not started drinking excessively until his late 20s. He could be up and down, sometimes he was depressed; he could change very quickly and be impulsive.

2.3 Ms R and the family had tried to get help for CR. They got an appointment at a psychiatric hospital but CR was a few minutes late and the hospital staff were unwilling to see him. Ms R said CR begged them to see him, but they refused and then he smashed the place up. The police were called. CR was arrested and he had to pay £2 - 3,000 for the damage.

2.4 Ms R was aware of an occasion when CR had threatened to jump from an eighth floor. She did not know anything about him trying to set a fire a few weeks before he was arrested and knew little about the circumstances of his arrest. CR's sister and brother both believed that these incidents were cries for help and that if CR had been able to communicate he would have said that he never meant it to go this far.

CHAPTER THREE: CR'S ARREST, HIS TIME IN POLICE CUSTODY AND HIS REMAND TO BY THE MAGISTRATES' COURT TO HMP SWANSEA

The circumstances of CR's arrest - Friday 20 November 2015

3.1 Early on Friday morning 20 November, CR attempted to set fire to himself at his home in a block of 11 flats. The Fire Brigade and the police attended. CR was pulled from the fire and the police took him to hospital, suffering the effects of smoke inhalation. He was arrested at the hospital at 4.25am and charged with arson, with intent to damage or destroy property or being reckless as to whether property would be destroyed or damaged, and intending to endanger life or reckless as to whether life was endangered. The police custody record says he told a police officer that his partner had recently died, that he had liver failure, that he wanted to end his life, and that he had covered himself in toilet roll and set fire to the side of the bed using deodorant and a lighter.

3.2 CR was assessed at Morriston Hospital, Department of Psychological Medicine. He was considered to be at high risk of suicide and sent back to police custody for a full assessment. He arrived at the police station on Friday afternoon at 1.30pm, and a healthcare professional was requested. The custody record says CR told the police he drank six litres of cider per day that he had liver disease and was supposed to take medication for alcoholism but had not had his medication that morning. He said he had tried to kill himself that day and had tried in the same way the previous week but he told police he was all right while he was in the police station.

3.3 In representations justifying continued detention of CR, the police record says the fire service had attended the same flat a couple of weeks previously when CR appeared to have fallen asleep with a cigarette, causing a fire. He was also said to have been convicted in 1996 of arson endangering life. This document would not have been passed to the prison.

3.4 A mental health nurse attended. The nurse recorded mild signs of alcohol withdrawal, including shaking. CR gave no history of alcohol withdrawal fits but said he was never without alcohol and refused medication for withdrawal. The nurse's note says she explained the risks and encouraged CR to take sweet fluids and regular meals.

3.5 The nurse's record says she telephoned the hospital mental health nurse who had assessed CR as a high risk of suicide. The hospital nurse told her CR had made a similar attempt to end his life the previous week and that both events seemed to be due to the recent death of his partner. CR had told the hospital nurse he did not know if he would try again.

3.6 The nurse at the police station found CR tearful. He said he had attempted to end his life, but it had been an impulsive act when he was drunk and he was now remorseful because of the impact on his family, especially his young niece with whom he had a good relationship. He said his family were supportive. He had not wanted to burden them, but would now seek their support. His mother and two sisters were very supportive and his uncle had said he could live with him as long as necessary and that he would help him to repair the flat. CR was said to recognize that alcohol was his main problem and that he would like to engage with agencies.

3.7 In summary, the nurse noted that she felt the issue was CR's current life circumstances, namely the loss of his partner, exacerbated by alcohol use, as opposed to a serious mental illness. But he was now remorseful and spoke positively about the future, saying the incident was a wake-up call. He just wanted to go home to his uncle. The nurse reduced the risk level from high to standard. At the police station, CR was checked every 30 minutes.

3.8 The custody record says that CR asked for an uncle and solicitors to be informed of his arrest. A solicitor held a private consultation with him at 5.30pm.

What CR's family knew about his arrest and time in custody

3.9 The investigation has been unable to locate CR's uncle to establish whether CR spoke with him at all while he was in custody. CR's sister says that the family were unaware at the weekend that he had been arrested, or about the fire. After they had not seen CR on Saturday night his mother went to the police station. The police would not say where he was or why he had been arrested but only that he was OK. No-one had telephoned the family. Ms R said that CR may not have known family members' phone numbers without his mobile phone.

Travel to court, remand in custody, escort to HMP Swansea - Saturday 21 November 2015

3.10 At 08.25am on Saturday 21 November, CR was taken from the police station to the Magistrates' Court.

3.11 The Person Escort Record (PER) is a document that travels with a prisoner, from the police station, to the escort staff, to the custody suite at the court, and to the prison. It contains essential information that each agency needs to know about a person in their custody. It includes a section to indicate risks of which the agencies need to be aware. The risk indicator completed by the police said that CR was charged with arson. It identified a risk of suicide/self-harm, in that he set himself on fire and there were other incidents in November 2015 and September 2012. No details are given of these other incidents. He was also said to have indicators from 2007/8 for violence/risk to others, and health risks identified were that he suffered from depression and was an alcoholic who suffered from fits and liver disease.

3.12 The police gave CR into the custody of the escort and custody service who would take him to court and supervise him in the court cells until his appearance in court. When CR arrived at the court, an Acting Senior Custody Officer completed a Suicide and Self-Harm Warning Form. It states CR attempted suicide by setting himself on fire on 20

November 2015 and that on 18 April 2012 he had attempted to throw himself from an eighth floor flat. He was to be observed at 10-minute intervals.

3.13 In court, CR was remanded in custody until 30 November to await trial in the Crown Court for arson. The warrant from the Magistrates' Court stated that the reason for refusing bail was that CR '*wishes to take his own life and committed his offence regardless of the safety of others*.' The signatory to the warrant has added a handwritten note that CR '*seems vulnerable*' with '*suicidal tendencies*'.

Findings

3.14 CR attempted to set fire to himself and was rescued by the Fire Service. He told the police, a nurse and a custody officer at the court he had intended to kill himself and that he had tried to do the same thing a week or so previously. He was distressed by the death of his partner and by his physical condition. He also spoke of having tried to throw himself from an eighth floor flat three years earlier. Describing his feelings after the fire-setting, CR explained what he had done as an impulsive act when he was drunk that he now regretted because of the impact on his family. He said he was all right while he was in the police station and is said to have called the episode a wake-up call and spoken positively about the future.

3.15 The prison would not have seen the police custody record, or the grounds for continued detention, or the assessment of CR's risk made by the hospital nurse whom he told he had also set another fire the previous week.

3.16 The documents that accompanied CR to prison included the Person Escort Record, the Suicide and Self-Harm Warning Form and the warrant. These all recorded a risk of suicide on the basis of CR's deliberate attempt to take his own life by setting himself on fire.

3.17 The Person Escort Record noted that there were also previous incidents which they did not specify, and CR's depression and poor physical health. The Suicide and Self-Harm Warning Form completed by the escort service referred to the fire-setting and a previous suicide attempt in 2012. The warrant said that CR was charged with arson with intent or reckless as to whether life was endangered. The Magistrates' Court recorded that CR wished to take his own life. A note on the warrant said CR appeared vulnerable, with suicidal tendencies.

CHAPTER FOUR: 21 - 23 NOVEMBER 2015 - CR'S INDUCTION AT HMP SWANSEA

Admission procedures

4.1 CR was registered at Swansea Prison on Saturday afternoon, 21 November, at 12.10pm. New prisoners are interviewed in Reception by a Prison Officer (the Reception Officer) and by a healthcare professional. The Reception Officer receives the documents accompanying the prisoner, which in this case would have included the Person Escort Record (PER), the warrant authorising his detention, and the Suicide and Self-Harm Warning Form completed by the escort service. The Reception Officer obtains information from the prisoner and the paperwork and completes various forms. The Reception Officer signed the PER and the Suicide and Self-Harm Warning Form at 12.10pm and 12.15pm respectively, to acknowledge receipt.

4.2 The record of CR's personal details completed in Reception includes the name and address and a mobile phone number for his mother as next of kin. It notes a previous six-month prison sentence for assault served in Swansea but gives no date. We do not know whether this was completed by the Reception Officer who dealt with the other paperwork or by someone else.

4.3 At the bottom of the form for personal details there is a note on 'Disclosure of Information' for the prisoner and the officer to sign. The note requires the prisoner to confirm that the information in the form is correct and to indicate '*where any consent is necessary, I do/do not… in an emergency, on transfer to another establishment, or … on other occasions as necessary*' authorise the prison to contact his next of kin or other emergency contact. Neither *'do' or 'do not'* has been marked, so CR's wishes are not recorded. CR's initials are written in the space for the prisoner's signature. The officer has not signed the form as required and the entry for the officer's name is indistinct.

Initial health screening

4.4 A mental health nurse, Nurse 1, conducted an initial assessment of CR's physical and mental condition. When we met Nurse 1 in February 2019, she was unable to recall whether she or the Reception Officer spoke with CR first. That would have depended on which of them was free. Nurse 1 said that if the Reception Officer saw a prisoner first, the officer would copy the escort record and give it to the nurse. However, if she saw CR before he saw the Reception Officer, she might not have had access to the records that came with him.

4.5 It seems likely that Nurse 1 saw CR after he saw the Reception Officer. Her note of the meeting in the clinical record is timed at 2.23pm and, whether or not Nurse 1 had access to the paperwork, it is clear from her note that in addition to an extensive enquiry into CR's alcohol dependency and general physical condition, she spoke with CR about the circumstances of his arrest and his present mood.

4.6 Nurse 1's note says CR told her that when he started a fire he was under the influence of alcohol and intended to kill himself but said he had no current thoughts of self-harm or suicide and was now no risk to himself. He said he was upset by the recent death of his partner. He said he had no psychiatric nurse or care worker in the community but had had treatment from a psychiatrist in Cefn Coed Hospital two weeks previously and was taken to Swansea Central police station. Nurse 1 noted that CR suffered from liver disease as a result of excessive alcohol misuse. Medication (diazepam) was prescribed, and administered at 4.05pm. CR would be monitored while he was detoxing from alcohol and would be referred to the primary mental health team.

4.7 As part of the admission procedures, both the Reception Officer and the healthcare professional are required to contribute to a 'Cell-Sharing Risk Assessment' and a 'First Night Suicide/Self-Harm Screening Tool'

Cell-Sharing Risk Assessment

4.8 CR was assessed in Reception as suitable to share a cell. The cell-sharing risk assessment standard form is designed to identify prisoners who pose a high risk of severe violence to a cellmate or are at high risk of severe violence from a cellmate. It contains no prompt for identifying risk of suicide/self-harm, which on its own is not considered to indicate a heightened risk of harm to or from others.

4.9 Part one of the Cell-Sharing Risk Assessment is the Operational Assessment to be completed by the Reception Officer. In CR's case, the offence with which he was charged is said to be arson. In a checklist on the form it is correctly noted that there was knowledge of arson to a house/flat but this entry has been altered. It is not clear when. Initially the 'No' box was ticked. Comments in Part One in the box for free text comments says only that CR is a new prisoner who spent six months in prison many years ago. In the box for indicating whether a prisoner is on remand, the entry says 'Trl', presumably meaning, correctly, that CR was awaiting trial.

4.10 The role of the healthcare professional as indicated on the form is to say, on the basis of observations and – if available – clinical records, the Person Escort Record, and Forensic Medical Examiner report, whether there are any healthcare factors that indicate that a prisoner may be at risk of severely harming another in a locked cell. The healthcare assessment by Nurse 1 in Part Two of the form ticks the box that there is no indication that CR poses such a risk.

4.11 The Reception Officer and the nurse both recorded CR as standard risk for cell-sharing. The form says that an officer can authorise standard risk, but if any evidence of increased risk is found, a manager must decide on the risk rating.

4.12 Prison Service Instruction PSI 20/2015 effective from May 2015 sets out HMPPS policy and guidance on the cell-sharing risk assessment. Paragraph 1.4 lists known indicators of heightened risk, which include arson or fire setting, either in the community or in

custody. Paragraph 3.6 says that the Instruction does not rule out cell-sharing by prisoners who pose a risk but guides risk management. Where any of the factors indicating increased risk are found, the assessment must be referred to a manager for decision. That was not done in this case.

Early Days in Custody - Reception, First Night and Induction - PSI 07/2015

4.13 Prison Service Instruction PSI 07/2015, effective from February 2015, states that all prisoners must be interviewed in Reception to assess the risk of self-harm, and that all incoming prisoners must be medically examined by a qualified member of the Healthcare team, who has been trained in ACCT procedures, to determine whether they have any short or long term physical or mental health needs. If a prisoner is identified as being at risk of suicide or self-harm an ACCT must be opened.

4.14 Annex B to the instruction says that a Suicide and Self-Harm Warning Form received with a prisoner must be forwarded from Reception to all staff in contact with the prisoner, particularly Reception, Healthcare, and First Night Unit staff. The warrant should be forwarded to Reception, Safer Custody, First Night, and Security.

4.15 Annex D, on Healthcare Screening, Suicide Prevention, Self-harm Management and Disabled Prisoners, identifies categories of prisoners who are known to be at enhanced risk of self-harm. It includes those with a history of self-harm or attempted suicide and those with mental health problems or drug/alcohol dependency.

First Night Suicide and Self-Harm Screening Form

4.16 For every prisoner, the Reception Officer and the Reception Nurse also complete a First Night Suicide and Self-Harm Screening form, which contains a checklist of factors to consider when assessing risk of self-harm.

4.17 The nurse noted that CR was undergoing detoxification and there were mental health issues to consider. In the section for recommendations she stated, '*medication administered - discussed at length – no thoughts of DSH/suicide.'* (DSH means deliberate self-harm.)

4.18 The Reception Officer noted among other things that there was a current or historic suicide/self-harm warning notice, that CR had no current thoughts of self-harm or suicide and that he was being allocated to a shared cell. The officer's entries on the form also state (incorrectly) that CR was not on remand. This is significant as the statutory Prison Rules say that in no circumstances can a prisoner who has not been convicted be required without their explicit consent to share a cell with a convicted prisoner *(Prison Rule 7(2) (b)* (1.4)).

4.19 The form was signed off by the Reception Officer. There is no requirement to refer to a Governor for authorisation unless a Cell-Sharing Risk Assessment, including reference to the police record, has not been completed, or the prisoner is not being allocated to a shared cell.

The case notes in CR's electronic 'Core Record'

4.20 For each prisoner there is an electronic 'Core Record' which is accessible to staff on the wings. Part of the record is a Case Note History which is a record of significant events. The entry for CR's admission to the prison says only that he was admitted to HMP Swansea at 12.10pm on 21 November as an unconvicted remand prisoner from Swansea Magistrates' Court. It gives no further information about his alleged offence or any risk of self-harm.

Induction on the wing

4.21 CR was allocated to a shared cell on B wing, which was the induction wing where new prisoners were usually located. Wing Officer A recorded completion of 'first night induction' at 4.55pm. This was a one-to-one meeting in an office to inform a new prisoner about the prison rules and regime, to make them aware of support services and to identify any concerns and immediate needs.

4.22 Wing Officer A entered her note of the meeting on the 'Compact Declaration Form' and also on the Case Note History in the electronic core record. She noted that CR had previous experience in custody; he stated he had no thoughts of deliberate self-harm or suicide; he was happy to move wings when required and stated he had no issues with other prisoners. The note says all avenues of support were explained and offered and that CR stated he had no concerns. A hospital appointment for his liver condition would need to be re-arranged. He appeared jaundiced. He was issued with tobacco but no PIN code for the telephone system as none were available.

4.23 CR's sister told us that the family did not know that CR was in prison. Prison Service Instruction PSI 07/2015 on Early Days in Custody says that newly arrived prisoners must be given access to a telephone in Reception, or their first night location, to contact their legal adviser, to address urgent domestic issues or to advise a family member where they are being held.

4.24 The PIN code is normally required for prisoners to make telephone calls. They must also give the prison authorities a list of the telephone numbers that they want to phone and the identity of the people they will call. We asked Wing Officer A what was meant by saying no PINs were available and whether this meant that CR was unable to make any telephone calls, if so, for how long, and whether he was able to inform his family of his whereabouts. Officer A told us CR would have been provided with a PIN not later than Monday, having been admitted to the prison on Saturday, but, regardless of whether PINs were immediately available, new prisoners would always

be offered a phone call to their nominated person and if there was no answer he would have been offered another.

4.25 We asked Officer A what documents accompanied prisoners to the wing. She told us that the Cell-Sharing Risk Assessment is passed to the wing and the prisoner's Compact Form travels with them and would show any concerns. At the time, the PER and Suicide and Self-Harm Warning Forms completed by the Escort Service were not passed on to the wings. A POA representative told us that recently there has been a change so that copies of Suicide and Self-Harm Warning Forms are now passed on to the wings. We understand there is currently no written protocol at Swansea prison requiring this and we have not been able to establish whether in practice Suicide and Self-Harm Warning Forms that arrive with the prisoner, or only the less informative local Suicide and Self-Harm Screening Tool, are passed on to the wings.

4.26 Be that as it may, Prison Service Instruction PSI 07/2015 on Early Days in Custody says unequivocally in Annex B that a Suicide and Self-Harm Warning Form received with a prisoner must be forwarded from Reception to all staff in contact with the prisoner, particularly Reception, Healthcare, First Night Unit staff. The warrant should be forwarded to Reception, Safer Custody, First Night, and Security.

