Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Benjamin Donnelly, a prisoner at HMP Cardiff, on 20 December 2022

A report by the Prisons and Probation Ombudsman

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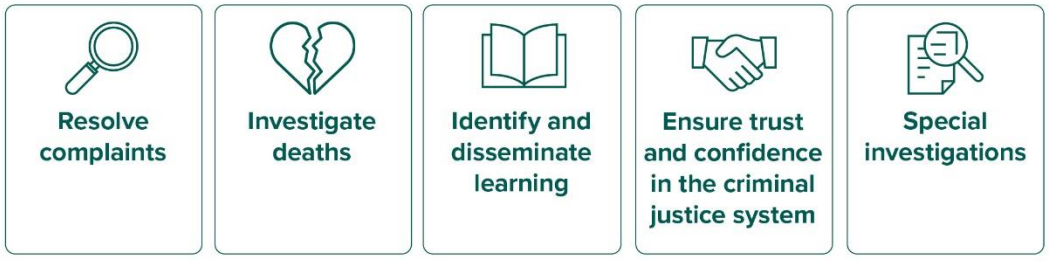
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Benjamin Donnelly was found hanged in the F Wing laundry at HMP Cardiff on 14 December 2022. He died a week later in hospital. He was 39 years old. I offer my condolences to Mr Donnelly's family and friends.

There were seven self-inflicted deaths at Cardiff in the three years before Mr Donnelly died.

The day before he was found hanged, Mr Donnelly was sentenced via video link to an extended determinate sentence of five years. He had been in prison for short periods before for similar offences and he was not expecting such a long sentence. His telephone calls that day showed his shock and distress at the outcome. We found no evidence that Mr Donnelly was suicidal before he was sentenced.

In March 2021, the Director General of HMPPS required all prisons to introduce local guidance to ensure prisoners attending court via video link are adequately risk assessed. Mr Donnelly's is the fifth death since then in which my office has found that the relevant prison did not have a local policy as required, and that there was none or inadequate risk assessment of prisoners following video court appearances. I make a national recommendation to ensure consistency across all prisons.

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

Adrian Usher
Prisons and Probation Ombudsman **June 2025**

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Summary

Events

1. Mr Benjamin Donnelly had a history of anxiety, depression, alcohol misuse and substance misuse. He had a number of previous convictions for violence against family members and partners and had served several short prison sentences.

2. On 15 October 2022, Mr Donnelly was arrested for assaulting his mother at her home while under the influence of alcohol and drugs. He appeared at Cardiff Magistrates Court on 17 October and was remanded to HMP Cardiff the same day.

3. On 18 October, the prison identified Mr Donnelly as a domestic violence perpetrator and therefore suitable for offence-related monitoring of his prison telephone calls and mail.

4. On 13 November, Mr Donnelly pleaded guilty and was convicted at Cardiff Crown Court. On 18 November, a prison offender manager reviewed the monitoring of Mr Donnelly's telephone calls and mail and decided monitoring should stop.

5. On 13 December, Mr Donnelly appeared at Cardiff Crown Court via video link. He was sentenced to an extended determinate sentence of five years, comprising four years in custody and a year on licence. This meant that Mr Donnelly would be able to apply to the Parole Board for release two thirds of the way through his four-year custodial term.

6. An officer was present when Mr Donnelly was sentenced and took him back to his cell afterwards. He said Mr Donnelly was quieter than usual but otherwise himself. He told the wing movements officer that Mr Donnelly had been sentenced. Wing staff did not make a subsequent welfare check on Mr Donnelly.

7. That afternoon Mr Donnelly made several calls to his aunt, mother and partner that indicated he was extremely distressed by the length of his sentence and media reporting of his case. He referred to ending his life more than once. Mr Donnelly's cellmate and a close friend were aware he was very distressed but did not think he was at risk of harming himself and so did not tell staff.

