REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Police Minister, Home Office** **2. Governor of HM Prison, Cardiff**
1	**CORONER** I am Christopher John Woolley, Assistant Coroner, for the Coroner area of Cardiff and the Vale of Glamorgan
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 26th September 2013 I commenced an investigation into the death of Christopher Shapley aged 42. The investigation concluded at the end of the inquest (held with a jury) on 6th March 2014. The medical cause of death was: 1A Hanging. The jury delivered a narrative conclusion. They found that Christopher Shapley had hanged himself but that his intentions in doing so were unclear.
4	**CIRCUMSTANCES OF THE DEATH** Christopher Shapley was arrested by the police in the early hours of 17th September 2013. He was taken soon after arrest to Prince Charles Hospital, Merthyr for alcohol withdrawal symptoms and fitting. He was certified fit to be interviewed and charged on the 18th September. He was charged with a number of offences against his mother, including threats to kill and possession of an offensive weapon. On the 19th September 2013 he was remanded in custody from Pontypridd magistrates' court on being sent for trial and taken to HMP Cardiff. The magistrates sent a "self-harm" warning form with the warrant to the prison. The "Person Escort record" was sent with him, but a form which a police officer had stapled to the PER form giving advice as to the risk factors had become detached prior to arrival in prison and was not seen by the prison. On arrival at the prison Christopher Shapley was screened by reception, and then by the health care assistant. In evidence the health care assistant conceded that she had not picked up on the fact that Christopher Shapley was on remand for domestic violence offences and said she had never seen the "self-harm" form. Her main concern was alcohol withdrawal. She was not aware (and no one in the prison was aware) that Christopher Shapley had been admitted to Prince Charles hospital after arrest. Christopher Shapley was then seen by the reception prison officer who was aware of the self-harm form and the alcohol withdrawal but conceded that he had not picked up on the fact of domestic violence. Christopher Shapley was then taken to the wing where he was interviewed by a trusted inmate and by a further prison officer. It was noted that there was a recommendation that he should be in a shared cell because of his alcohol withdrawal. The prison officer on duty did not have the full documentation but only the "Cell sharing risk assessment" and the "first night suicide" form completed by the previous prison officer. He noted the recommendation that Christopher Shapley be put in a shared cell for "detox". Christopher Shapley was however a non-smoker and no other non-smoker

	could be found to share with him. He was therefore put into a cell alone. This decision was made by the officer on duty on the wing that evening. No special checks were carried out on him during the evening and night. The night staff were not made aware that he was a first time prisoner, that he was on remand for domestic violence offences, and that he was suffering from alcohol withdrawal. He was found hanged on the morning wing checks on the 20th September 2013.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – **For the Police Minister, Home Office** **(as the PER form is a national form and the re-design of this form a matter for the Home Office)** (1) The jury found it of concern that the information that Christopher Shapley had been in Prince Charles Hospital after arrest was not known to the prison. Had it been known his condition may, they felt, have been treated more seriously and he would have been kept under greater observation. There would seem to be no reason why the PER (Person Escort Record) could not contain a section dealing with medical or hospital treatment received while in police custody prior to remand (e.g. the section at the foot of page 2 could also include a prompt for any health treatment received). This information will not only advise prison staff of the current medical circumstances of the prisoner but will also prompt them to call for any hospital discharge notes (or consult with the Force Medical Examiner) so that effective treatment can be continued. (2) The PER form had a number of staple holes where extra documents had been attached. It is evident that one of these documents was a warning form prepared by a police officer enumerating the risk factors affecting Christopher Shapley. This document would have been of material assistance to the prison staff, but had become detached before it reached them. A system of stapling documents to the PER is prone to human error and accidental detachment. It would appear possible for a system to be devised that ensured that any such warning form should stay securely with the PER. **For HM Prison Cardiff** (1) The Health Care Assistant who interviewed Christopher Shapley conceded that she did not look at all the pages in the PER and that she had never seen the "self-harm" form sent by Pontypridd magistrates court (and had never in fact seen any such form in all her experience in the prison). Had she seen and recognised the importance of all this information her assessment would have been broader and she would have taken into account all the risk factors rather than just alcohol withdrawal. (2) The reception prison officer was aware of the self-harm form and the alcohol withdrawal risk factor but relied heavily on the interview with Christopher Shapley in determining his care. Reliance on interview by prison staff, rather than undertaking a balanced assessment of all the known risk factors, was a feature of the evidence before the jury. The jury did however find that it was appropriate not to have raised an ACCT. (3) Despite the recommendation that he be put in a shared cell because of his alcohol withdrawal no non-smoker could be found to share with him and therefore the decision was made to put him in a cell alone. The jury found that insufficient efforts had been made to find a suitable prisoner to share with him. The jury was told that it is very rare to find a non-smoking prisoner and that it was against the regulations to ask a trusted inmate to share and desist from smoking. The risks to a first night prisoner alone in a cell with identified risk factors however go well beyond health and safety concerns and a reasoned recommendation that such a prisoner be in a shared cell should not be defeated by practicalities. (4) The jury were concerned that the handover arrangements for Christopher Shapley were not adequate to identify him as a prisoner who might benefit from increased observations, and that formal regular checks should have been put in place during the

	night. The jury were told of new arrangements that had come into force very shortly after Christopher Shapley's death (such as an A4 warning sheet on the cell door of every first night prisoner). The risks to vulnerable prisoners such as Christopher Shapley have been highlighted in a number of previous reports from the Cardiff Coroner to HMP Cardiff (e.g. into the death of Andrew Paul Hawkins – inquest 12th and 14th June 2012) and such arrangements should be robust and permanent.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that (1) The Police Minister, Home Office and (2) The Governor of HM Prison Cardiff have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th April 2014. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] I have also sent it to the following persons: 1. HM Inspectorate of Prisons 2. HM Inspectorate of Constabulary 3. South Wales Police 4. National Offender Management Service 5. Independent Advisory panel on deaths in police custody 6. Prisons and Probation Ombudsman 7. Independent Police Complaint Commission 8. HM Treasury Solicitors I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**11th March 2014** **C J Woolley** **Assistant Coroner, Cardiff and the Vale of Glamorgan**