4.27 Officer A said that when CR first came in he seemed happy and cheery but that she could not recall any detail of their conversation during induction except that CR was concerned about his liver. We asked Officer A whether she was aware of the offence with which CR was charged. Officer A told us that she knew it was arson but did not know whether she knew this at the time and she did not know the circumstances. In assessing whether someone was at risk of self-harm, Officer A said she would look at their demeanour, about how they talked, their mannerisms, and what they said, to build up a picture. She would ask questions to see how they were feeling, such as whether they felt vulnerable in the prison environment, whether they had ever self-harmed in the past. If she felt in any doubt she would open an ACCT document.

Sunday 22 November 2015 - further induction procedures

4.28 On CR's second day in prison, Nurse 1 took a further detailed history, investigating CR's physical and mental health. She noted that he was due to attend Morriston General Hospital on 25 November for gastroscopy. She used structured questionnaires to assess alcohol dependency and depression. To the questions about depression, CR responded that on most days he felt little pleasure in doing things, felt down, depressed or hopeless, experienced sleep problems, lacked energy, ate too little or too much, had trouble concentrating, and felt bad about himself and that he had let his family down. He said anti-depressants worked well for him. To the questions about thoughts of self-harm or that he might be better off dead, the nurse recorded 'N/A'. CR was said to be low in mood but said he had no current thoughts of deliberate self-harm or suicide and that he had set the fire impulsively when drunk.

4.29 When we interviewed Nurse 1, it was more than three years after the event, and she could not say exactly how she made the judgment that CR was not at risk of self-harm. She remembered in the first assessment being particularly concerned about his liver failure and excessive drinking and that she went through the alcohol withdrawal scale to get some history about how much he was drinking and what they could put in place to help him overnight. Nurse 1 told us her usual practice was to look at historical facts if they were to hand, and to consider how the person presented, and to ask if they had any thoughts of self-harm. Some of it was gut instinct. Nurse 1 said there were assessment scales for risk of self-harm but it seemed she had not used them in the Day 2 assessment. She was aware of the fire but said CR had no burn injury. A referral to 'Lighthouse', the Primary Mental Health Clinic, was noted. At interview, Nurse 1 could not remember if an appointment had been booked but there is no record of CR having been subsequently seen by the Primary Mental Health Clinic.

4.30 Nurse 1 told us that she had been trained in ACCT procedures when she first came to work at Swansea in August 2012. It was a generic course not specific to healthcare staff, about opening the ACCT, filling it out and who needed to be informed.

4.31 CR also saw the prison's GP, who prescribed Fluoxetine (anti-depressants) and medication for alcohol dependency. The GP is now deceased.

4.32 After the Day 2 screening, prisoners usually meet a Chaplain, a member of the Dyfodol (formerly CARATs – drug treatment) team, and an officer from the Offender Management Unit who completes a Basic Custody Screen.

4.33 CR's Case Note History says that a Chaplain visited him at 14.07pm on 22 November, that he advised CR of the support the Chaplaincy could provide, and that there were '*no issues'*.

Monday 23 November 2015

4.34 CR remained on B wing. Nursing staff monitored CR's condition. At 12.39pm he was said to be uncomplaining of any symptoms or side effects of detox and would be reviewed again the next day.

4.35 Entries in the Case Note History made on 23 November say that alerts for drugs, violence and suicide were noted, apparently as a result of information from police records. No details are given.

Basic custody screening

4.36 An entry in the Case Note History timed at 14.12pm by Mr C, an Offender Supervisor from the Offender Management Unit, says that he completed Basic Custody Screening. It says CR engaged in the process, said he had no current thought of deliberate self- harm or suicide, and that he was made aware of, and appeared to understand, the support networks available in the prison.

4.37 The Basic Screening interview follows a standard pattern. The interviewer completes a template requiring information about any criminal justice history, education, training

and employment, financial and domestic circumstances, health and well-being, and any risks. In particular, it asks the staff member completing the form whether, from what they know about the prisoner, there have been, or are currently, any concerns about risk of suicide or self-harm.

4.38 The Basic Custody Screen for CR had not been retained among the documents that were collated after his life-threatening self-harm. We had hoped to be able to obtain it from an archive but have been told that this has not been possible. We spoke to Mr C who conducted the basic custody screening interview with CR but this was more than three years after the event and Mr C was not able to call to mind any memory of the interview.

4.39 Attempting to re-construct what he would have done, Mr C said he would always check the electronic information system for any alerts. He would routinely look at the PER, any Suicide and Self-Harm Warning Form and the warrant. He would have to look at the warrant in order to enter the offence with which CR was charged. He commented that a Governor would have had to check the Cell-Sharing Risk Assessment as CR was charged with arson. Mr C said that if there were any alerts about suicide or self-harm, he would certainly raise this with the prisoner to see if they had any current thoughts of self-harm. An interview would generally last between 10 and 20 minutes. Afterwards a prisoner would have an opportunity to see the St Giles Trust, who were able to advise and assist with, for example, housing and or education issues. The case record confirms that CR saw the St Giles Trust that afternoon.

The drug support service - CARATs/Dyfodol

4.40 As part of the induction process, all new prisoners also see the Drug Support Team. At the time this was called CARATs, meaning Counselling, Assessment, Referral, Advice and Throughcare, but in Wales it is now called Dyfodol, meaning Future.

CARATs/Dyfodol are not on duty over the weekend so a prisoner admitted on a Saturday would see someone from the team on Monday.

4.41 CR was seen briefly by a member of the CARATs team on Monday as part of his induction. The referral form notes alerts for drugs, violence and suicide, as recorded on his Case Note History as a result of information from the police. The records say he wanted to engage with the service and was referred to a caseworker.

The investigation's observations

4.42 Documents from the police, the court and the escort service all indicated that CR was considered to be at risk of suicide. The documents contained information about the circumstances of CR's arrest and some previous history of suicide attempts. Yet the staff with access to that information in the prison did not identify CR as being at risk of self-harm. If the staff had thought there was a risk, they would have opened an ACCT Plan, which would have led to special support, and monitoring of CR's risk of suicide. It must be very difficult for CR's family to understand why they did not do so. Neither do we have an entirely satisfactory answer. (Chapter 1 of this report gives an outline of the ACCT scheme.)

4.43 We have not been able to interview the Reception Officer, who has left the Prison Service and apparently lives overseas. The basic custody screen is no longer available for us or for the officer who completed it to refer to. We were able to examine the clinical record. Nurse 1 answered our questions conscientiously and openly and we were impressed with the care she showed in her concern for CR's physical condition, but our interview with her was more than three years after the event so we could not expect her to have a detailed memory of her meetings with CR on his first and second days in prison. From the clinical record, it is clear that she spoke with CR about the fire-setting and that he said he had intended to kill himself but dismissed as an impulsive act when he was drunk. Nurse 1 recalled that she had attended training on ACCT when she started at Swansea Prison in 2012. Her description of the training

course seemed to emphasise the mechanics of the ACCT Plan rather than identifying risk and when it was appropriate to open a plan.

4.44 From the accounts of what CR said about his feelings, as recorded in the police records and Nurse 1's clinical record, he was inclined to dismiss his suicide attempts and to reassure those who spoke to him that he was now all right and looking forward positively. He said his family were important to him, they were supportive and he was sensitive to the impact that his self-harm would have on them. Assessing risk of suicide is not an exact science and staff will not always get it right. Staff whom we interviewed spoke thoughtfully about how they tried to engage with prisoners and to assess their feelings, not just from what they said but how they engaged in conversation and their general demeanour. We are conscious of the luxury of hindsight but we have some concerns about the processes for risk assessment and information sharing when CR was admitted to Swansea.

4.45 After the reception procedures CR was placed on B wing, the induction wing for new prisoners. It is evident from our investigation that the staff on B wing were not aware of the circumstances of CR's arrest or the warnings in the paperwork that accompanied him. At the time, neither the PER, the warrant or the escort service's suicide warning was sent to the wing. This was in breach of Prison Service Instruction PSI 07/2015 on Early Days in Custody. We have been told anecdotally by the POA that Suicide and Self-Harm Warning Forms are now copied to the wing but we do not know whether that is a firm policy that happens in every case.

4.46 The electronic Case Note History was accessible to staff on the wing but in CR's case no entry was made about the warnings that accompanied him to the prison. Security alerts for suicide and other risks were entered on the record, subsequently, on Monday 23 November, as a result of records routinely received from the police but with no detail.

4.47 From the evidence we have seen, we find that the various warnings from other agencies were not made known to the wing so that, for example, when Officer A interviewed CR and drew up his compact in the afternoon of his admission she was unaware that his alleged offence of arson was a self-confessed suicide attempt. Nor was she aware of the warnings that accompanied him to the prison. Likewise, other staff who were concerned with CR later made their judgments about his risk of suicide in ignorance of this history. That cannot be right.

4.48 There is some evidence that reception procedures by the discipline staff were sloppy. The personal details form in the Core Record was not completed properly. The officer completing it failed to sign it and the officer's name is indistinct. CR was apparently not asked to say whether his next of kin should be contacted in an emergency. There was a significant breach of Prison Service policy in that the Reception Officer did not refer the cell-sharing risk assessment for consideration by a manager. Prison Service Instruction PSI 20/2015 states that this is a requirement where a prisoner is charged with arson. Risk of self-harm is not necessarily an impediment to cell-sharing but it is possible that consideration by a manager might have led to another view as to CR's suicide risk.

Findings

4.49 The staff who saw CR in Reception knew he had tried to kill himself two days earlier and that the police, the escort service and the court considered him to be at risk. We do not know what factors influenced the Reception Officer but the nurse was reassured by CR's manner and his explanation that the fire and a similar attempt two weeks previously were impulsive acts committed when he was drunk. Neither member of staff opened an ACCT.

4.50 CR had a history of attempted suicide, and he was known to have mental health problems and alcohol dependency. These are all factors indicating an enhanced risk of self-harm. Coupled with the warnings from other agencies, there should, in our view,

have been a presumption in favour of opening a precautionary ACCT. We are not persuaded that CR's assurances and demeanour were sufficient reason to overturn that presumption.

4.51 Suicide prevention is everyone's responsibility in prison. It is important that healthcare staff are appropriately trained in the ACCT ethos and procedures and that they do not leave it to the discipline staff to take the initiative.

4.52 The wing staff who completed CR's induction and were responsible for his first days in prison were not aware of the warnings that accompanied CR to prison and they did not know he had tried to kill himself. Contrary to Prison Service Instruction PSI 07/2015 the suicide and self-harming warning and the warrant were not passed to the wing.

4.53 The electronic Case Note History was accessible to staff on the wing but there was no entry about the warnings that accompanied CR to prison.

4.54 The personal details form in the Core Record was not completed properly. The officer did not sign the form and it was not clear whether CR gave consent for his next of kin to be contacted in an emergency.

4.55 The Reception Officer knew that CR was charged with arson but contrary to Prison Service Instruction PSI 20/2015 he did not refer the Cell-Sharing Risk Assessment for consideration by a manager. Risk of self-harm is not necessarily an impediment to cell-sharing but it is possible that consideration by a manager might have led to another view as to CR's suicide risk.

CHAPTER FIVE: TUESDAY 24 NOVEMBER TO TUESDAY 1 DECEMBER - CR BECOMES ILL AND SPENDS FIVE DAYS IN HOSPITAL

5.1 This chapter contains a summary of events, principally from CR's prison records. The clinical review has considered CR's clinical condition in more detail, with reference to the prison's clinical record and the hospital records. The findings of the clinical review are in Part Three of this report. Further clinical detail is appended as a confidential annex for the Interested Parties.

Tuesday 24 November 2015

5.2 On Tuesday evening 24 November at 7.36pm, an officer on CR's wing was concerned about his condition and requested a nurse. The medical record says CR was up and walking around in his cell. His speech was slurred and he was responding with only short answers. He declined to let a nurse take observations but agreed to drink water and lie down for a rest.

Wednesday 25 November 2015

5.3 In the morning, a nurse was called again, as CR's speech was slurred and incoherent. He said he had not taken any drugs. Wing officers were asked to observe CR and call healthcare if they were concerned. The CARATs caseworker tried to see CR but he was unwell and staff were waiting for healthcare to see him so the CARATs assessment was postponed.

5.4 CR was seen again by nurses twice in the afternoon. He was sleepy, unsteady and incoherent and seemed in an intoxicated state. His cellmate said he was falling over. Detox medication was withheld.

5.5 In the evening, CR's condition was worse, his speech was slurred, and he appeared disorientated and jaundiced. Healthcare consulted 'SOS' (a telephone Health line)

who advised calling for a non-emergency ambulance. When this had not arrived after four hours, the call was upgraded to an emergency. An 'Insider' (a trustworthy prisoner recruited to provide support and advice to others) who knew CR well outside prison said CR told him he had definitely not taken any illicit drugs since coming into prison.

5.6 A risk assessment was prepared for transfer to hospital. In response to the question 'Any known or identified risks from visits?' the staff member completing it has written: *'No visits, no mobile, no access to phone…'.*

Thursday 26 November and Friday 27 November 2015

5.7 The ambulance arrived after midnight, at 0.50am on Thursday morning, and took CR to hospital. CR was seen by a doctor in A&E at 9.15am. Because CR remained in the custody of the prison, two prison officers stayed with him at all times in the hospital. This is called a 'bedwatch'. The 'bedwatch log' maintained by the officers says that CR remained in a confused and agitated state; at times he was aggressive, and he sometimes refused medication.

5.8 The overnight bedwatch log for Thursday night and Friday morning says CR remained unstable and confused, seemingly hallucinating and with no perception of his current situation or reality. He pulled a cannula out of his hand. He had no concept of time and, after sleeping for a while, he woke at 3.30am on Friday and became '*verbally disruptive'*, demanding to phone his mother and sister and to have them visit immediately. The officers noted that he wished to discharge himself, but nursing staff advised he needed to be assessed by a doctor.

5.9 The daytime bedwatch log for Friday says that the doctor told CR he would have to stay in hospital for a few days to allow the medication to work and that CR was still confused and detoxing from alcohol. Also, that CR told the officers that his husband

had died about six weeks ago, and that he used to be in Cefn Coed (Psychiatric Hospital).

5.10 A nurse at the prison obtained information from the hospital about CR's condition. An entry in his prison medical record at 10.47am on Friday 27 November says CR was being treated for an infection of unknown source and receiving antibiotics intravenously. He would be reviewed by a consultant next day.

5.11 In the course of Friday, CR's demeanour was unstable. At times he was said to be confused, and sometimes frustrated and aggressive. He was physically restrained several times. At other times he was calm. Sometimes he said he wanted to discharge himself so he could smoke. At 3pm, a doctor advised that he needed to take his medication or would quickly become more ill because of his liver problems. Hospital notes recorded that he refused observations and medication.

Saturday 28 November 2015

5.12 The overnight bedwatch log for Friday/Saturday says CR refused to have his blood pressure checked, then slept intermittently through the night. On Saturday morning, he was still confused but cooperated with treatment, ate breakfast and was talkative. He asked to telephone his sister, and an escort officer phoned the prison for advice. Permission was given to telephone the sister to tell her CR was in hospital. CR's mother rang the hospital to ask if she could visit. She was advised to contact the prison. The escort officers were informed that CR was allowed visits. CR became tearful when given this news. Overall, CR was said to be well-behaved, polite and respectful. He was fully compliant, took medication and had a shower. By Saturday afternoon he seemed less confused.

5.13 CR's sister (Ms R) and stepbrother told the investigation that, to the best of their knowledge, no-one from the family knew what had happened, or that their brother was in prison, until sometime in the middle of the week when his mother happened to

meet someone in town who told her that another prisoner had mentioned seeing him in Swansea Prison. CR's sister says that the family did not know that CR was in hospital until the phone call on Saturday. They asked why the prison had not told them on Thursday that CR had been taken to hospital.

5.14 On Saturday evening CR's mother and one of his sisters visited for 35 minutes. The bedwatch log says that CR seemed relaxed for a while but later he became distressed and anxious and had to be coaxed to accept treatment. The summary report by Officer A says CR:

'presents well physically but mentally is in a very confused state. He is lucid at times but mainly his thought process is extremely random. He doesn't know where he is.

He is polite, respectful and compliant most of the time, however he gets confused between his medication and treatments (he is against drugs).'

5.15 Officer A told the investigation it was evident that CR was extremely well loved by his family. Officer A was the officer who had been responsible for CR's induction on B wing. Officer A was unaware of CR having any history of self-harm. She said that his family didn't say anything about self-harm. They '*thought the world of him'* and Officer A thought that it '*wouldn't have entered their thought process*'.

Sunday 29 November 2015

5.16 CR's sister, Ms R, visited him in hospital on Sunday with other family members. Ms R told the investigation that CR seemed all right, though unusually calm, probably because of medication. An officer went out to have a cigarette and CR asked if he could do the same. Ms R said that CR smoked but was not a heavy smoker; it didn't control him. He was expecting to stay in hospital until Monday or Tuesday.