8. The next morning at 7.51am, Mr Donnelly took a sheet and chair from his cell to the prison laundry and hanged himself. His cellmate and close friend found him 15 minutes later and raised the alarm. Officers and nurses arrived promptly and administered cardio-pulmonary resuscitation. Paramedics arrived 25 minutes later and were able to restart Mr Donnelly's heart. He was taken to hospital and put on life support.

9. On 20 December, the hospital confirmed Mr Donnelly would not recover, life support was withdrawn, and he died.

Findings

10. Although Mr Donnelly had some risk factors for suicide and self-harm, including a history of domestic violence and substance misuse, we have found no evidence

that he was in crisis until after he received a much longer than expected sentence on 13 December.

11. We do not consider that Mr Donnelly was adequately risk assessed following his court appearance, however we have seen no evidence to indicate that staff were made aware of his increased risk on 13 December or had reason to initiate suicide and self-harm support and monitoring.

12. When Mr Donnelly died there was no standard procedure at Cardiff for prison staff to risk assess prisoners after video link court appearances. This was not in line with national guidance to all prisons issued in 2021.

13. Mr Donnelly's death is the fifth self-inflicted death since March 2021 in which we have found that the relevant prison did not have the required procedure to risk assess prisoners following a video court appearance. This needs to be addressed.

14. Staff did not call a code blue when they found Mr Donnelly, but this did not lead to a delay in him receiving emergency aid from staff. There was a small delay before staff on scene asked the control room officer to ring an ambulance.

15. Cardiff's orderly officers (the managers responsible for running the prison day to day) carry a mobile phone to aid communication with the ambulance service during emergencies. Unfortunately, the phone did not work in this case which resulted in a delay of seven minutes before the 999 operator dispatched an ambulance. This has not been an issue in previous investigations and appears to have been a result of the unusual location of Mr Donnelly's death rather than a systemic problem. In both calls to the 999 operator, prison staff were unable to tell them whether Mr Donnelly was breathing. This is essential information they need before an ambulance is despatched, although we accept in the second call an ambulance was dispatched after two minutes.

Recommendations

- The Director General of HMPPS should issue guidance to ensure that prisons are clear about their responsibilities to ensure that prisoners who attend court by video link are assessed for their risk of suicide and self-harm and seen by healthcare staff in the same way as prisoners attending court in person. Prison Group Directors should monitor compliance with this guidance.

The Investigation Process

16. HMPPS notified us of Mr Donnelly's death on 20 December 2022.

17. The investigator issued notices to staff and prisoners at HMP Cardiff informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

18. The investigator obtained copies of relevant extracts from Mr Donnelly's prison and medical records. She obtained CCTV, radio traffic and body worn camera footage from 14 December and listened to Mr Donnelly's prison telephone calls from 13 December. The investigator obtained further information from Wales Ambulance Service.

19. The investigator interviewed seven members of staff and two prisoners between 26 January and 2 March 2023.

20. Health Inspectorate Wales (HIW) commissioned a clinical reviewer to review Mr Donnelly's clinical care at the prison.

21. We informed HM Coroner for South Wales of the investigation. The Coroner did not request a post-mortem examination. We have sent the Coroner a copy of this report.

22. The Ombudsman's family liaison officer contacted Mr Donnelly's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Donnelly's next of kin asked why he was in the laundry room on his own and why Mr Donnelly was not subject to Prison Service suicide and self-harm monitoring procedures (known as ACCT). We have answered these questions in this report.

Background Information

HMP Cardiff

23. HMP Cardiff holds around 750 remand and sentenced men, many of whom arrive from local courts. Cardiff and Vale University NHS Health Board provides primary physical and mental health services. Psychosocial substance misuse support is provided by Dyfodol integrated partnership services.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Cardiff was in July 2019. Overall, inspectors reported that the prison had made real progress since the previous inspection in 2016. Much of this was attributed to the excellent relationships between staff and prisoners. Inspectors were extremely worried about an increase in the level of self-harm, which was over three times higher than during the previous inspection. They found no clear strategy to reduce it, although all prisoners who harmed themselves were being interviewed as part of a new initiative to understand the underlying causes. PPO recommendations were not always embedded into practice.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to August 2021, the IMB reported that self-harm had reduced by a quarter in the reporting year. The prison was relatively safe but the reduced regime operating during the COVID-19 pandemic had affected the relationship between staff and prisoners and the ability of board members to visit as often as they would have liked.