5.17 An entry in the bedwatch log at 6pm on Sunday says that CR was becoming irrational and demanding to return to prison because he was not allowed to smoke. He was seen by a doctor, who was unwilling to discharge him because of his mental state. The hospital's clinical notes say that CR refused a nicotine patch and inhaler and continued to refuse observations and medications,

5.18 Later that evening, CR's mother and an aunt visited for half an hour. By then he was said to have calmed down and to be more compliant with orders and in his general behaviour. However sometime later he refused medication saying it would not benefit him, and again became agitated when told he was not allowed to smoke.

Monday 30 November

5.19 The overnight bedwatch log says that at 1am on Monday CR became aggressive and was restrained and handcuffed. He slept for a while and was calmer when he woke up. At 5.30am he said he would take his medication and do as the doctor asked.

5.20 The daytime log for Monday 30 November says that at 6.45am CR had a shower and clean clothes. He said he felt better and was keen to get treatment under way. He was expected to stay in hospital for another two days; he was able to walk and get about a little and was waiting for test results. The overnight log reports a quiet night with no concerns. CR was in a stable condition, receiving treatment and medication.

5.21 Hospital records show that at 9am on Monday 30 November CR was reviewed by a gastroenterology consultant who noted alcoholic hepatitis with a background of cirrhosis and a plan for gastroscopy.

Tuesday 1 December 2015 - CR returns to the prison

5.22 According to the bedwatch log, there were no concerns early on Tuesday morning. At 9.30am CR was seen by a doctor and it was decided he would return to the prison.

The hospital clinical notes say CR was keen to go back to prison. He was taken by taxi and arrived at 11am. He returned to B wing to a new cell. In the afternoon he was issued with tobacco as his own was wet from when he was ill.

5.23 Discharge communication from the hospital noted only changes in CR's medication. Our Clinical Reviewer was unable to identify any further discharge communication from the hospital relating to CR's condition, treatment provided or any follow-up required, and there was no documentation of any verbal handover of such information between the services. (See Part Three of this report, the Clinical Review, especially paragraphs 10.7, 10.11, 10.24)

5.24 Entries in the SystmOne medical record and in P-Nomis case notes, apparently made on Tuesday evening 1 December, say that CR discharged himself from hospital against medical advice. We have established that this was not the case. A note by a consultant at the hospital at 8.50am on Wednesday morning 2 December says CR was discharged by the AMAU (Acute Medical Assessment Unit).

Findings

5.25 CR was dependent on alcohol, and healthcare supervised a detox regime. He was known to have liver damage. On his fifth day in prison CR became ill and was admitted to hospital. At first he was agitated and irrational for much of the time and unwilling to cooperate with treatment. This appears to have been in large part due to his illness.

5.26 Arrangements were made to notify CR's next of kin of his illness on his third day in hospital, at his request. He was by then more rational and the family visits went well. One of the bedwatch officers who knew CR from the wing observed that he belonged to a close and loving family.

5.27 CR was discharged by the hospital three days later. He had been keen to leave the hospital but, contrary to some entries in the prison records he did not discharge himself against medical advice.

CHAPTER SIX: TUESDAY 1 DECEMBER TO WEDNESDAY 2 DECEMBER: CR CUTS HIMSELF; AN ACCT PLAN IS OPENED; LATER HE BECOMES UNWELL AND GOES BACK TO HOSPITAL

6.1 This chapter contains a summary of events, principally from CR's prison records. The clinical review in Part Three of this report considers CR's clinical condition in more detail, and with reference to the prison's clinical record and the hospital records.

Tuesday evening 1 December

6.2 CR returned from hospital on Tuesday morning 1 December. The same evening, at 7.45pm, he was found to have been cutting or scratching cuts to his left forearm with a plastic knife. According to prison case notes, Nurse 2 attended and cleaned and dressed the wounds. We were not able to interview Nurse 2, who no longer works at the prison.

6.3 ACCT stands for Assessment, Care in Custody and Teamwork. It is a set of policies and procedures to safeguard prisoners identified as being at risk of self-harm. Chapter 1 of this report explains the scheme in outline. At 8.08pm Prison Officer D opened an ACCT document for CR with an immediate 'Concern and Keep Safe Form'. This is the first step in drawing up a care plan to safeguard against self-harm. Officer D noted that CR was withdrawing badly from alcohol and/or drugs and had not been coherent all afternoon. His new cellmate (Prisoner 1) said he had asked for a razor earlier. There is no reference in the form to any prior known risk of self-harm. Officer D told us that he does not recall having any knowledge of the circumstances of CR's arrest or the offence with which he was charged.

6.4 Prison Service Instruction 64/2011 says that within an hour of the ACCT being opened, a manager must talk to the prisoner and complete an Immediate Action Plan, register the ACCT Plan, record it on the prisoner's electronic record, inform healthcare so that it can be noted in the clinical record, make arrangements for the prisoner to meet a

trained ACCT assessor and for a multi-disciplinary case review, and ensure that the prisoner has been offered an opportunity to talk to a Listener or the Samaritans.

6.5 An Immediate Action Plan was recorded, pending a full assessment interview and panel review. This is signed by Custodial Manager S, who was on duty as the Night Orderly Officer (now called the Night Operational Manager - a custodial manager who is the most senior staff member on duty inside the prison overnight. Custodial managers used to be called principal officers.) The action plan said CR was to be in shared accommodation, with hourly observations to be recorded, to see the medical officer as soon as possible, to have access to Listeners and to make phone calls.

6.6 The ACCT form asks the person completing the action plan to say whether phone access refers to calling the Samaritans, or family members, or someone else, but the plan for CR just says '*allow relevant access'*. Whilst shared accommodation and hourly observations are recorded as implemented immediately, no schedule is given for seeing the medical officer, or for access to the telephone or. (Listeners are prisoners trained by the Samaritans to be available in prison for prisoners contemplating suicide or self-harm)

6.7 The ACCT Form contains CR's mother's name and address as next of kin but no telephone number.

6.8 Prison Service Form 213SH, which records injury to a prisoner through self-harm, was completed by Officer D, recording CR's injuries. Officer D also entered on the electronic Case Note History an alert for self-harm and that an ACCT had been opened as a result of CR cutting himself. The note says it was

'hard to speak to CR as to why he had done this as he is detoxing badly from alcohol and/or drugs.'

6.9 CR's cellmate, Prisoner 1, was a convicted prisoner who transferred from HMP Cardiff on 1 December 2015. Prisoner 1's cell-sharing risk assessment is dated 2 November 2015 and endorsed on 1 December 2015 by healthcare to say no increased risk.

CR became unwell in the course of the evening

6.10 During the evening, CR became unwell and at 10.40pm he was taken back to hospital. This was said to be because of severe alcohol withdrawal. He arrived at the hospital at 11.00pm. Escorting officers were Prison Officers E and F. The first entry in the ACCT record of events is at 10.40pm when CR and the escorting officers left the prison for Morriston Hospital Accident and Emergency.

Wednesday 2 December

6.11 An entry in the electronic Case Note History at 1.59am says that CR has gone back to hospital due to concerns for his health, having been on a bed watch for the past week but having '*signed himself out of hospital against medical advice'*

6.12 There is no reference in CR's prison clinical record to him having cut his arms, the attendance of the nurse, or that an ACCT Plan was opened. Nurse 3 made a retrospective entry at 6.02am on Wednesday which replicated information from an undated and unsigned 'Prison Healthcare Transfer Summary' in the clinical record. The entry noted that CR was drowsy, weak and lethargic and looked ill. The note said he had been hospitalised for the past week with possible sepsis/liver cirrhosis and discharged the previous day '*against medical advice'*. (Part Three of this report and the confidential annex for Interested Parties gives further detail from CR's hospital records.)

6.13 ACCT plans are recorded in the prison clinical record only if a member of the healthcare staff enters a note manually. Healthcare staff noting that a patient has an open ACCT Plan should also activate a red flag that appears on the electronic record to

alert anyone who opens the healthcare record. There was no reference to the ACCT Plan and no red flag in CR's clinical record.

6.14 CR remained at the hospital overnight and had various tests. The hospital's clinical notes say that CR had been admitted to the hospital a week ago but

'self-discharged as he had a disagreement with a police officer. In prison today felt lethargic and agitated. Tried to cut wrists with a plastic knife as he was angry about the conversation he had with the police officer at the hospital.'

This account does not correspond with any entry in the prison records.

6.15 At the hospital, on Wednesday morning, CR was seen by the same doctor who had reviewed him the previous Monday (see paragraph 5.21). The doctor's note at 8.50am says that CR had been discharged from hospital by the Acute Medical Unit Team on Tuesday, there was no change, and he was medically stable. The note is not entirely clear but there is reference to outpatient follow-up and consideration of what services were available in prison. It says it was decided that CR could be discharged back to prison *'with mental health support*'. CR returned to B wing at the prison at 10.10am on Wednesday morning 2 December.

6.16 Back at the prison, CR was checked once an hour from 11am. Most of the entries are on the hour and record that he was asleep. He collected meals and was once seen talking to his cellmate. Several of the signatures are unclear. The only references to interaction with staff during the day and evening of 2 December are by Officer L that there were '*no issues*' when CR '*collected lunch*' at 5pm and that at 11pm he asked Officer E if he could check when he was due in court.

6.17 A note by a CARATs caseworker on 3 December says that CR was back from hospital and looked a lot better. She had a conversation with him and planned to see him for

an assessment the following Monday. This is not recorded in the ACCT record of events and we do not know whether the caseworker knew that CR was on an ACCT.

Findings

6.18 On Tuesday evening, after his discharge from hospital that morning, CR inflicted superficial cuts to his arms. A nurse attended and an ACCT Plan was opened. There was no reference to either event in the clinical record.

6.19 The officer who opened the ACCT Plan had no knowledge of CR's prior history of self-harm or the circumstances of his arrest. Apart from a requirement to record hourly observations and for CR to remain in shared accommodation, the provisions of the Immediate Action Plan were non-specific, with no timescales or allocated responsibility for actions.

6.20 CR became unwell and was taken back to the hospital. He was in A&E overnight. His condition was related to his withdrawal from alcohol not the cuts to his arms. The electronic record and the clinical record said wrongly that he had discharged himself from hospital the previous day against medical advice. This erroneous information may have originated from the hospital records.

6.21 CR returned to the prison on Wednesday morning. There is no reference in the ACCT record of events to the provisions in the Immediate Action Plan for CR to have access to Listeners and to make phone calls, and to see the medical officer as soon as possible. He appears to have slept for much of the day and entries in the ACCT record of events are not informative as to his state of mind.

6.22 Whilst we see no connection with CR's mood or his self-harm, we note that CR's cellmate was a convicted prisoner. Contrary to the Prison Rules there is no record that CR, as an unconvicted prisoner, was asked to agree to share a cell with someone who was convicted.

CHAPTER SEVEN: THURSDAY 3 DECEMBER - THE ACCT PLAN

7.1 Chapter 1 of this report contains a brief outline of the ACCT, which stands for the Assessment, Care in Custody and Teamwork scheme. This is the Prison Service strategy for protecting prisoners from self-harm. Policy and guidance on ACCT is contained in Prison Service Instruction PSI 64/2011.

The ACCT Plan

7.2 Instructions in the ACCT document say that once an ACCT Plan has been opened a trained Assessor must interview the prisoner within 24 hours of the Concern and Keep Safe Form being opened, unless there are exceptional circumstances such as a prisoner being admitted to outside hospital and being too ill to be interviewed. The First Case Review must also be held within 24 hours of the Concern and Keep Safe Form being opened, and ideally immediately after the Assessment interview.

Entries in the ACCT record of events

7.3 There was no assessment interview or review on Wednesday after CR returned from hospital so on Thursday the interim provisions in the Immediate Action Plan were still in force. There is no reference to referral to the medical officer or facilitating his access to phone calls to his family or to Listeners or the Samaritans.

7.4 The action plan provided for hourly checks to be recorded. Entries in the ACCT document record observations overnight at intervals between 35 and 75 minutes. At 0.30am on Thursday morning CR appeared to be asleep, at 1.05am he was watching television, at 2.20am he was talking to his cellmate, at 3.35am and 4.30am he appeared to be asleep.

7.5 At 5.15am CR asked Officer E if he could have something to eat as he said he had not been eating for days. Officer E told him that as it was night, he had no access to

anything and CR would have to wait. At 6.20am, 7am and 8am, CR appeared to be asleep. Officer C noted that at 9am the cell was unlocked for CR to receive medication from a nurse and he asked about incoming mail, seeming '*okay and more coherent'*. At 10am he was asleep, then at 11.20am he collected food.

7.6 There is no further entry in the record of significant events and conversations until Nurse 1's entry some three hours later at 2.45pm that CR was seen for an ACCT review. Some of the three hours between 11.20am and 2.45pm would have been occupied by the assessment interview and ACCT review but it is not recorded when those began.

The ACCT assessment interview

7.7 The assessment interview was held in the early afternoon of Thursday 3 December. Ms G was the ACCT assessor. She had formerly been a CARAT caseworker but in 2015 was working as an administrator in the Offender Management Unit, which is concerned with sentence planning and rehabilitation. Ms G told us that the assessment interview would probably have lasted about 45 minutes to an hour.

7.8 According to the note of the interview, CR said he *'did not want to be here and that's why he'd decided to take his life'*. He referred to the recent death of his partner from pleurisy and said that six months ago he had tried to jump from the eighth floor of a building. He was worried about how he would cope as a homosexual in prison. He said he was withdrawing from alcohol, and seeing things, and that he had cut himself and swallowed a knife. He was now feeling more comfortable as he had a new cellmate whom he liked. He was said to have no current thoughts of self-harm.

7.9 Another concern recorded was that he had lost his false teeth. Actions planned were referral to CARATs (now called Dyfodol - the substance abuse treatment programme) and referral to Lighthouse (the prison's primary mental health team). Under 'previous acts of self-harm', the assessor notes CR having '*recently attempted to jump from the*

8th floor of a building (approx. 6 months ago)'. There is no reference to CR having tried to set himself on fire.

7.10 The assessor noted that CR said he was close to his mother, and in recording the part of the interview concerned with reasons for living and coping resources, the assessor wrote: '*Mother, sister, close friend'.*

7.11 Ms G told us that before meeting a prisoner for an ACCT assessment interview she would look for any alerts, previous ACCTS, and why they were in prison. The primary source of information would be the electronic core record. She had some recollection of the interview but not a clear memory. She recalled that CR was still upset about the death of his partner and that was why he was drinking heavily. She said that when she wrote on her note that CR '*doesn't want to be here*' she had understood him to mean that he didn't want to be in prison, not that he was contemplating suicide. She did not recall CR's alleged offence or any surrounding circumstances. She said that if she had been aware of the fire-setting she would definitely have written that in her note, especially if he had set himself alight. She thought that CR's electronic record would have said arson but not the circumstances.

7.12 Ms G signed her note of the assessment interview at 2.30pm. Ms G told us that she puts the time when she signs the note, which she would generally write up immediately after the interview. She said that writing a lot of notes during the interview could get in the way of engaging effectively with the prisoner but she wanted to make the note before it slipped her mind.

7.13 The ACCT case review followed immediately after the assessment interview. Whilst it was often a matter of when the right people were available, she had been keen to get the review under way because CR had been anxious and tearful at the start of the interview but at the end of it she felt he was all right. She would have probably written her note of the interview during the case review. She did not usually take a prominent part in the case review discussion but would jump in if she felt the prisoner

was not expressing himself and putting his feelings across. The panel of two or three extra people in a review could be intimidating and prisoners were not always able to share their feelings in that setting. In this case the panel Chair had come across as very sympathetic and Ms G had been impressed. She recalled that at the end of the review she felt that CR was going to be all right.

7.14 After the review Ms G had a period of leave. When she returned, she was shocked and distressed to be told what had happened.

The ACCT case review

7.15 The note of the first case review gives the time of the review as 2.25pm. Those attending were Senior Officer H, designated case manager, Ms G who had just conducted the assessment interview, Nurse 1, who had conducted the initial health screening interviews when CR was admitted to prison, and CR. Like Ms G, at the time, Senior Officer H, the case manager, worked in the Offender Management Unit.

7.16 The ACCT document template includes a list of suggested factors for the case review to consider. In CR's case review the items have been marked as follows:

- to remain in current location
- interaction with wing staff was to be encouraged
- Listeners, peer support, Samaritans, Chaplaincy, to be available as required
- Other agency - Lighthouse (the mental health team)
- accommodation - yes
- counselling - yes
- gym - encourage
- wing activities - encourage
- labour - not applicable
- education - yes
- relaxation classes - no

- family contact - yes

7.17 There is no indication of who would be responsible for encouraging CR's engagement with staff, participation in activities, access to support services, engagement with staff or family contact.

7.18 A 'CAREMAP', which CR has signed, lists issues of concern and action required. Pending actions identified in the CAREMAP were:

- To explore the side effects of detox with Lighthouse, the mental health team, via the Healthcare Centre, to be arranged by Nurse 1
- To alleviate the symptoms of bereavement through the Chaplaincy
- To assist with abstinence from alcohol through CARATs.

7.19 The summary of the review prepared by the Case Manager says:

'CR was happy to attend the review and openly engaged throughout. He stated he lost his partner almost 8 weeks ago due to an illness which started him drinking heavily…and states he is withdrawing.
CR stated he cannot remember the incident which resulted in the ACCT being opened but stated he just wanted to be with his late partner and was hallucinating.
CR is a gay man and has worries about being in custody. These were dispelled by all present during the review
[CR] was previously on a constant watch and states he feels a lot better since coming out of c/w conditions. .
He stated that his current cell mate is very supportive, and they get on very well and [CR] wishes to remain in his current location with his cellmate. This will be facilitated.
….'

7.20 (We understand the reference to constant watch to refer to the hospital bedwatch, where Prison Officers were always present, throughout the day and night.)

7.21 The summary went on to say that Nurse 1 would ensure that CR was assessed by Lighthouse (the Mental Health In-Reach Team) and he would be referred to CARATs about his alcohol addiction issues. The Chaplaincy would be contacted to enable CR to light a candle and say a prayer for his deceased partner.

7.22 Finally, the summary says that

'CR states he has no further thoughts or feelings of DSH [deliberate self-harm] or suicide and is aware of all the support services available to him.'

7.23 The risk of self-harm initially and at the time of the review was said to be low. Hourly observations were to be continued and recorded during day and night.

The Clinical Record

7.24 There was no entry on the clinical record to say that an ACCT Plan had been opened for CR. Nor was there any entry about the ACCT review. Nurse 1 told us that the existence of an ACCT Plan has to be entered manually on SystmOne (the electronic clinical records system), and where this is done there is a flag indicating this in the corner of the screen. It is not possible to access the ACCT documents from the clinical record.

7.25 The case manager's summary of the review was entered in full on CR's electronic core record at 3.14pm.

The staff's recollections of the case review

7.26 Senior Officer H, the case manager, told the investigation he remembered the case review and particularly that CR had been concerned about being openly gay in prison. The panel had reassured him that there were other openly gay prisoners who had not experienced any issues and if he should come across any discriminatory behavior the

staff would support him. CR had been easy to engage with; he was very reasonable and articulate.

7.27 Senior Officer H had no knowledge of CR other than what was disclosed in the assessment interview and at the case review. He said he would not have known anything about CR's offence unless it had been raised in the assessment or review. Usually, Senior Officer H would not want to know a prisoner's offence or charge, in order to avoid any prejudice.

7.28 Senior Officer H said the length of reviews varied but they would probably take about 25 or 30 minutes. In assessing risk, Senior Officer H said he would take account not just of what the person said about their intentions, but also their body language, how they engaged, and their history, and he would encourage people to talk about plans for the future.

7.29 Nurse 1 said she was not able to call to mind any active memory of the review or of having any concerns. She thought she would probably have been aware that she had met CR previously in Reception but could not recall her opinion at the time. She believed she had been on leave in the intervening period and she noted that there was no reference in the clinical record to her having met CR in the meantime, though the record showed that other nurses touched base with him every day while he was detoxing from alcohol.

Entries in the ACCT record of events after the case review

7.30 Nurse 1's entry in the ACCT record of events, timed at 2.35pm, is the first entry after 11.20 that morning. It says:

'Seen for review. Much more positive in mood. States no thoughts of DSH/suicide. Settled throughout review – states more settled in cell with new cell mate. Will be seen in Lighthouse for full mental health review.'

7.31 The next entry is by Officer A at 3.32pm.. It says:

'CR's cellmate came to the office and asked to move wings. [Prisoner 1] stated that his mother was disabled and he needed to work to earn money.'

7.32 Entries in CR's ACCT record by Officer J are as follows:

At 4.30pm: *'Was not happy his cell mate was relocated to D wing.'*
At 5.30pm: *'Refused food'*
At 6.30pm: *'Now has a new cell mate seems happier.'*
At 7.15pm: *'Appears asleep'*

7.33 Notes made by a police officer who came to the prison after the discovery of CR's self-harm also say that Officer D told him that at 8.00pm CR said he was unhappy that his previous cellmate had been removed.

What staff told us about CR's change of cellmate

Prison Officer A

7.34 Officer A said that in the afternoon of 3 December CR's cellmate, Prisoner 1, came to her and said that CR had money sent in but he didn't, as his mum was disabled. He said he was *'looking after [CR]'* but he wanted to move to another wing where he could work and earn money. Officer A had said she couldn't make him stay and agreed to arrange a move. The conversation was probably in the office. CR was not present. At this point Officer A knew nothing about what had been said in the case review, which was being written up elsewhere.

7.35 Then Senior Officer H, the ACCT case manager, came to her while she was in the cell talking with CR, while Prisoner 1 was packing his bags. Senior Officer H asked for a word. He explained there had just been a case review and Prisoner 1 was to stay in

the cell with CR. Officer A said she couldn't make Prisoner 1 stay and as soon as another suitable new prisoner came on to the wing they put him in with CR. Officer A said she remembered talking to CR, who assured her the new cellmate was fine, so she had been satisfied, and left the wing at the end of her shift.

Senior Officer H - the ACCT case manager

7.36 Senior Officer H told the investigation that CR had taken a liking to his cellmate and was able to tell him a lot of things. However, the cellmate had his own issues and asked to be move. Senior Officer H had agreed that they couldn't keep the cellmate there as that would cause more problems, but he knew from the review that the move could be a trigger point so he had gone back to see CR later in the afternoon or early evening and CR had said the new cellmate was '*a great guy*' and it was '*not a problem*'. There is no entry in the ACCT record to this effect.

Prison Officer J

7.37 Officer J made entries in the ACCT record at 4.30pm, 5.30pm and 6.30pm about conversations with CR, first about him being unhappy Prisoner 1 had been moved, then refusing his tea meal, and then saying he seemed happier now he had a new cellmate.

7.38 Officer J told the investigation that, from memory, he thought there had been a history of CR having arguments with one or more cellmates, and that possibly this was why he and Prisoner 1 were separated. He believed he remembered an altercation after the case review with CR screaming and threatening a cellmate and that he had to separate them. On reflection, Officer J was not sure whether this was Prisoner 1, or the new cellmate, Prisoner 2. There was no reference to an altercation between CR and any cellmate in any of the records we have seen.

Prison Officer E

7.39 Officer E was on the night shift and would have come onto the wing about 7.45pm. He told the investigation he remembered CR asking why his cellmate had been moved. Officer E had just come on duty and the only information he had was that the cellmate had finished his induction so had been moved to make space for other new prisoners on the induction wing. CR had a new cellmate and he did not seem distressed or angry. Officer E was not certain whether CR had rung his bell to ask about Prisoner 1, or whether Officer E had been doing an ACCT check. He noted that he had not made an entry in the ACCT record, which suggested it was just a passing conversation and there was nothing to make him think he should document it.

The new cellmate - Prisoner 2

7.40 Prisoner 2 was an unconvicted prisoner remanded for trial. He was admitted to the prison at 5.09pm. A cell-sharing risk assessment indicated standard risk. A note by Officer J timed at 6.19pm says he completed the first night interview.

The ACCT record

7.41 Officer J noted in the ACCT record that at 7.15pm CR appeared to be asleep. Officer E told the police that at 8pm. CR asked why his cellmate had been moved.

7.42 An entry in the ACCT record by Operational Support Grade (OSG) K says:

'Awake. Watching TV. Pressed cell bell instead of light'

7.43 The entry in the ACCT record says this was at 8.15pm, though according to a police officer's note made later that evening, OSG K said that it was at 8.25pm that she saw CR that he was standing beside his bunk and was fit and well. Prisoner 2 was asleep on his bunk.

7.44 OSG K told our investigation that as an operational support grade she had little contact with prisoners and had not met CR before. She was tasked with checking the prisoners on ACCT plans. Her practice was to make a note of the prisoners she needed to see, and to make notes against their names as she went round the wing. She would then write her notes up on each of the ACCT plans back in the office where the files were kept.

7.45 In an email to the Night Operational Manager, at 2.51am on 4 December, OSG K said she was on her way to check on CR when the cell bell rang and when she arrived at the hatch CR was standing out of his bed. He apologised for the cell bell and said he had pressed it by mistake instead of the light. OSG K asked if everything was OK and CR said yes. Prisoner 2 was lying in the top bunk bed. There seemed no apparent issues. (We confirmed from our own observation that the cell bell and the light switch are located close together).

7.46 The next entries in the ACCT record are about the discovery of CR's self-harm and the action that followed. This is described in Chapter 8 of this report.

Findings

7.47 There is no indication in any of the ACCT documentation or in our interviews with officers that the discipline staff responsible for CR's risk assessment and care plan on 3 December knew how he came to be in prison. The trigger for the ACCT Plan was CR's superficial self-harm in his cell two days earlier. We cannot know whether CR believed that the ACCT assessor and the review panel knew about the fire-setting but there is nothing in any of the ACCT documents to indicate that they did. The only reference to previous self-harm in the assessment interview is that CR had tried to jump from a building some months before. Nurse 1 had spoken with CR about the fire-setting when she met him in Reception but when we spoke to her during the investigation she was unable to recall whether at the time of the review she linked CR in her mind with having met him during his reception and induction into the prison.

7.48 This confirms our concern that the significant evidence of risk that accompanied CR on his admission to prison was not passed on to the staff responsible for his management on the wing. This vests too much authority in the judgments that were made at admission. The information should have been passed on, to be taken into account if circumstances changed or there were other indications of risk.

7.49 Not only were the panel not aware of the extent of CR's recent history of attempted suicide, only Nurse 1 had had any prior contact with him before the assessment interview. None of the panel members could be said to have known CR, as advised by provisions on preventing self-harm in Prison Service Instruction PSI 64/2011, nor would they have any continuing relationship with him on the wing. There were officers who knew something of CR. Several had spent time on bedwatch when he was in hospital. Officer A, among others, had met family members.

7.50 The assessment interview and review were held some 42 hours after the ACCT Plan was opened. This was not an undue delay given that CR had spent part of that time in hospital. But there was little evidence of active engagement with him until the assessment interview. We have noted above that, except for a requirement for CR to remain in shared accommodation and to record hourly observations, the provisions of the Immediate Action Plan were generalised, with no timescales or allocated responsibility and there is no indication of any measures to implement the action plan, other than hourly observations, which appear cursory.

7.51 From the record of the assessment interview and the summary note of the review, we are satisfied that the assessor and the case manager undertook their tasks with sensitivity and diligence in light of the information they had. However, we have reservations about the adequacy of the CAREMAP. The three actions identified were appropriate, though without timescales, and the referrals to Lighthouse and CARATs were already in place with initial assessments awaited. The only personalised intervention for CR's particular circumstances was the plan for CR to meet the Chaplaincy and light a candle for his late partner. Moreover, needs identified in the

list of factors for consideration, to encourage family contact and engagement in activities, were not carried over into the CAREMAP so no responsibility was allocated for them. In Chapter Six of this report, we expressed a similar concern about the Immediate Action Plan (see paragraph 6.19). In Chapter Eleven, we say more about families as a protective resource.

7.52 We noted in Chapter Six (paragraph 6.12) that there was no entry in the clinical record that an ACCT Plan had been opened in the evening of 1 December. Nor was there any entry for the ACCT review, even though a member of the healthcare staff attended. There was no red flag on the clinical record alerting healthcare staff to the risk of self-harm.

7.53 In the ACCT review, CR's relationship with his cellmate was identified as a protective factor and, according to the summary of the review, he was assured that this would be facilitated. From the record, and the staff's memories some three years after the event, we cannot be precisely sure of the circumstances of Prisoner 1's request to move. Nor can staff place on other prisoners the responsibility to take care of prisoners at risk of self-harm. However, Prisoner 1's move, coming so quickly after the assurance he was given may well have seemed a breach of trust, and it needed careful management.

7.54 From what we have been told, staff were aware of the sensitivity of the cell move, at least in part. Officer A placed another prisoner with CR as soon as she could. The Case Manager visited him. Officer J noted his conversations with CR about the new cellmate. However, the entries by Officer J and Officer E indicate that CR continued to be bothered about the move.

CHAPTER EIGHT: CR'S ACT OF SELF-HARM AND THE RESPONSE BY THE STAFF

Summary

8.1 At about 9pm on Thursday 3 December, CR was found to have ligatured with a twisted prison sheet attached to the bars of the widow to his cell. His cellmate rang the cell bell to alert staff. Officers and a nurse attended. They removed the ligature and attempted to resuscitate CR. An ambulance was called. Paramedics arrived first and took over CR's care with the help of the prison nurse and an officer. The ambulance crew arrived soon after and continued resuscitation attempts. At about 10.20pm CR was taken to hospital. At the hospital, a scan showed hypoxia, brain injury through oxygen starvation. The clinical prognosis was that if CR did not die, he would be seriously disabled and not make any form of recovery.

8.2 On 18 December the police were informed that charges had been dropped against CR. On that date he was formally released from custody and prison staff ceased attendance at the hospital. CR's condition remained unchanged in hospital. He was moved to a nursing home and it was considered unlikely he would make any recovery.

The staff's response to the discovery of CR's self-harm

8.3 There were no statements from prison staff among the documents the prison provided to the investigation, and when our investigation began in 2017 the prison's Control log for the day was no longer available. There was an entry by Nurse 3 in the SystmOne clinical record and a report prepared at 4.5am on Friday 4 December 2015 by the Night Orderly Officer, Mr M, who attended and assisted at the scene, and who was the most senior member of staff in the prison overnight. During the investigation, Mr M provided some emails from staff members which formed part of the basis for his report, and Nurse 3 gave us a report that she had prepared at the time in case it was needed later. We also obtained records from the police and the ambulance service.

We comment in Chapter 11 on the absence of any significant investigation by the prison.

The evidence of Prison Officer F

8.4 In an email to the Night Orderly Officer, Mr M, at 3.57am on 4 December, Officer F says he answered a cell bell at about 9.05pm. When looking through the observation glass he saw CR's cellmate, Prisoner 2, pointing at CR, who was at the back of the cell, facing the window, with an apparent ligature round his neck. The Orderly Officer, Mr M was called, along with Nurse 3. Mr M opened the cell and entered with Officers E and F. Prisoner 2 was supporting CR's weight. The three officers took CR's weight. The ligature was a sheet wrapped round CR's neck. CR was laid on the floor and the three officers and the nurse started CPR (cardio-pulmonary resuscitation). An ambulance had been called by Control. At approximately 9.20pm a paramedic took over the CPR and at 9.25pm an ambulance arrived. At about 10.20pm CR was taken to the ambulance and left the prison.

8.5 When we interviewed Officer F in February 2019, he said he had no actual recall of what happened that night. Sadly, it was not the only time he had discovered a prisoner who had ligatured. He said that he must have raised the alarm over the radio then entered the cell with other staff and healthcare. He would have had a sealed pouch containing a key that would allow access to a cell at night but he would not have entered the cell until a second officer was present. They would have taken CR's weight, used a 'fish knife' to cut the ligature then administered health care. He was not First Aid trained so would probably not have done CPR but stood back and let the others do it.

The evidence of Prison Officer E

8.6 In an email at 11.50pm on 03 December, Officer E said that at 9.05pm he responded to a cry for staff from Officer F, and attended cell B3-10. Prisoner 2 had rung the bell to alert staff to the fact that CR was at the back of the cell with a ligature round his neck. Officer E followed Officer F and Mr M into the cell. He assisted with releasing the ligature from around CR's neck. He contacted the healthcare nurse to attend the cell. He continued to assist with CPR until the ambulance service arrived and offered further support by assisting the ambulance staff to take CR to the ambulance.

8.7 Officer E told the investigation he remembered Officer F coming to the top of the stairs to say there was a ligature. Mr M, Officer F and Officer E all ran to the cell. Officer E was behind and could only remember CR being placed on the floor that the ligature was removed and they started doing CPR, first Officer F, and then Mr M. Officer E left the cell to call for the nurse, who arrived and took the lead on CR's physical care. Mr M and Officer F continued CPR. Officer E was back and forth, having conversations with Control and the Duty Governor to update them. He believed that a request to Control to call an ambulance would have come over the radio immediately as a result of Officer F's call for assistance.

8.8 Officer E said he was first aid trained from a previous employment. He had not done first on scene training for five or six years, though that course used to be every year.

N**urse 3's entry in the clinical record**

8.9 Nurse 3 made an entry in the medical record at 2.28am on 4 December. She had received an emergency call at approximately 9pm. When she reached the cell, CR was on the floor, chest compressions were commenced by Mr M, on examination CR was not breathing, his lips were blue, and there was no capillary refill and no pulse evident. A guedel was put in place to protect CR's airway and electrodes placed on his chest. Then

'CR in PEA [pulseless electronic activity], non shockable rhythm, chest compressions recommenced at a ratio of 30/2 breaths given by ambu bag, continued CPR until paramedics arrived. CR still in PEA as paramedics worked on CR, still no pulse. Eventually CR was in shockable rhythm, VF, weak pulse. CR was moved to ambulance once stabilized and taken to Morriston ITU. CR was last checked by officers at approx 20:30 hrs, cell mate unsure how long CR had been hanging. Prisoner 2 was holding CR's legs when officers entered the cell.'