Previous deaths at HMP Cardiff

26. Mr Donnelly was the twelfth prisoner to die at Cardiff since January 2020. Of the previous deaths, six were self-inflicted and five were from natural causes. We found no significant similarities in the findings across these investigations. As Mr Donnelly's was the third self-inflicted death at Cardiff in 2022, the prison was identified as a cluster site and is receiving additional support and monitoring from regional and national safety teams.

Extended determinate sentence

27. Extended sentences are imposed in certain types of cases where the court has found that the offender is dangerous, and an extended licence period is required to protect the public from risk of serious harm. The judge decides how long the offender should stay in prison and fixes an extended licence period up to a maximum of eight years.

28. Two thirds of the way through the prison term the offender can apply for parole. If not released before, the offender will be automatically released at the end of their

custodial term. In either case, following release, they will be subject to the licence where they will remain under supervision until the expiry of the extended period.

Key Events

29. Mr Benjamin Donnelly had a history of anxiety, depression, alcohol and substance misuse. He had a number of previous convictions for violence against family members and partners and had served several short prison sentences.

15 October 2022 – 12 December 2022

30. On 15 October 2022, Mr Donnelly was arrested for assaulting his mother at her home while under the influence of alcohol and drugs. Police completed a suicide/self-harm warning form because their records showed Mr Donnelly had threatened to harm himself in 2001, 2012 and 2019. Mr Donnelly's last recorded act of self-harm was on 12 April 2019 when he made superficial cuts in police custody.

31. On 17 October, Mr Donnelly appeared at Cardiff Magistrates Court and was remanded into custody charged with assault occasioning actual bodily harm. He arrived at HMP Cardiff the same day.

32. Mr Donnelly told a nurse at an initial health assessment that he had a history of depression and was prescribed Sertraline (an antidepressant). He said he had last self-harmed about five years previously and had no intention of doing it again. He said he intended to plead guilty and was expecting a sentence of around six or seven months.

33. During the assessment Mr Donnelly took a urine test which was positive for cannabinoids and the nurse referred him to the substance misuse team for assessment. He said he only drank alcohol between two to four times a month and so the nurse did not complete the alcohol use questionnaire. As he was prescribed antidepressants, the nurse referred him to the mental health team. A GP at Cardiff continued his prescription for Sertraline.

34. The next day, 18 October, Mr Donnelly saw a nurse a mental health nurse. He said he had no current mental health issues or feelings of suicide or self-harm. The nurse advised him that he could contact the mental health team if his situation changed. At a second day health assessment he told another nurse that he had hurt his arm during his arrest, and she referred him to the GP.

35. Mr Donnelly also saw a nurse from the substance misuse team. He denied using drugs or alcohol. She advised him how he could contact the team if he had any future issues.

36. Also on 18 October, a Supervising Officer (SO) from the prison's offender management unit (OMU) identified Mr Donnelly as a domestic violence perpetrator and therefore suitable for offence-related monitoring of his prison telephone calls and mail. (All prison telephone calls are recorded but in general, staff only listen to calls when they have specific reason. When a prisoner is subject to monitoring, control room staff listen to each day's calls overnight. The decision to monitor a prisoner's calls is subject to regular review.)

37. On 19 October, a worker from Dyfodol (the psychosocial substance misuse service) assessed Mr Donnelly. Mr Donnelly reported a history of recreational alcohol and

cocaine use and said he would like support. She gave him harm minimisation advice. She assessed him as suitable for the brief intervention service (for prisoners not deemed to be at high risk from substance misuse) and added him to the waiting list. Staff shortages meant Dyfodol did not see Mr Donnelly before he died.