8.10 When we interviewed Nurse 3 in March 2019, she gave us a written report. This is not dated but Nurse 3 said she prepared it shortly after CR's self-harm in case it was needed. In addition to the information in the clinical record the report says that Nurse 3 received a Code Blue call at approximately 9pm. (A Code Blue is a call for an emergency response when a patient's breathing or heart has stopped.) She was working in healthcare and ran to A wing treatment room to get the responder bag and CPR machine. When she reached the cell, the three officers were present, with the Orderly Officer, Mr M, doing chest compressions. She was told that an ambulance had been called. CR showed no obvious signs of life. The nurse inserted a guedel with an ambu bag to support CR's airway. There was no heart rhythm that could be stimulated by electric shock by a defibrillator so they continued chest compressions until the paramedics arrived. The paramedics took over chest compressions. CR still had no pulse at this point. After a few minutes they tried to shock him once more, and obtained a faint pulse. The paramedics took over, while Officer F continued to control CR's airway. The paramedics secured CR on to a type of spinal board and when he was stable, the nurse, the officer and the paramedics took him to the ambulance.

8.11 The investigation's Clinical Reviewer considers in detail in Chapter 10 of this report the procedures prison staff and the nurse followed and finds that CR received appropriate and timely emergency care (see paragraph 10.34).

The Orderly Officer's Report

8.12 Mr M's Orderly Officer's report was emailed to the Duty Governor, Mr N, at 4.55am on 4 December. The report states that at about 9.05pm Officer F answered an emergency cell bell from the cell occupied by CR and Prisoner 2. On looking through the observation glass the officer could see Prisoner 2 pointing to CR facing the window at the back of the cell with an apparent ligature round his neck. Mr M responded to a shout for assistance from Officer F and opened the door of the cell to find Prisoner 2 holding CR up by the waist and with a ligature (a prison sheet, which was not knotted or ripped) around CR's neck. The ligature was removed without cutting and CR was laid on the cell floor where Officers E and F and Nurse 3 took turns to administer CPR. CR was not breathing and had no pulse.

8.13 The report says an ambulance was called straightaway, that paramedics arrived at about 9.20pm and assisted with CPR, and that the ambulance crew arrived at about 9.30pm and took over. The Duty Governor, Mr N was informed at about 9.30pm. The ambulance left at about 10.20pm, escorted by two officers from the night staff. CR was still not breathing but had a faint pulse.

8.14 The police were informed at 10.10pm. Three detective constables came at about 0.30am and interviewed staff, inspected the cell from outside and interviewed Prisoner 2. They left at about 2.10am. The National Operations Unit at Prison Service headquarters was informed at 2.25am.

8.15 Mr M informed CR's next of kin at 0.20am when he had confirmation from the hospital of CR's condition. The information from the hospital at the time of the report was that CR was in the Intensive Therapy Unit on a ventilator with suspected brain damage and that the next 48 hours would be crucial.

The ambulance service records

8.16 Ambulance service records indicate that the 999 call was received at 9.14pm, the ambulance crew were at the patient's side at 9.33pm and at the hospital at 10.26pm. A transcript of the 999 call says the officer telephoning said he had just seen staff running to a cell.

The consequences of CR's attempted hanging

8.17 An entry dated 11 December in the clinical record noted that CR had failed to regain consciousness since his attempted hanging. He was deeply comatosed, (meaning a deep state of prolonged unconsciousness), with no response to voice or pain and no spontaneous movement. He was able to breathe but was still ventilated and had had fits which were controlled with medication. The summary concluded that CR's neurological outlook was extremely poor, though an accurate prognosis was impossible at that time. CR was likely to remain in hospital for weeks or months and was likely to remain in institutions for the rest of his life due to severe neurological disability.

Findings

8.18 We have not been able to obtain exact timings for when Prisoner 2 raised the alarm but, from the evidence available, we were satisfied that there was no delay in opening CR's cell and providing assistance. That is partly due to the compact nature of Swansea Prison. Both the nurse and the Night Operational Manager were located close to the wing.

8.19 The Clinical Reviewer to the investigation concludes that the staff gave timely and appropriate care in line with national standards. (See paragraph 10.34 of this report). They should be commended for their diligence.

8.20 Despite the best efforts of the staff who attended him, CR's injuries caused severe and life-changing harm which left him unable to move or communicate and wholly dependent on institutional care. CR died some four years later in October 2019.

CHAPTER NINE: THE POLICE INQUIRY

9.1 The police record says that the occurrence was reported by the prison Control Room at 10.28pm. A police officer attended. The report by the police senior investigating officer at 04.59am on 4 December says:

> '*at approximately 21.15 hrs …[CR] was located in his cell (B310 B Wing) hanging in an upright position with his feet on the floor from a bedding sheet which was wrapped around his neck and tied to bars in the window of his cell. CR's cell mate [Prisoner 2] has apparently woken up after dropping off to sleep while watching television (believed to be 15 minutes or so) and upon waking up, has found CR hanging as previously described. [Prisoner 2] then alerted staff by shouting for help and activated the cell alarm buzzer. Prison staff have then attended the cell and observed Inmate [Prisoner 2] attempting to hold up the body of CR who appeared to be suspended by bedding sheets wrapped around his neck.*
>
> *Staff have entered the cell and have managed to free the bedding from around his neck by lifting him up and then lowering him onto the ground. They have started CPR and called ambulance. CR has then been taken to Morriston Hospital (ITU) where he remains in a critical condition.*
>
> *Hospital staff have stated that at this time there are no indications of any other marks other than the ligature marks and on initial assessment they have no concerns of any third party involvement*'.

The cell had been secured for forensic examination. A green coloured bed sheet and a ripped white towel were recovered. Two footwear marks were examined from the pipe that ran below the window. Photographs taken by the police show the accessible bars to the window, pipes running beneath the window with footmarks apparently from a pair of trainers, a toilet close to the pipes and the window, and shielded from

the rest of the cell by a waist high screen on one side, metal bunk beds, a television, a washbasin, a stool and two small cupboard and shelf units. Our investigation visited cell B3-10 in December 2017. We found it cramped and dingy. Most of the floor space was occupied by the bunk beds, leaving only a small passageway between the furniture.

9.2 A police officer spoke to Officer E, OSG K and the Night Operational Manager, Mr M, but no formal statements were taken from any staff.

The letter from Prisoner 2

9.3 A letter written by Prisoner 2 was found in the cell. Among other things, the letter complains about a woman friend and says:

> *'maybe I'll just finish everything by tying my bedding to the bars of the window and just kick the chair away.'*
>
> Later, the letter says:
>
> *'I've been put in with a bloke who drinks 16 litres of white cider a day and cuts himself. I've told him and the staff I'm fucking moving in the morning, cause if he cuts himself I'll give him something to bleed about.'*

9.4 The police assessment says that during early conversations with prison staff this initially raised concerns as there was indication that Prisoner 2 had included in the letter a threat towards CR, but on later assessment this did not seem to be the case and was more a case of Prisoner 2 complaining about CR's suicidal tendencies to cut himself and of wanting to move cells.

9.5 The police were satisfied there was no evidence of foul play and interviewed Prisoner 2 as a witness. The report says prison staff said that Prisoner 2 assisted in basic first aid on CR in the presence of prison staff.

Prisoner 2's statement

9.6 In his statement, Prisoner 2 said he had arrived at the prison at about 4.15pm on Thursday 3 December having been remanded by the Magistrates' Court in relation to a past domestic incident. After being interviewed by prison staff he was taken to cell B3.10 where another male was sleeping in the bottom bunk.

9.7 At about 7.30pm the cell was locked and this woke CR up. He asked if tea had finished and Prisoner 2 told him that it had and the cell had just been locked for the night. They then had a sort of conversation where CR told Prisoner 2 about his health, that he was a heavy drinker, that his liver was failing and he wasn't in a good state of health. CR then smoked a rolled-up cigarette and fell back to sleep a short time later.

9.8 At about 8.30pm Prisoner 2 was watching television from his bunk when he heard the sound of tablets being popped out of a medication blister pack. He must then have dozed off. He woke up a little later. He was still on his bed with his head nearest the end wall where the window is, on the opposite side of the cell to the door. He turned and glanced towards the window, where he saw CR slumped against the back wall facing the window. The only light in the cell was from the television.

9.9 Prisoner 2 said he could tell right away that something was not right with CR's position. He could see a green sheet wrapped round his neck and the opposite side going through the bars in the cell window. He could also see a yellow blanket over his shoulders. He was slumped over to the right-hand side. Prisoner 2 took hold of him to relieve the pressure from round his neck. He was limp and still. Prisoner 2 started to shout for help. He continued to hold CR up. It was clear that CR could not support his own weight. Prisoner 2 gently lowered him and ran to the cell door to push the

emergency button. He then went straight back to CR and supported him round his middle, lifting him to take the pressure from his neck.

9.10 A short time later an officer came to the hatch but did not have a key to enter and ran for further help. A short time later the cell door was opened and three officers came in and went straight to CR. Prisoner 2 said he saw the officers lift CR away from the wall and lay him on the floor where they started CPR. Prisoner 2 was then taken away and placed in a cell with three prisoner cleaners, one of whom he knew.

9.11 Prisoner 2 said that from the time he woke up until he was taken to the three-man cell, Prisoner 2 saw no response from CR. He remembered one of the staff performing CPR saying there was a pulse.

9.12 With reference to his letter in which he wrote of hanging himself in a similar manner to CR, Prisoner 2 said he wrote this only because he was upset to be back in prison with Christmas coming but he had no intention to carry out his threat. He had written the letter before falling asleep. He had referred to CR but he said he had not really had time to get to know him and his letter was just a rant because of being back in prison. Prisoner 2 said he had never met CR before and he never threatened CR or fell out with him in any way.

Closure of the police inquiry

9.13 On 5 February 2016 the police concluded that all lines of enquiry were completed and there were no suspicious circumstances. Their enquiry was closed pending any further information.

Findings

9.14 The police took the lead in investigating the immediate circumstances of CR's hanging. A letter written by his cellmate and found in the cell raised concern. We cannot know

if Prisoner 2's conversations with CR had any effect on CR's state of mind. Prisoner 2 undoubtedly had his own problems and he was not responsible for CR's welfare. He acted appropriately in supporting CR's weight and calling for staff. The police were satisfied that there were no suspicious circumstances.

9.15 We note the reference in Prisoner 2's letter to tying his sheet to the window bars. The cell offered obvious ligature points to occupants feeling despair.

PART THREE: THE CLINICAL ADVICE TO THE INVESTIGATION

CHAPTER TEN: THE FINDINGS OF THE CLINICAL REVIEW OF THE STANDARD OF CARE OFFERED TO CR

Introduction

10.1. The investigation commissioned a clinical review, to advise on relevant health issues, including mental health assessments and CR's clinical care during the time CR spent in prison custody from 21 November 2015 until his life-threatening self-harm on 3 December 2015.

10.2. The review was conducted by Mr Anthony Pritchard. Mr Pritchard is a Registered Nurse in mental health and general nursing, who has graduate and postgraduate qualifications in health service management, health strategy and executive coaching and mentoring. Following initial roles within mental health, infection control and emergency nursing, Mr Pritchard has held a range of senior clinical, managerial and leadership roles within the National Health Service.

10.3. Mr Pritchard was asked to advise, in particular, on the following questions:

- Were Mr CR's physical care needs identified and responded to in an appropriate and timely way including assessment, care planning and referral?

- Were Mr CR's mental health needs identified and responded to in a timely way, including assessment, planning, monitoring and referral?

- Was Mr CR appropriately supported in the management of his alcohol dependence, including assessment, treatment, monitoring and referral to relevant specialists?

- Were appropriate decisions made about the most suitable location for Mr CR?

- Was the emergency treatment of Mr CR appropriate and reflective of the standards outlined in the Resuscitation Council (UK) guidelines (2015)?

- Was the care Mr CR received equitable to that which he could have expected to receive in the community?

- Were events leading to Mr CR's condition foreseeable and preventable?

10.4. Mr Pritchard's findings, his recommendations, and some additional observations are set out below. The clinical review has been provided in full for the Interested Parties as a confidential Annex to the investigation report. We have drawn on Mr Pritchard's advice elsewhere in the investigation report in relating to the sequence of events but, for the sake of CR's privacy, the full clinical review, containing personal clinical data, will remain confidential and will not be published with the investigation report.

The findings of the clinical review

Were Mr CR's physical care needs identified and responded to in an appropriate and timely way including assessment, care planning and referral?

10.5. An initial assessment of CR's health was completed appropriately when he was received into HMP Swansea. This included vital signs, past medical history, his current health status and medication. This also noted bruising from restraint. Second health screening took place the following day which included CR's smoking history and hepatitis B vaccination along with noting a pending appointment for gastroscopy.

10.6. Wing Officers appropriately contacted the healthcare team on **24 November 2015** to review CR when there were concerns about his condition, and a subsequent review was appropriately documented within the *clinical record.* Healthcare staff were again alerted on the morning of **25 November 2015**. They appropriately assessed and documented CR's presentation whilst providing advice to officers about the need for continued observation. At a later review, CR's detox medication was withheld as he was believed to be intoxicated. Staff completed a further review in the afternoon where CR appeared to be intoxicated and observations were noted. Staff contacted the on-call GP service when CR was observed to be confused and unwell, and transfer to A&E was advised. Healthcare staff continued to observe CR whilst awaiting an ambulance, and subsequently escalated the ambulance request when CR was noted to have deteriorated further.

10.7. Following inpatient treatment, discharge communication from the hospital noted only changes to CR's medication. I was unable to identify any further discharge communication from the hospital relating to CR's condition, treatment provided or any follow-up required and there was no documentation of any verbal handover of such information between the services.

10.8. CR was discharged from hospital on **1 December 2015**, and later that day an ACCT was opened. Related *ACCT documents* refer to healthcare treatment for cutting/scratches to CR's left forearm and subsequent attendance at A&E. There is, however, no reference to either the opening of an ACCT or to the treatment provided to CR by healthcare staff within the *clinical record*. An entry to the *clinical record* appeared to replicate information from a hand-written prison healthcare transfer summary. This detailed a comprehensive summary of CR's condition and current health status but wrongly stated that he had previously been discharged against medical advice, and there was no reference to an ACCT having been opened. In addition, the summary did not identify the location, date, time, author or their designation.

10.9. *Hospital notes* from CR's attendance in A&E on **02 December 2015** wrongly state that CR had previously self-discharged as he had a disagreement with a police officer. In an entry to the *hospital notes* and subsequently scanned to the prison *clinical record*, a Consultant noted that CR was medically stable and that the plan was for discharge back to prison with mental health support. A second entry to the *hospital notes* was also scanned to the prison *healthcare record*. This detailed the tests and investigations completed and stated that CR was to be seen by the prison mental health team due to self-harm and to have a follow-up outpatient appointment. This entry does not identify the location, time, author or their designation. It is dated **01 December 2015** but relates to discharge **on 02 December 2015** as it refers to an incident of self-harm.

10.10. Following CR's attempted hanging on **03 December 2015**, there is evidence within the *clinical record* that prison healthcare staff maintained contact with the hospital healthcare team and noted updates on his current health status, investigations and prognosis along with the relevant liaison with family members.

10.11. **In summary**, I conclude that CR's physical health needs were appropriately assessed on his reception to HMP Swansea, including his past medical history, current presentation and his usual medication, whilst second health screening was appropriately undertaken the following day. There was evidence that prison staff alerted the healthcare team when there were changes in CR's condition and that there was ongoing liaison, monitoring, and observation of him whilst awaiting transfer to secondary care, though there was no evidence of suitable discharge information when he initially returned to prison from hospital. There was evidence that healthcare staff were alerted and provided appropriate treatment when CR self-harmed, though this was not documented in the clinical record. Hospital discharge information following CR's A&E attendance was poor. Once CR was hospitalised following his attempted hanging, there was evidence of regular communication and liaison between prison and hospital healthcare teams.

Were Mr CR's mental health needs identified and responded to in a timely way, including assessment, planning, monitoring and referral?

10.12. Prior to CR's arrival at HMP Swansea, the Person Escort Record (PER) identified a risk of suicide/self-harm and that CR had set himself on fire. A Suicide and Self-Harm Warning Form was completed in court whilst a warrant gave the reason for bail refusal as CR seeming vulnerable with suicidal tendencies. In addition, he had been assessed by a mental health nurse whilst in custody and deemed to be at a high risk of suicide. Nurse 1 explained in *interview* that on reception, prisoners may see either the healthcare team or the Reception Officer first. If they see a nurse first, they may not have their accompanying paperwork, but if seen after the Reception Officer, accompanying documentation would be photocopied and given to the healthcare staff.

10.13. An assessment of CR's mental health status was undertaken on **21 November 2015** as part of initial health assessment on reception to HMP Swansea. It was noted that CR had tried to harm himself outside prison as he set fire to his flat, that he was under the influence of alcohol and intended to kill himself. No current thoughts of deliberate self-harm or suicide were noted, and it was considered that CR was no risk to himself. CR attributed the offence to him being drunk at the time and that the recent death of his ex-partner was the reason he set fire to the flat. It was noted that CR had seen a Psychiatrist within the last two months and had received medication for depression.

10.14. Nurse 1 could not recall in *interview* if she had seen the PER (Person Escort Record) but thought it must have been seen because CR was questioned about it and gave answers. She explained that she looks at historical facts if they are to hand and looks at the person as they present. In addition, there are some assessment scales to assess how the individual is presenting, their sleep pattern and their mood at the time. Nurse 1 would also ask the individual if there are any thoughts of self-harm. She considered that her judgment was made from talking to CR and from the

answers that he gave. Nurse 1 didn't have any concerns at that time and didn't feel that CR posed any risk (to himself, which is why she didn't initially open an ACCT.