38. The same day Mr Donnelly attended a resettlement assessment. He said he had been working with Dyfodol in the community to address his alcohol and drug issues and also the mental health charity MIND. The worker made appropriate referrals to both for when Mr Donnelly was released from prison. Mr Donnelly spoke to his keyworker. He said everything was fine and he would like to get a prison job working in the canteen. A prison GP examined his arm and decided he needed further examination in hospital.

39. Also on 19 October, a multi-agency risk assessment meeting put in place a non-contact order preventing Mr Donnelly from contacting his partner, at her request.

40. On 20 October, staff took Mr Donnelly to hospital. An X-ray showed he had a broken bone in his forearm and his arm was put in a cast and sling. On 22 October, he told a GP in the prison, that he had fallen in the shower and made his arm worse. The GP prescribed anti-inflammatory pain medication.

41. On 26 October, Mr Donnelly told a prison offender manager (POM) that he had his own business in the community and his two employees were keeping it going while he was in prison. He said he had put effort into making positive changes in his life. Mr Donnelly said he had been with his current partner for two and half years and she was a supportive influence.

42. Later the same day, an officer formally notified Mr Donnelly of the non-contact order with his partner, and Mr Donnelly signed a form to say he understood.

43. On 30 October, an officer discovered during telephone call monitoring that Mr Donnelly was in touch with his mother via his aunt and they had passed a message to him from his partner. As his mother was the victim of his offence, but also a close family member, she was allowed to contact him, but the prison needed to be certain she was happy with the contact first. (The no contact order prevented Mr Donnelly from contacting his partner directly, although he does not appear to have done this at this stage.)

44. The officer submitted a security information report, and, on 31 October, Mr Donnelly was charged with breaking prison rules and required to attend a prison disciplinary hearing (known as an adjudication). The Head of Security later dismissed the charge. Cardiff was unable to locate the record of this hearing, so we do not know exactly why the charge was dismissed. However, it is difficult to see which prison rule Mr Donnelly broke given that there was no evidence in this conversation that he had been in direct contact with his partner.

45. The same day, Mr Donnelly went to hospital for a check up on his arm. Records showed the fracture was well-aligned and he had a good range of motion in his elbow.

46. On 8 November, the POM told Mr Donnelly that his mother had withdrawn her support for the charges against him but that the Crown Prosecution Service might

continue with the case because of his pattern of similar offences. Mr Donnelly told her that he intended to plead guilty so that his mother did not have to attend court.

47. On 13 November, Mr Donnelly pleaded guilty at Cardiff Crown Court and was convicted of assault occasioning actual bodily harm.

48. On 18 November, a prison offender manager reviewed the monitoring of Mr Donnelly's phone calls and mail. He noted Mr Donnelly had not breached public protection measures since 30 October and decided monitoring should stop. His decision was authorised by the then Head of OMU on 20 November.

49. Also on 20 November, Mr Donnelly told an officer during a keywork session that he was keen to start a prison job. He said he had just resolved issues with his bank and was feeling fine.

50. On 28 November, Mr Donnelly started a job in one of the workshops. On 2 December, he moved to a job in the prison canteen.

Events of 13 December

51. On 13 December, Mr Donnelly appeared at Cardiff Crown Court via video link. The prison's video link court list showed that his hearing finished at 10.35am. The Judge sentenced him to an extended determinate sentence of five years, comprising four years in custody and a year on licence. This meant that Mr Donnelly would be able to apply to the Parole Board for release two thirds of the way through his four-year custodial term.

52. An officer was present for Mr Donnelly's sentencing. He said he knew Mr Donnelly from previous periods in Cardiff and that he was a model prisoner, always polite and good spirited. He said Mr Donnelly was quiet in court and very apologetic to the Judge. When they were walking back to F Wing, Mr Donnelly asked him what his sentence meant and how long he would have to serve in prison. He said he explained to Mr Donnelly what it meant for him and that he would probably be transferred to HMP Parc to serve his sentence. He offered to ask someone from the offender management department to visit Mr Donnelly and explain his sentence to him.

53. The officer said Mr Donnelly was quieter than usual but otherwise himself. When they got back to F Wing, he told the movements officer that Mr Donnelly had returned from court and that he had been sentenced. Wing staff did not make a subsequent welfare check on Mr Donnelly.

54. Between 10.41am and 5.41pm, Mr Donnelly made 41 phone calls from his cell. Only twelve of these connected. He spoke to his solicitor twice and these calls were not recorded due to legal privilege. It was clear from the other calls that Mr Donnelly was aware that his solicitor intended to appeal his sentence.

55. My Donnelly spoke to his aunt twice. He cried throughout both calls and told her he could not serve three years in prison and that his life was over. He spoke to his mother three times via his aunt's number. Mr Donnelly was clearly upset and told his mother he could not serve three years. In one call he said would kill himself but then apologised to her and said he did not mean it and was just angry. He said in

another call that he would not see her again. Mr Donnelly's mother tried to calm him down and promised she would speak to his solicitor and visit him, which seemed to reassure him.

56. Mr Donnelly spoke to his partner four times (he had added her to his contacts under a different name after the prison stopped monitoring his calls). Again, he cried throughout their conversations. He said he was ringing to say goodbye and wanted her to move on. He told her that he was "that close to killing myself". She reassured him that she would not leave him. They discussed his medication, and he told her he intended to complete offence related courses so he could move to open conditions as soon as possible. Mr Donnelly became upset after she told him his case had appeared on the Wales Online website. He asked several questions about who had seen it, whether anyone had commented on it and whether it was "on Facebook". His partner tried to distract him, but he kept returning their conversation to the article.

57. In their last conversation at 5.41pm, Mr Donnelly sounded quiet and said that everyone would be sharing the Wales Online article. He kept going back to the article and asked her to read it out. He said it was a "really bad story". He promised to come out of prison a better person and said that he would talk to doctors about changing his medication. He said his credit was running out and they agreed to talk until that happened. They told each other they loved each other, and he said he would call her at 11.00am the next morning if he had more credit.

58. Prisoner A said he had shared a cell with Mr Donnelly for about five weeks and had known Mr Donnelly since the age of six. He said before he was sentenced Mr Donnelly had been his usual happy self. When he returned from work at lunchtime on 13 December, Mr Donnelly was sitting in their cell with his head in his hands. He was deeply upset and depressed about his sentence. He said Mr Donnelly had served short sentences before and this one was as long as all of them put together. He said Mr Donnelly had not expected such a long sentence.

59. Prisoner A said Mr Donnelly was "a mess". He tried to comfort him and told him that he would be able to apply for category D status and move to an open prison after about eight months. He said he did not think this was necessarily true but had wanted to make Mr Donnelly feel better.

60. Prisoner B said he had known Mr Donnelly for many years and had been in prison at the same time as him on different occasions. He also lived on F Wing and worked in the same workshop as Mr Donnelly. He said before he was sentenced, Mr Donnelly appeared to be his usual self. He was a little bit worried about being sentenced but had been expecting to be released relatively quickly.

61. Prisoner B said he spoke to Mr Donnelly at work in the afternoon. He thought the length of the sentence had come as a bit of a surprise to him. The prisoner explained to him what an extended determinate sentence was and how long it would be before he could apply for parole. He told him to see him if he needed anything or wanted to talk. He said Mr Donnelly appeared a bit low, but he had not been concerned for his welfare. He said that if he had been worried about Mr Donnelly he would have alerted staff.

Events of 14 December

62. Prisoner A said in the morning of 14 December Mr Donnelly told him, “I can’t do this anymore”. He tried to reassure Mr Donnelly that he would get through his sentence, but Mr Donnelly just stared into space with tears in his eyes. He said he saw Mr Donnelly briefly that morning and thought he seemed OK. He told Mr Donnelly he would see him in a bit and went to collect his medication.