10.15. During second health screening on **22 November 2015**, it was noted that CR had set fire to his flat with the intention to kill himself but was under the influence and that this was an impulsive act. No thoughts of suicide or deliberate self-harm were noted. Symptoms of depression were noted, but CR stated that anti-depressants worked well for him. A referral to Primary Care Mental Health Service was noted. Nurse 1 thought in *interview* that CR would probably have been quite high priority. She could not remember if an appointment had been booked but there is no evidence of CR having been subsequently seen by the Primary Care Mental Health Service.

10.16. Following an incident of self-harm on **01 December 2015**, healthcare staff were alerted appropriately and provided treatment to CR. An ACCT was opened with hourly observations but there was no record of either the treatment provided or the opening of an ACCT within the *clinical record.*

10.17. In an ACCT assessment interview on **02 December 2015** CR stated he did not want to be here which is why he decided to take his life and that he cut himself and swallowed a knife. It was noted that he had no current suicidal thoughts or intentions and that he was identified for CARAT service intervention and a primary mental health referral. An ACCT first case review took place the following day and was attended by Nurse 1. CR stated that he had no further thoughts or feelings of deliberate self-harm or suicide and was aware of available support networks. It was noted that an initial assessment of risk of self-harm was low and that the current likelihood of further risk behaviours was also low. CR wanted to remain with his current cellmate who was supportive. Actions were for Nurse 1 to ensure he was assessed by the Primary Care Mental Health Team as soon as possible, a referral to the CARAT service for alcohol addiction issues and the Chaplaincy service for bereavement issues. Hourly recorded observations were to be noted day and

night. There was no reference to the initial events prior to CR's detention and no record of this case review within the clinical record. Nurse 1 acknowledged in *interview* that she had not recorded this but said that healthcare staff are aware if an ACCT is opened and they are involved in the ACCT process as much as they can be. She explained that an entry to the clinical record would summarise the assessment and any changes to observations etc. An 'at risk' flag is entered manually on the clinical record when an ACCT has been opened**.** However, on review of the *clinical record*, no ACCT flag was evident.

10.18. **In summary**, I conclude that clear concerns about CR's risk of suicide/self-harm had been documented by hospital healthcare staff, the police and court prior to CR's reception at HMP Swansea. It is not clear if this information was taken into account at the time of the initial health assessment and this is not explicitly referred to in the clinical record. However, CR presented with a number of factors that would alert to an increased risk of suicide/self-harm and would indicate the need for an ACCT to be opened. However, it appears that clinical assessment was based on the perception of CR's presentation and the responses that he gave in relation to any thoughts or intention of suicide or self-harm. At the later initiation of the ACCT process on **01 December 2015**, these earlier concerns were not referred to, which indicates that they were not considered in the management of CR's risk to himself. In addition, the involvement of healthcare staff in the ACCT process was not recorded in the clinical record and there was no evidence of an ACCT flag within the *clinical record*. The intended referral to Primary Care Mental Health Services was indicated in the *clinical record* and *ACCT documents* and the need for this was also indicated in his hospital discharge information. However, there is no evidence that CR was seen by the service.

Was Mr CR appropriately supported in the management of his alcohol dependence, including assessment, treatment, monitoring and referral to relevant specialists?

10.19. An appropriate assessment of CR's alcohol dependence was made during initial health assessment on **21 November 2015**. This noted liver disease due to excessive alcohol intake prior to custody. A drug screening test was undertaken to assess CR's current symptoms and concluded that there were signs of withdrawal. Medication to support detoxification was administered under a Patient Group Directive (PGD) that was in place within the service at that time. First night detoxification monitoring was recorded appropriately in the *clinical record.*

10.20. Administration of detoxification medication under PGD was again documented on **22 November 2015**, and a detoxification regime was then prescribed by the prison GP along with CR's previously prescribed medications. During second health screening there was further assessment of CR's use of alcohol through FAST (Fast Alcohol Screening Test) and AUDIT (Alcohol Use Disorder Identification Test). A referral was documented as 'alcohol abuse'. Nurse 1 explained in *interview* that the Counselling, Assessment, Referral, Advice and Throughcare service (CARAT) would normally have been present during the second reception process during the week, or on Monday if reception was during the weekend. Nurse 1 added that there is a seven-day detox managing process during which time individuals are monitored by the wing nurse along with detox monitoring for the first three nights. She explained that there was an alcohol clinic and thought that CR would have also been seen from a mental health perspective though there was no evidence of this within the *clinical record.* The Nurse Manager who is the prison's Healthcare Lead explained that there is an ad-hoc alcohol clinic as a component of the Primary Care Mental Health Service, which sees people with a wide range of alcohol issues. People are added to a list as they are identified, and once there are sufficient numbers, a clinic will be arranged, though there is no triaging or standard time from referral to first appointment for the clinic.

10.21. Second night detoxification monitoring was evident in the *clinical record* along with a further nurse review on **23 November 2015** whilst CR was also seen by a member of the CARAT service. We were told that CR would have been made aware of the

service and support offered at this point along with basic harm reduction work. Third night detoxification monitoring was noted on **24 November 2015.** CR was due to be seen again on **25 November 2015** by the CARAT service for assessment, but the CARAT caseworker noted that CR was unwell and that she could not see him so he was unable to be assessed. The caseworker noted that she again attempted to make contact with CR on **26 November 2015** but was informed he was in hospital. Following CR's discharge from hospital, the caseworker noted in the CARAT *case notes* on **3 December 2015** that CR looked a lot better and that she had arranged for a further assessment to be carried out. She subsequently noted on **07 December 2015** that CR had been admitted to hospital following a suicide attempt.

10.22. **In summary**, I conclude that CR was appropriately assessed in relation to his alcohol dependency and was initially provided with suitable medication to support detoxification via a PGD and a regime was subsequently prescribed by a doctor. CR was appropriately observed by members of the healthcare team during the first three nights of detoxification and this was noted in the clinical record. As CR was received into prison on a Saturday, he was subsequently seen by the CARAT service on the following Monday and there was evidence of subsequent attempts to follow-up on this initial contact. A referral titled 'alcohol abuse' appears to relate to a clinic provided by the Primary Care Mental Health Service though there was no evidence of an appointment having been made and referral records relating to this were not available.

Were appropriate decisions made about the most suitable location for CR?

10.23. On 21 November 2015, the clinical record notes that a First Night Risk Assessment Form was completed and that CR was fit for normal location, work and any cell occupancy. When CR became unwell on **25 November 2015**, the out of hours GP service were contacted and appropriately advised transfer to A&E via a non-

emergency ambulance. When CR's condition deteriorated further this was appropriately escalated by healthcare staff via the ambulance service.

10.24. Following CR's initial period in hospital, the *hospital notes* documented on **01 December 2015** that CR's observations were stable and that he was keen to go back to prison and the plan was for him to be discharged. The *clinical record* refers to receipt of a transfer of care letter. The information within this relates only to medications and there was no evidence of communication about CR's condition, tests, investigations or ongoing needs on discharge from hospital to prison.

10.25. When CR was re admitted to hospital on the evening of **01 December 2015,** there is reference to self-harm in the *ACCT documentation* but no reference to this within the *clinical record.* A hand-written prison healthcare summary provided a comprehensive summary of CR's background and current condition but the location, time, date and author of this were not identified and it appears that this information was subsequently entered to the *clinical record* by another member of the healthcare staff the following morning.

10.26. Following CR's A&E attendance, an on-call Consultant documented in the *hospital notes* on **02 December 2018** that CR was medically stable. The plan was to discharge him back to prison with mental health support. A copy of this was scanned to the prison *clinical record*. An unidentified Registered Nurse summarized in the *hospital notes* (dated **01 December 2015**) that CR was seen by medical team and consultant. Blood tests, urine sample, ECG and chest X-ray were completed, and CR was to be seen by the prison mental health team due to self-harm and to have a follow-up outpatient appointment. A copy of this was scanned to the prison *clinical record*. Nurse 4 noted in the *clinical record* at 13.37 that CR was discharged from hospital, but there was no reference to the need for mental health support.

10.27. **<u>In summary</u>**, I conclude that appropriate decisions were made about the most appropriate location for CR. Staff recognized and responded to the deterioration in

CR's condition on **25 November 2015** prior to his transfer to hospital. He was again appropriately transferred to A&E following concerns about his physical condition on **01 December 2015**. The *hospital notes* and *discharge communications* indicate that CR was suitable for discharge back to primary care at the time of discharge. A concern is noted, however, in relation to documentation relating to the transfer/discharge of CR between prison and hospital services. Prison transfer information did not note the location and was not dated, timed or signed. Discharge summaries from the hospital service were not always comprehensive whilst required actions following discharge were not noted in the *clinical record*.

Was the emergency treatment of Mr CR appropriate and reflective of the standards outlined in the Resuscitation Council (UK) guidelines (2015)?

10.28. On **03 December 2015**, CR was found hanging by a ligature in his cell by Prisoner 2 at approximately 9.00pm. In his *statement* Prisoner 2 recalled that on finding CR hanging he called for assistance by using the cell bell and that Prison Officer F responded promptly to this call. There was no evident delay in Prison Officer F calling for help from colleagues in order to obtain keys and to then enter the cell. Prison Officer E recalled that the Night Orderly Officer, Mr M, raised an alert and that Mr M entered cell with Officer F whilst he followed. Officer F recalled that he then left the cell with Mr M to contact Hotel 1 for a nurse to attend.

10.29. From Prisoner 2's recollection of events, it would appear that resuscitation was commenced promptly. Officer F recalled that CR had been placed on the floor and the ligature was removed whilst Officer E commenced CPR.

10.30. The Orderly Officer, Mr M, recalled that Nurse 3 arrived straightaway, after which they undid the ligature and got CR to the floor to check breathing and perform CPR. Officer E recalled that when a nurse arrived, Mr M and Officer F did chest compressions, whilst he helped and also liaised with Control and the Duty Governor whilst an ambulance was called from the control room.

10.31. Nurse 3 documented in a retrospective entry to the *clinical record* on **04 December 2015** and in an undated *statement* that there was a 'code blue' at approximately 21.00. She stated that she collected a responder bag and 'CPR machine' and when she arrived at CR's cell, Mr M was already doing chest compressions whilst Prison Officers F and E were also present. She was informed that an ambulance had already been called and this was logged at 9.14pm.

10.32. It was evident that the required emergency equipment was available and was taken to the scene of the incident. Nurse 3 undertook an appropriate assessment of CR, noting that there was no obvious chest movement or signs of life and that he was cyanosed with no pulse or capillary refill. Appropriate actions were then taken to establish an airway and administer rescue breaths through the use of a Guedel airway and ambu-bag. Appropriate action was also taken to assess for cardiac activity through the attachment of chest electrodes and use of an automated external defibrillator[1] (AED).

10.33. It is evident that cardio-pulmonary resuscitation was commenced appropriately and continued at a ratio of 30 to 2 breaths and that CR was periodically re-assessed. Following arrival of paramedics, resuscitation attempts were continued and CR was then transferred to hospital at 22.10, arriving in A&E at 22.30.

10.34. **<u>In summary</u>**, I conclude that CR received appropriate and timely emergency care by prison staff including Nurse 3. The exact sequence and timing of events from statements, interviews and documentation are not consistent. However, it is evident that there was prompt recognition and appropriate action following CR's attempted hanging. Prison staff appear to have initiated CPR whilst an ambulance was called. A nurse responded promptly and the required equipment to support resuscitation was available. The nurse undertook a suitable assessment of CR's status and continued attempts at resuscitation in line with guidance whilst awaiting

[1] An *AED* is a portable electronic device that automatically diagnoses life-threatening cardiac arrhythmias and is able to treat them through defibrillation

paramedical support. A concern identified during investigation was around the completion of annual resuscitation training updates by healthcare staff as there appeared to be no clear process for monitoring the completion of this training within the service.

Was the care Mr CR received equitable to that which he could have expected to receive in the community?

10.35. There is evidence that CR was able to access healthcare services whilst in prison, and that he was appropriately referred to secondary healthcare services when this was indicated. There is evidence that CR's concerns about his sexuality within a prison environment were discussed with him and that he was offered reassurance in this respect. There is evidence of appropriate liaison between prison and hospital healthcare teams, though the documentation to support handover and communication between these teams was not always robust.

10.36. **In summary**, I conclude that CR received healthcare which was equitable to that which he could have expected to receive within the community.

Were events leading to Mr CR's condition foreseeable and preventable?

10.37. There is evidence that there was a range of risk factors present when CR was initially detained at HMP Swansea and that these would have indicated a significant risk of suicide/self-harm. These relate to the preceding events and the alleged offence, along with CR's existing depression, bereavement, alcohol dependence and long-term health issues. It is therefore concluded that the risk of suicide/self-harm was foreseeable.

10.38. However, as CR was under an ACCT which included 60-minute observations at the time of his attempted hanging, it is not possible to conclude for certainty that the incident was preventable.

Recommendations

10.39. A range of information including that from assessment during custody and from court proceedings should be considered along with the presenting risk factors when undertaking an initial assessment of an individual's risk of suicide/self-harm and the opening of a potential ACCT.

10.40. A triaging process should be in place for individuals requiring referral to Primary Care Mental Health Services to ensure that those with significant needs are prioritized for early review, intervention and referral to secondary care mental health services when indicated.

10.41. The opening of an ACCT and a summary of key issues and actions from ACCT reviews should be documented in the clinical record to ensure that this information is easily accessible to members of the healthcare team. In addition, the ACCT flag function should be used to ensure that all staff who access the record are aware that an ACCT is in place.

10.42. The date and time of an individual's transfer to secondary care and discharge back to prison should be documented in the clinical record. This should include any required actions which are identified on discharge from secondary care.

10.43. Paper documentation which is generated and subsequently scanned to the electronic Patient Record should clearly identify the location, date, time and author along with their designation.

10.44. Individual staff log in details should not be shared or used by other members of the healthcare team to make entries to the electronic Patient Record.

10.45. An auditable system should be implemented to monitor completion of annual resuscitation training updates for staff within the healthcare team.

Additional considerations

10.46. Though outside the scope of this review, it is recommended that work is taken forward to develop discharge summary templates within secondary care to ensure that relevant information about diagnosis, condition, treatment and ongoing needs are communicated at discharge. It is also of concern that entries to the hand-written *hospital records* were not consistently dated or timed on each page and did not routinely identify the designation of the person making the entry, whilst a significant proportion of the records were also illegible.

PART FOUR: GENERAL ISSUES EMERGING FROM THE INVESTIGATION

CHAPTER ELEVEN: ENGAGING WITH PRISONERS' FAMILIES

Questions asked by CR's family

Family contact when CR was admitted to prison

11.1. The fire at CR's flat was early on Friday morning, 20 November. CR's sister, Ms R, says that the family did not know about the fire at the time. After they had not seen CR on Saturday night, 21 November, his mother went to the police station. By this time CR had been remanded to Swansea Prison but the family say the police would not say where he was or why he had been arrested but only that he was OK. No-one had telephoned the family. Ms R said that CR may not have known family members' phone numbers without his mobile phone.

11.2. According to the police records, when he was detained at the police station, CR asked to telephone an uncle. We have not been able to locate CR's uncle to find out whether CR spoke to him at all from the police station or prison. When CR was admitted to prison, he named his mother as next of kin and gave a mobile telephone number for her. Prison staff assured us that CR would have been able to telephone his family when he arrived at Swansea Prison, and later. We have not been able to obtain any telephone records to see whether he made any telephone calls.

When CR was taken to hospital

11.3. CR's sister says the family only found out he was in prison on Wednesday 25 November, through a chance meeting with someone who had heard this from another prisoner. Nor did the family know until Saturday 28 November that

shortly after midnight on Thursday 26 November CR was taken from the prison to hospital.

11.4. CR was discharged from hospital in the morning of 1 December but taken back to A&E that night. The family knew nothing about him having cut his arms in the evening of Tuesday 1 December, or that he was later taken back to hospital. His sister told us that she noticed marks on his arms when she saw him after he had tried to hang himself but she said there was too much else to think about then and she hadn't asked about it. She asked why the family weren't contacted on Tuesday evening, 1 December.

Prison Service policy: family contact when a prisoner is ill

11.5. We asked members of staff about the circumstances in which the prison would contact a prisoner's family if he was taken ill. Officer F said that the prison would not inform a family about superficial cuts, but only if a condition was life-threatening.

Prison Rules and policy: the special rights of unconvicted prisoners
Unconvicted, Unsentenced and Civil Prisoners - Prison Service Order (PSO) 4600

11.6. CR was an unconvicted prisoner who was remanded to HMP Swansea pending trial in the Crown Court. Unconvicted prisoners are presumed to be innocent. They have certain rights and privileges over and above those accorded to prisoners who have been sentenced to custody after a conviction.

11.7. The Prison Service Order says that:

'instructions or practices that limit their activities must provide only for the minimum restriction necessary in the interests of security, efficient administration, good order and discipline and for the welfare and safety of all prisoners' (1.1)

11.8. Among other things:

- Next of kin: the prison should endeavour to identify whom the prisoner considers next of kin. In the case of serious illness, the prisoner should be asked whether he or she objects to next of kin being informed. The prisoner's wishes should be respected but encouragement and facilities to inform their next of kin should be given.