63. The prison showed the investigator CCTV footage from 7.50am. It was not time stamped and so the times below have been calculated from time elapsed and comparison with time stamped body worn video camera footage (BWVC) and radio traffic.

64. At 7.51am, Mr Donnelly asked a member of staff to unlock the wing laundry which was diagonally opposite his cell. Prisoner B said the laundry was often unlocked for workers in the morning as they were allowed to leave their washing in there before going to work.

65. At 7.56am Mr Donnelly walked from his cell into the laundry carrying what appeared to be a sheet. He immediately returned to his cell and carried a chair into the laundry at 7.57am. No one else entered the laundry until Prisoners A and B at 8.11am.

66. Prisoner B said he saw Prisoner A at the medication hatch and, once they had both had their medication, they went to look for Mr Donnelly. They could not see him out on the wing so, on the way to Mr Donnelly’s cell, they looked in the laundry. Prisoner B said he did not think Mr Donnelly was in the laundry when he first went in. He only saw him when he turned around to leave the room. Mr Donnelly was hanging from the pipes behind the door. He had made a noose by twisting a sheet tightly to form a rope and was fully suspended with his feet off the floor. Prisoner B said he held Mr Donnelly up while Prisoner A shouted for staff. Two officers responded immediately, followed by another.

67. Officer A said he ran to the laundry as soon as he heard prisoners calling for staff. He entered the laundry just behind Officer B. He and Prisoner B held Mr Donnelly up while Prisoner A and Officer C tried to remove the noose. Officer C said he tried to use his cut-down tool to cut the sheet from around Mr Donnelly’s neck, but it was too thick. They managed to remove it with their hands and laid Mr Donnelly on the floor.

68. Officer C said Mr Donnelly was not breathing. Officer A started cardio-pulmonary resuscitation (CPR). He said he had attended a CPR refresher course three months previously and was confident he knew what to do. He said he did not radio a code blue emergency because his priority was to start CPR. He told Officer B to get help.

69. CCTV showed that Prisoner B became upset and angry when he left the laundry and Officer B intervened to calm him down. Many prisoners had gathered outside the laundry and the scene was very crowded. No one called a code blue emergency.

70. A nurse and a Healthcare Assistant (HCA) were in the wing treatment room. The HCA heard a loud commotion, saw many prisoners on the landing and officers

running from the wing office. He said he assumed a fight was taking place and pressed the general alarm button. Radio traffic showed the general alarm was pressed at 8.11am.

71. A Custodial Manager (CM) was the B Wing manager that morning. He said he heard a general alarm on the radio and went to F Wing. He said a general alarm usually indicated a violent incident, often a fight between prisoners. When he arrived, there were a lot of prisoners out of their cells waiting to go to work. Someone directed him to the laundry, and he saw Mr Donnelly on the floor with officers giving him CPR.

72. The CM radioed the control room for an ambulance and more healthcare staff to attend the scene. Radio traffic showed he did this at 8.13am. At Cardiff, the orderly officer carries a mobile phone for use in emergencies. As the first manager on scene, the CM retained responsibility for managing the incident and the orderly officer gave him the mobile phone.

73. Not long after the general alarm, an officer told the HCA and the nurse they were needed in the laundry but did not say why so they did not take the emergency equipment. The nurse and the HCA entered the laundry at 8.14am. The nurse said Mr Donnelly was on the floor with Officer A performing CPR. She collected the emergency equipment bags from the wing office and returned to the laundry.

74. The nurse inserted an airway to give Mr Donnelly oxygen and attached a defibrillator to his chest. As she was doing so, another nurse arrived and took control of the scene.

75. The second nurse said she was working in C Wing treatment room when she heard the radio call for an ambulance. As this indicated an emergency, she made her way to F Wing to provide support. On arrival, she helped her colleague with the oxygen cylinder and Ambu-bag and, as the most experienced nurse, assumed control of the scene. The nurses and officers continued CPR according to the instructions of the defibrillator. The defibrillator did not identify a shockable heart rhythm, so they continued with oxygen and chest compressions.