- Visits: an unconvicted prisoner is entitled to receive as many visits as he/she wishes, subject to requirements of security, operational need and practical considerations.

What happened in this case

11.9. CR's family were not informed that he had been taken ill and to hospital during the night of Wednesday/Thursday 25/26 November. When he arrived at the prison, CR gave his mother's name as his next of kin and gave her telephone number, but the personal details form was not completed properly so it was not clear whether he had consented to her being contacted (see paragraph 4.3). There is no indication that he was encouraged or enabled to inform his next of kin that he was ill.

11.10. According to the prison records, at 3.30am on Friday 27 November, CR was said to be demanding to phone his mother and sister and have them visit immediately. The next reference to his family is that on Saturday morning CR asked again to telephone his mother and sister. The bedwatch officers phoned the prison for advice, and permission was given to telephone CR's sister to tell her CR was in hospital. CR's mother asked the hospital if she could visit, then obtained permission for the visit from the prison. Family members visited on Saturday and Sunday.

The investigation's observations

11.11. When CR was taken to hospital by emergency ambulance and was in hospital from 25 November to 1 December his condition may not have been life-threatening but it was undoubtedly serious. The bedwatch officers were correct to seek authority from a prison Governor to inform CR's family that he was in hospital and to ask his mother to obtain permission for family members to visit. Though to families it may seem harsh, a hospital is not a secure environment and, for unconvicted as well as convicted prisoners, prison staff remain responsible for ensuring that prisoners do not escape. The initial risk assessment overnight stated that there should be no visits and no access to phones. That appeared to be the default setting. However, in our view, the prison should have reviewed the risk assessment on Thursday, the day CR was taken to hospital or, at the latest on Friday, after CR had asked during the night for his family to be contacted and allowed to visit. There should be a presumption in favour of informing next of kin when a prisoner is admitted to hospital, and as an unconvicted prisoner CR was entitled to unrestricted family contact so long as this was consistent with security.

11.12. When CR cut his arms on 1 December, a prison nurse cleaned the cuts, which were not deep, and that was not the reason CR was taken to hospital that evening. He was in A&E overnight, but, having returned to the prison, in the morning, he would have been able to telephone his family himself. However, family contact was part of the ACCT Immediate Action Plan and there is no evidence of any measures to encourage or facilitate this.

Protecting prisoners from self-harm

11.13. CR's sister and brother asked why he was not on 'suicide watch' and they described the kind of strip cell and clothing which is sometimes used to prevent people hurting themselves.

Protecting prisoners from self-harm - the investigation's observations

11.14. CR was on an ACCT Plan that required staff to check on him every hour but that did not prevent his self-harm. When it is clear that someone is determined to harm themselves, prisons will sometimes use physical means, such as placing them in an unfurnished cell or by special clothing to prevent this. That is used only briefly and in extreme circumstances where a prisoner is immediately intent on self-harm. Arguably, it is inhumane and degrading and it may have a negative effect on a prisoner's state of mind. From the evidence we have seen, there was nothing about CR's demeanour or behaviour to warrant any such treatment.

11.15. However, there are also 'safer cells' that, through design of the environment, reduce the opportunities for prisoners to tie a ligature. CR was able to tie a ligature to the bars of his cell window. As indicated in the disturbing letter from Prisoner 2, these offered an obvious ligature point. Moreover, the cramped and dingy cell with an only partly screened toilet was, in our view, not a decent environment. Prisoners are known to be at particular risk in their first days in prison. We question whether the cell we saw on B wing was a suitable environment for the induction wing. We understand that the induction wing is now to be located elsewhere but we have not visited it.

Family links as a protective factor against self-harm

11.16. It may be impossible always to prevent, through physical or environmental means, someone who is determined to end their lives. A prisoner's state of mind is the most important factor in preventing self-harm. It is arguable whether the prison should have notified CR's mother about his illness as next of kin but there is a broader point about family contact as potentially one of the most important ways of protecting prisoners from self-harm. It is not straightforward. Family relationships can be complicated and where prisoners are in a position to give consent their wishes should be respected. But by definition, prisoners are cut off

from the sources of support they can access in the community and family is potentially among the most important.

Prison Service policy: Prison Service Instruction PSI 64/2011

11.17. The importance of family links is recognized in the Prison Service Instruction on protecting prisoners from self-harm and also in the ACCT Plan document.

- ‘PSI 64/2011 states as a mandatory action that procedures must be in place to encourage family engagement in managing and reducing the risk of prisoners who self-harm (page 5)

- Among the factors identified as fundamental to reducing risk are positive family relationships (page 26)

- Consideration must be given to inviting family/next of kin to a case review where this is thought to be beneficial (page 28)

- Family contact is one of the factors to be considered in devising the CAREMAP (page 29)

- The ACCT Case review team must document in the Care Plan details of how the prisoner will engage with purposeful activity and contact with family and friends (page 34)

- Contact with home and the community may provide an important source of support and provide further information for staff. Contact should therefore be facilitated wherever possible and appropriate (page 34)

- HMPPS recognizes that '*strong support from families and friends can make an enormous difference to prisoners who are at risk of harm'* and *'successful engagement with families can reduce the risk posed by prisoners' (page 60).*

11.18. The action plan on the Concern and Keep Safe Form said that CR was to have access to phone calls to the Samaritans and to his family. Officer D said that he could have made phone calls if he had requested it.

11.19. In the assessment interview CR identified his mother, sister and a close friend as a 'reason for living' and a 'coping resource'. Yet there was no reference in the CAREMAP to engaging family support.

The new ACCT document

11.20. At the time of our investigation Swansea was testing a new ACCT form as part of a pilot scheme. The Head of Safer Custody commented that it highlights consideration of contacting families. One page of the form is for a 'Nominated Support Source'. The Case Manager is required to check next of kin or other personal contact details when a new ACCT Plan is opened and at least monthly while it is in use. In the case review summary, the Case Manager has to say whether the person at risk has consented to involving a family or friend, whether the family has been given the opportunity to engage in the review, and to summarise actions taken to encourage family involvement. The Head of Safer Custody said that it was necessary to take care in involving family. In some cases, family relationships could be a negative factor, and it was necessary to be cautious about inviting a family member to a case review, but talking to family members could be enormously effective.

The care given to CR after his life-threatening self-harm

11.21. The family asked the investigation whether the attempts to resuscitate CR were in line with professional standards.

11.22. From our investigation, we find that the paramedics from the ambulance service took the lead after the first 20 minutes and the Clinical Reviewer to the investigation considers that prison staff provided appropriate and timely emergency care reflecting the standards outlined in the UK Resuscitation Council guidelines.

Liaison with CR's family after his self-harm

11.23. CR's sister said that a prison governor came to see the family at the hospital. He asked if they had any questions. They asked how CR had been in the afternoon, and what he had used to hang himself, but the governor did not know the answers so there was no point in him seeing them. No-one gave them any more information. Ms R had no knowledge of any Family Liaison Officer.

11.24. In 2015, Senior Officer P was in charge of resettlement at the prison and also acted as the prison's Family Liaison Officer (FLO). He said that the Resettlement Unit was required to nominate a member of staff for family liaison. He had arranged a course for a member of the team but they then learned that, at that time, the FLO had to be a senior officer and Mr P was the only senior officer available.

11.25. The prison was unable to locate a Family Liaison log. Mr P was not certain whether he had completed a log at the time but he reconstructed a record from his notes. Mr P said he was told what had happened to CR at 8am on Friday 04 December. He spoke to CR's mother at 10.30am and asked if he could meet her, wherever was convenient. He met CR's mother, sister and other members of the family at 1.35pm at the hospital for a quarter of an hour. He gave them his contact details,

asked if they had any questions and invited them to contact him later if they wished. They did not get in touch with him again, but after CR was discharged from custody Mr P arranged to take his property to his mother's home. The family had welcomed him and he had not felt there was any ill feeling.

Prison Service policy on family liaison after serious self-harm

11.26. Prison Service Instruction PSI 64/2011 which contains the Prison Services policies on safer custody emphasises the importance of family relationships in preventing self-harm, and also gives guidance on engaging with families where a prisoner is seriously or terminally ill, and after a death in custody. Prisons are required to have a nominated Family Liaison Officer to be a named point of contact for families if a prisoner has died in custody. There is no requirement as to the grade of the member of staff appointed to this role. There is a training course for family liaison officers but it is not mandatory. An FLO must be supported either by the Safer Custody Team Leader or through line management. In the case of the death of a prisoner, before meeting the family the FLO must be familiar with the details of the death and the prisoner's history.

Findings

11.27. The disclosure of information declaration on CR's personal summary sheet form was not completed properly on his admission to the prison so it was not clear whether CR had expressed a view about whether his family should be informed in an emergency.

11.28. It was only on his third day in hospital that at CR's request his family were informed he was in hospital. CR had asked before when he was in an agitated state for his family to be allowed to visit. A risk assessment should have been conducted on his first day in hospital and contact with his family facilitated and encouraged. As an

unconvicted prisoner CR was entitled to unrestricted family contact so long as this was consistent with security.

11.29. It was not unreasonable that the family were not informed when CR spent a night subsequently in A&E.

11.30. There was nothing in CR's behaviour or demeanour to suggest that he should have been placed in an unfurnished cell or in restrictive clothing to prevent him hurting himself. These are emergency measures used briefly in crisis and can be counter-productive.

11.31. However, the cramped and dingy cell with an only partly screened toilet and conspicuous window bars is not in our view a decent environment, especially for new prisoners.

11.32. Prison Service policy recognizes the importance of families in protecting prisoners from self-harm. Wing officers had seen CR's interaction with his family when he was in hospital and knew them to be supportive. CR told the ACCT assessor that family members were a resource and a reason for living.

11.33. The Immediate Action Plan and the ACCT document referred to telephone access to family but with no measures in place to encourage or facilitate it. The plans were too passive. Many prisoners have low expectations of staff's willingness to help them and left to themselves will 'keep their heads down'. It is not safe to assume that if a prisoner wants something he or she will take the initiative and ask for it. This is especially so if the prisoner is in poor health or at risk of self-harm.

11.34. Prison Service policy goes further and requires that ACCT review panels should always consider whether there is scope for actively involving families, must facilitate family contact wherever appropriate, and must document what

arrangements are made for the prisoner to have contact with family. There is no evidence that this was done in CR's case.

11.35. The Clinical Reviewer to the investigation has confirmed that prison staff provided appropriate and timely emergency care in compliance with professional standards.

11.36. The family say that the Family Liaison Officer was unable to answer their questions. When a prisoner dies in custody, Prison Service policy requires a Family Liaison Officer to be nominated and before meeting the family the Family Liaison Officer must be familiar with the circumstances and the prisoner's history. It should be made clear that similar considerations apply where a prisoner suffers life-threatening self-harm.

11.37. We recommend that Swansea Prison considers the selection, appointment and training of a Family Liaison Officer as a member of the Safer Custody Team to promote engagement with families as part of the ACCT scheme, to monitor the operation of this in practice, and to report periodically to the safer custody meeting.

11.38. Maintenance of family ties is a factor in reducing reoffending and in resettlement of prisoners. The Family Liaison Officer in the Safer Custody Team might work in conjunction with appropriate staff in the Offender Management Unit to develop opportunities for prisoners to have constructive involvement with their families during their imprisonment.

CHAPTER TWELVE: THE PRISON'S INVESTIGATION

12.1. Prison Services policies require that the circumstances of any serious incident must be investigated to establish the facts, to learn from them, and to establish any accountability.

Reports at HMP Swansea after CR's self-harm

Report to the Duty Governor

12.2. At 04.55am on 04 December 2015 the Night Orderly Officer, Senior Officer M who attended and assisted at the scene and who was the most senior member of staff in the prison overnight sent a report of the night's events to the Duty Governor. During our investigation, Mr M provided some emails from staff members which formed part of the basis for his report (see paragraphs 7.45, 8.4 and 8.6).

12.3. As well as his report to the Duty Governor, Mr M completed a Serious Self-Harm Incident Questionnaire and a Fact-Finding Report. Both these documents are completed to templates provided by HMPPS.

Serious Self-Harm Questionnaire

12.4. In the questionnaire, Mr M identified, as possible triggers for CR's distress, alcohol withdrawal, loss of his partner and being concerned over being in custody as a gay man. He confirmed that there had been an open ACCT Plan for CR, which required observations hourly.

Fact-Finding Report into a Serious Self-Harm and/or Assault Incident

12.5. The Fact-Finding Report contains similar information to Mr M's report to the Duty Governor on the night of CR's self-harm but also some additional information. As

background, the report states that CR was in custody for *'arson with intent'*, that it was his first time in custody, and that there were warnings on his PER for violence, suicide and drugs.

12.6. In the section of the form for any information about possible reasons or triggers, the report sets out the summary of CR's ACCT case review. It goes on to say that it is too early to say if there are issues to be identified or lessons to be learned, and the police findings are awaited.

12.7. Mr M's report concluded that, from the case notes and support offered to CR, he was confident that good practice had been followed, that CR was looked after to the fullest abilities of staff, avenues of support were offered, a care plan followed and healthcare involved in his care. He made no recommendations.

12.8. On 8 December, the questionnaire and fact-finding report were sent by the Swansea Safer Custody Team to the Equality, Rights and Decency Group of HMPPs Headquarters.

Prison Service Policy on investigating serious incidents - Prison Service Order (PSO) 1300 Investigations

12.9. The Prison Service Order says that whenever an incident takes place the circumstances of the incident must be assessed by the appropriate manager who will determine whether and how the incident will be investigated (paragraph 1.1 and 1.2.1).

12.10. The level of investigation into an incident must be decided by line management based on a judgment of its nature, seriousness and how much is known about its circumstances. If the incident resulted in serious harm to any person, formal investigation will be necessary. Formal investigations are managed through HMPPS Professional Standards Unit's Investigation Support Section. Normally the

investigation will be carried out by a local team but the investigation must be registered with the Investigation Support Section who can advise on procedure and who undertake analysis of findings, recommendations, and the quality of reports.

12.11. The Prison Service Order says that any inquiry by the police into a serious crime will have primacy, so that an internal investigation does not prejudice that inquiry or the fair conduct of any subsequent prosecution, but the Prison Service investigation must continue unless the police consider its continuation likely to compromise an investigation of serious crime and request its suspension.

Investigations and learning following incidents of serious self-harm or serious assaults - Prison Service Instruction PSI 15/2014

12.12. There are special requirements for investigating incidents of serious self-harm. The Instruction says the aim of this policy is to ensure that all reportable incidents of serious self-harm and serious assaults are followed up so that learning is identified and disseminated, and to ensure that, when required, an independent investigation is commissioned which meets the requirements of the State’s investigative obligations of Article 2 of the European Convention on Human Rights.

12.13. The Instruction lists mandatory actions for Governors, including:

- That all the relevant staff are aware of the requirement to investigate the circumstances of incidents of serious assaults and serious self-harm.

- That all such incidents are reported to the National Operations Unit (now called the Incident Management Unit), and investigated at an appropriate level.

- That when requested by HMPPS Equality, Rights and Decency Group (ERDG), a questionnaire on serious self-harm is complete and returned within three

days of the incident being reported. Where ERDG indicates that an independent investigation may be required all documentation relating to the prisoner involved in the incident must be retained.

- In all cases in which a questionnaire was returned to ERDG, Governors must ensure that a copy of the investigation report is submitted to ERDG not later than one week after the investigation is completed.

- The Governor must ensure that an appropriate level of investigation is commissioned and that any lessons are learned. In circumstances where the harm to self or others may cause long-term serious injuries to the prisoner concerned, advice on the appropriate level of investigation should be sought from the ERD Group.

- Governors are required to put in place local procedures to facilitate and disseminate learning from incidents of self-harm to prevent future occurrences and improve delivery of safer custody. Analysis of self-harm incidents may show patterns in time, place, method and triggers. Regular consultation with staff on safer custody matters is also recommended as a complement to data analysis.

What happened in this case

12.14. There was no further investigation of CR's self-harm by Swansea Prison beyond the reports completed by the Orderly Officer. The Duty Governor on the night, who was Head of the Offender Management Team at the time, said he would have reported to the daily morning meeting of managers and that he would have expected the Safer Custody Team to gather the paperwork together and either the Governor or Deputy Governor to commission a further inquiry if one was required.

12.15. Nor were any staff members asked to make statements other than the brief emails sent by the two officers who attended to CR in his cell and the OSG who was the last member of staff to see him before the incident. There was no broader investigation into CR's management in the prison before his self-harm except for reporting the summary of the ACCT review.

12.16. We saw the Safer Custody Meeting minutes for 10 December 2015. The meeting was attended by five members of staff: the Head of Residence Safety, the Head of Learning and Skills, Mr M, who was the Night Orderly Officer on the night of CR's self-harm, and was designated Custodial Manager for Safer Custody, a representative of the Stop the Smoking Campaign and a minute taker from the Safer Custody Team. There were apologies from 10 people, including the Samaritans, who protested that the date of the meeting had been changed at the last minute. The minutes reported two recent serious attempts by prisoners to take their own lives but gives no information about the circumstances. Data analysis was said to be unavailable for the meeting.

12.17. We asked whether the Equality Rights and Decency Group at HMPPS Headquarters had given any advice to HMP Swansea on receipt of the fact-finding report. We were told that in August 2016 the Safer Custody Casework team wrote to the Governor of the prison to notify him that it was monitoring CR's injuries and had identified his case as one likely to require an independent investigation. The Governor was asked to satisfy himself that sufficient steps had been taken to investigate the incident internally.

12.18. Our investigation was commissioned in September 2017. The prison provided in a secure and orderly form most of the documents we required but this did not include everything we wanted to see. Because of the passage of time some documents that had not been retained were no longer available. In the absence of statements made at the time, staff whom we interviewed were often relying on distant memory.

Findings

12.19. The prison knew from the hospital on 4 December that the prognosis for CR was grave and he was unlikely to recover. Contrary to Prison Service Instruction PSI 15/2014 there was no follow-up to CR's self-harm to see whether there were lessons to be learned. There was no examination of CR's management before his self-harm and no consideration of why the ACCT Plan was insufficient to protect him. No staff were asked to make statements. There was no examination of what was known about CR's history of self-harm. Healthcare staff were not consulted.

12.20. A Senior Manager should have commissioned a systematic inquiry by someone who was not involved in CR's care or the incident, to examine the care and management of CR before his self-harm, including input from healthcare, and to advise on any lessons to be learned. Prison Service Order 1300 requires that this should have been a formal investigation registered with the Investigations Support Section at HMPPS Headquarters.

12.21. The police investigation may have inhibited the prison from investigating immediately although there is no evidence that this was considered. However, the police investigation would not cover wider questions about preventing self-harm and the prison should have liaised with the police to progress its own investigation without compromising the police enquiries.

12.22. The advice from Prison Service Headquarters in August 2016 came too late for the prison to remedy the failure to take statements from staff immediately after CR's self-harm.

CHAPTER THIRTEEN: SAFER CUSTODY AT HMP SWANSEA

Reports by Her Majesty's Chief Inspector of Prisons

Unannounced inspection of HMP Swansea in October 2014 (HMIP 2014)

13.1. In an unannounced inspection a year before CR's self-harm, the Inspectorate comment in their summary of safety at Swansea Prison that both the number of ACCT plans and the incidence of self-harm were low for a local prison, but in the six months before the inspection there had been several serious incidents of self-harm by prisoners in their early days in custody and the Inspectorate was not assured that the prison was sufficiently aware of this or their pattern (HMIP 2014, page 11, paragraph S5) Most related investigations undertaken by the prison were inadequate. The safer custody meeting discussed a range of data but analysis of incidents was insufficient and the resulting action points often remained unresolved. (HMIP 2014, page 22, paragraph 1.23).

13.2. The Inspectorate found that the quality of ACCT documents was poor: initial assessment interviews did not always take place within 24 hours; assessment of risk did not always take previous self-harm history into account; CAREMAPS did not always reflect need. The content of many staff entries did not demonstrate a good level of care. Overall the quality of ACCT documents was poor. Despite this, prisoners on ACCTs with whom the inspectors spoke were positive about the support they had received, and access to Listeners was good (HMIP 2014, page 22, paragraph 1.24).

13.3. Since the previous inspection, in 2011 there had been four self-inflicted deaths, all within three weeks of the prisoner's arrival, and not all the recommendations from death in custody reports had been acted on or routinely reviewed (HMIP 2014, page 11 paragraph S5).

13.4. HMIP recommended that:

The prison should thoroughly investigate all serious incidents of self-harm, and act on learning points and recommendations. It should implement learning points from recommendations in Prisons and Probation Ombudsman death in custody reports, and review them regularly (HMIP 2014, page 17, paragraph S38).

This was one of HMIP's five 'Main concerns and recommendations'.

13.5. The Inspectorate found that support for gay, bisexual and transgender prisoners was limited, and the equality team did not maintain figures for this group. However, gay prisoners whom the inspectors spoke to were positive about their experience of Swansea (HMIP 2014, page 34, paragraph 2.24). Another Main Recommendation was that the needs of prisoners with protected characteristics should be promptly identified and met through individual assessment, regular direct consultation with minority groups, effective care planning and monitoring. (HMIP 2014, page 17, paragraph S40).

Unannounced inspection of HMP Swansea in August 2017 (HMIP 2017)

13.6. HMIP inspected Swansea again in August 2017. They found a deterioration in some areas. There had been four further self-inflicted deaths, all within a week of arrival, but significant recommendations by the Prisons and Probation Ombudsman relating to ACCT and early days procedure had not been implemented. The rate of self-harm had increased threefold since the previous inspection, with 134 incidents in six months in 2017, though it was recognized that the ready availability of illicit drugs was having a significant impact. ACCT documentation was poor and much more needed to be done to analyse and understand what lay behind the suicides and self-harm in the prison. Initial risk assessment arrangements and early days support were weak. None of the Main Recommendations from the previous inspection had been achieved (HMIP 2017, page 5 and page 11).

13.7. HMIP recommended that all newly arrived prisoners should have a private interview to help identify vulnerability and risk, followed by systematic support during their early days in the prison. There should be rigorous support for prisoners identified as being at risk of self-harm and PPO recommendations should be implemented in full (HMIP 2017, page 16, paragraph S43).

13.8. HMIP noted that most prisoners reported good relationships with staff. Many officers engaged positively with prisoners and had an appropriate interest in their welfare (HMIP 2017, page 13, paragraph S15)

13.9. Prisoners who were on ACCT Plans again spoke positively about the support they received. However, the inspectors found deficiencies similar to those in 2014. ACCT documents did not indicate consistent and well planned care and the overall quality was poor. Many staff entries were perfunctory and predictable. Risk assessment was weak and some care maps did not reflect needs. There were no management checks of ACCT documents. The monthly safer custody meeting did not cover all areas of concern and analysis of incidents was inadequate (HMIP 2017, page 21, paragraph 1.20).

13.10. The management of equality and diversity work was improving. An officer had been appointed to work exclusively on equality. The identification of prisoners' protected characteristics was good. The equality officer saw most new prisoners shortly after arrival and gathered data on their protected characteristics. The equality policy was underpinned by a good action plan. Equality meetings were held every two months. Nine prisoners acted as equality representatives, who promoted equality work, helped prisoners to report discrimination, and encouraged them to disclose protected characteristics to the equality officer. (HMIP 2017, page 31, paragraphs 2.17-2.18).

What Swansea Prison told the investigation

13.11. We have seen the prison's action plan on HMIP's recommendations as it stood in February 2019. This indicated that some action had been taken on all the recommendations about prisoner safety.

13.12. The present Head of Safer Custody at Swansea was appointed after the 2017 inspection to improve this area of work. He told us that from his initial scrutiny of ACCT documentation coupled with conversations with prisoners he considered that the documentation did not do justice to the level of care that most staff delivered.

13.13. The new Head of Safer Custody introduced named case managers to achieve continuity, and a quality assurance system for checks on ACCTs, namely, 72 hour management checks on all new ACCTs, with daily checks by Duty Governors and a minimum of 10 per cent of ACCTs checked when they were closed. Safer Custody Meetings took place every month. They were now well attended and considered data on self-harm every month and trends over a year. This was supported by the minutes of the Safer Custody Meetings for 2017 that we examined.

13.14. The Induction Unit was moving from B wing to a newer building and the Head of Safer Custody would have managerial responsibility for it. A wellbeing coordinator had been appointed and there was an increase in counselling available for prisoners.

The Prison Officers' Association

13.15. We discussed with representatives of the Prison Officers' Association the operation of the ACCT scheme. They expressed a particular concern that ACCT case managers were appointed randomly to equalise workloads regardless of where they worked in the prison and the prisoner's location. In their view, case managers should be

from the prisoner's wing so that there was daily contact and they could build a relationship. Moreover, the fact that a case manager might have responsibility for prisoners on several wings, and work elsewhere meant that they were not well placed to ensure that actions in the CAREMAP were followed up. They said that, in practice, this meant that actions were likely to be chased up only at case reviews.

13.16. Prison Service Instruction PSI 64/2011 says that the first case review must

'*Be attended and chaired by the Residential Manager, or equivalent and/or the Case Manager (if different), the Assessor, whenever possible, a member of staff who knows the prisoner e.g. wing officer, the person who raised the initial concern, healthcare, and any other member of staff who has or will have contact with the at-risk prisoner and who can contribute to their support and care….The review should be timely and not unduly delayed to ensure full attendance*.' (Page 27).

13.17. We also spoke to the POA representatives about the quality of entries in the record of events in ACCT documents, many of which seemed uninformative and formulaic. The representatives commented that if the ACCT check was in the evening or overnight or at any other time when prisoners were locked in their cells, any conversation would take place through the hatch and in the presence of the other occupant of the cell, which would only serve to highlight his vulnerability to other prisoners.

Staff training - First Aid

13.18. Officer F, who assisted at the scene of CR's self-harm, had worked as a prison officer for 15 years. He said he was not first aid trained. Officer E, who also assisted at the scene joined the Prison Service in May 2015. He said he was first aid trained from a previous employment. Mr M, the Night Orderly Officer was a trained first aider. The Head of Safer Custody told us that the Orderly Officers – the

most senior uniformed officer on duty in any shift - must be a trained first aider but there is no requirement for all staff to be first aid trained.

13.19. Prison Service Instruction PSI 29/2015 sets out the requirements for First Aid provision in prisons. Trained first aiders must hold an up-to-date, valid certificate of competence in either First Aid at Work (FAW) or Emergency First Aid at Work (EFAW). FAW training includes EFAW and also equips the First Aider to apply First Aid to a range of specific injuries and illnesses. EFAW training enables a first aider to give emergency First Aid to someone who is injured or becomes ill in the workplace. HMPPS in-house trainers must be trained and currently certificated as competent First Aid trainers. Training for trainers must only be delivered through a national commissioned arrangement through Civil Service Learning. No other competency training will be recognized and the trainer must attend refresher training and requalification training as required by recognized UK standards and Civil Service Learning.

13.20. In prisons, at all times of day and night there must be at least one FAW trained staff member and sufficient numbers of EFAWs to provide emergency first aid to staff prisoners and others, the number to be determined by the local first aid risk assessment. Staff told us that it is not unusual for there to be more than one incident at the same time in the prison overnight, and it cannot be assumed that the night duty nurse will be able to attend in every case. Overnight staffing levels are low and reduced still further if night shift staff have to escort a prisoner to hospital.

13.21. The Clinical Reviewer has noted a concern that there appeared to be no clear process for monitoring the completion of resuscitation training by healthcare staff (paragraph 10.34).

Findings

13.22. Some of the concerns identified by HMIP reflect concerns that we have expressed about the management of CR's risk of self-harm in Swansea Prison. The 2014 inspection identified inadequate investigation of incidents of self-harm and inadequate interrogation of data by the safer custody meeting to identify any patterns and trends. Initial assessments did not always take place promptly. Self-harm history was not always taken into account. CAREMAPS did not always reflect need. Staff entries in ACCT records were often uninformative. In 2017, deficiencies identified in the previous inspection had not been remedied and initial risk assessment was weak.

13.23. In CR's case, the staff responsible for his management on the wing, and the ACCT assessor and review panel were unaware of his recent attempts to kill himself. The support identified in the CAREMAP was limited and mainly formulaic. After CR's life-threatening self-harm there was no examination of the surrounding circumstances, and the safer custody meeting showed no curiosity. We also know that there was poor communication between healthcare and discipline: CR's self-harm two days before his attempted hanging, and the opening of an ACCT Plan at that time, were not noted in the clinical record.

13.24. We have been assured that action has now been taken on all the recommendations of the Inspectorate about safer custody. It is beyond the scope of this investigation to verify how effective those changes are but it may be a useful exercise, under the direction of the Governor, for appropriate managers to consider each of the deficiencies we have identified in the case of CR, and to test whether there are now robust arrangements in place that will prevent similar shortcomings in future. We have made recommendations accordingly.

13.25. We note HMIP's comments in the 2014 and 2017 reports on equality and diversity. As part of our investigation, we spoke to CR's sister and to all the staff who were

interviewed about CR's reported concern about being a gay man in prison. This was identified as a concern by the ACCT assessor and the case review panel. CR's sister told us that CR was comfortable and open about his sexuality. Most of the staff we spoke to said they had no recollection of CR being gay. We have not found any evidence to indicate that CR's sexuality or any adverse treatment by staff or other prisoners was a factor in his self-harm.

13.26. We note the observation of the POA representatives that because of workload and logistics ACCT case managers may have no prior knowledge of the men whose ACCT plans they manage and no routine involvement with their daily life. In this case, the assessor and the case manager both worked in the Offender Management Unit. The only other member of the panel was a nurse. We have noted elsewhere that none of the staff who knew CR from his wing or from the bedwatch took part in the review.

13.27. We understand the pressures on prison staffing levels, and we were impressed with the diligence and sensitivity of the case manager and the assessor, but, in our view, as a minimum, the case review should include a member of staff from the prisoner's wing with whom the prisoner is familiar, who knows something of the prisoner's daily life and who can provide continuity between reviews.

13.28. We note that it is for Governors to determine on the basis of a local risk assessment the number and deployment of staff accredited to administer emergency first aid. We think it important that adequate and up-to-date provision is maintained and that this is regularly reviewed.

ANNEX ONE:

THE PROCEDURE THAT THE INVESTIGATION HAS FOLLOWED

Article 2 of the European Convention on Human Rights

1. I am required to conduct the investigation in compliance with Article 2 of the European Convention on Human Rights. Article 2, which safeguards the right to life, can require the State to mount an independent investigation when someone in custody suffers life-threatening self-harm.

2. In compliance with Article 2, the investigation will be independent, open, transparent and even-handed, and will provide an opportunity for CR, or those who can represent his interests, to participate in the investigation.

3. My objective is to ensure as far as possible that the full facts are brought to light and that lessons learned may save others from similar suffering.

4. The investigation will not consider any question of criminal or civil liability.

The investigation team

5. I will be assisted in the investigation by Andy Barber, as Assistant Investigator, and by the Personal Assistants to the Article 2 Secretariat.

6. The investigation may commission a suitably qualified health professional to provide clinical advice.

The investigation process in outline

7. The investigation will examine documents, establish relevant lines of inquiry, prepare a chronology, and identify relevant witnesses. Interviews with witnesses will be held in private. They will be recorded and transcribed. Documents and transcripts will be made available to the interested parties to enable them to participate in the investigation but are not for publication. Documents and interview transcripts may be quoted or referred to in the investigation report, which will be a public document and will be made available on the website of the Independent Advisory Panel on Deaths in Custody. Unless there are exceptional circumstances, individuals will not be named in the final report.

8. The investigation wishes to meet representatives of CR's family at an early stage to consult them about how CR's interests may be represented in the investigation.

9. Introductory visits and meetings may also be held with others, including the other interested parties.

The interested parties

10. The interested parties to the investigation are CR, through his family, Her Majesty's Prison and Probation Service, and the Abertawe Bro Morgannwg University Health Board. The Health Board is the current provider of healthcare at HMP Swansea but at the time of the events with which the investigation is concerned the Prison Service was responsible for healthcare at the prison.

11. Anyone else who considers they have a special interest in the proceedings or outcome of the investigation may ask me to consider granting interested party status.

Evidence

12. The investigation requests interested parties and anyone who holds documents that may be relevant to supply those documents to the investigation. The investigation may request further documents and/or oral evidence from the interested parties or other persons whom it considers hold relevant material.

13. The investigation makes a presumption that relevant documentary and oral evidence will be shared with interested parties, and with others where that is necessary for the conduct of the investigation. However, there are some circumstances where, exceptionally, documentary evidence may be redacted or withheld.

14. The terms of the investigation's commission stipulate that the Secretary of State may require redaction of documents on the basis of security, relevance or other sensitive matters before onward transmission to interested parties or others.

15. Where a witness or any other person considers that any part of a document, transcript, statement or other material they have provided should not be disclosed, he or she should inform the investigation of the reason for this view when the document or statement is provided. If any material which the investigation considers relevant is redacted by the Secretary of State or withheld at the reasonable request of a witness, the investigation will disclose to the interested parties the fact that material has been redacted or withheld and the reason for this.

16. The investigation may undertake interviews with witnesses it considers relevant. Witnesses will be provided with a written explanation of the investigation, terms of reference and the purpose of the interview. The investigation will have regard to the need for witnesses to have the means and opportunity to obtain support and representation if necessary. All the persons approached will be directed to the issues about which it is considered they may have relevant evidence. They will be supplied with copies of documents that are relevant. Interviews with witnesses will be recorded and transcribed.

Draft report

17. The investigation report will be made available in draft to the interested parties in confidence so that any factual inaccuracies may be addressed and any comments considered before final submission to the Secretary of State.

18. Any person who may be criticised in the investigation report will be given advance disclosure of the criticisms and be given the opportunity to respond before the report is finalised.

Final report

19. The investigation Report will be presented simultaneously to the parties, subject to appropriate redaction if necessary. It will be a public document and will be published on the website of the Independent Advisory Panel on Deaths in Custody but without the documentary and witness evidence.

20. The final report will not contain the proper names of any persons unless the investigation considers that, exceptionally, any individuals need to be named for the purposes of Article 2, for example, because that person has been involved in serious wrongdoing. If I am minded to name any individuals in the report for this or other reasons I am required to write to the Secretary of State in advance giving reasons.

Barbara Stow
Independent Investigator