76. Ambulance records and call recordings showed the control room officer telephoned 999 at 8.15am and asked for an ambulance. The call handler asked if the patient was awake, and the officer said he did not know but would put her through to the CM at the scene. He gave her the CM's mobile number in case he got cut off. He could not connect at the first attempt, so radioed the CM to ask for his nearest landline extension. The CM said the mobile line was clear again, so the officer tried again to put the call handler through to him. When this did not work, the call handler agreed to call the mobile phone direct.

77. When the call handler phoned the mobile it went to voicemail, and she left a message asking the prison to re-dial 999.

78. The CM said the mobile phone did not ring that morning. He said it had worked in other emergencies he had attended, and in hindsight he thought that the laundry might have been an area of poor reception.

79. Ambulance records and call recordings showed the control room officer called 999 again at 8.20am. A different call handler started the process of triaging the emergency from the beginning. The officer said he needed an ambulance urgently. The call handler asked if the patient was breathing. The officer said he did not know but that there were three people working on the patient and they were using a defibrillator. The call handler continued to ask whether the patient was breathing and several other questions. The officer repeated that he only knew what he had already told her. The call lasted almost nine minutes, although an ambulance was dispatched with priority one (indicating a response target of within 15 minutes) after two minutes at 8.22am.

80. CCTV showed paramedics arrived at the laundry at 8.36am. They gave Mr Donnelly adrenaline and attached a Lucas machine (an automated chest compression system). At 8.46am, Mr Donnelly's heart started beating again. Paramedics took him to hospital where he was put on a life support machine. Staff did not apply restraints at any time.

81. On 20 December, the hospital confirmed Mr Donnelly would not recover, staff withdrew life support, and he died.

Contact with Mr Donnelly's family

82. The prison appointed a family liaison officer, who contacted Mr Donnelly's next of kin as soon as he had been taken to hospital. A prison chaplain went to the hospital to meet the family that day. When it became apparent that Mr Donnelly would not recover, the family accepted the prison's offer for the Roman Catholic chaplain to give a service for Mr Donnelly. Mr Donnelly's family were with him when he died. The prison offered a financial contribution to the funeral costs in line with national guidance.

Support for prisoners and staff

83. After Mr Donnelly's death, a senior prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team and Trauma Risk Management (TRiM) team also offered support. One member of staff was escorted home. The prison chaplain spoke to Prisoners A and B.

84. The prison posted notices informing other prisoners of Mr Donnelly's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected. Prisoners A and B both said they had been well supported by the chaplaincy and staff. They both said they would have liked more support from healthcare as they had found it hard to sleep. Prisoner A said he was not offered counselling and would have liked to have had some. (He was released on 26 January 2023.)

Post-mortem report

85. HM Coroner for South Wales did not hold a post-mortem examination. He gave the cause of death as hypoxic brain injury due to hanging.

Coroner's inquest

86. The Coroner's Inquest concluded on 18 June 2025 and the jury returned a verdict of suicide.

Findings

Assessment of Mr Donnelly's risk

87. Although Mr Donnelly had some risk factors for suicide and self-harm, including a history of domestic violence and substance misuse, we have found no evidence that he was in crisis until after he received a much longer than expected sentence on 13 December.

88. Prisoners A and B were aware that Mr Donnelly was extremely distressed by his sentence but neither considered he was at risk of taking his life and so did not speak to staff. Mr Donnelly's phone calls also showed his distress, but these were not being monitored at the time.

89. As discussed below, we do not consider that Mr Donnelly was adequately risk assessed following his court appearance, however we have seen no evidence to indicate that staff were made aware of his increased risk on 13 December or had reason to initiate suicide and self-harm monitoring.

Mr Donnelly's court appearance by video link on 13 December

90. Prison Service Order (PSO) 3050, *Continuity of healthcare for prisoners*, says that events such as attending court or sentencing at court, are factors that might have a significant impact on the health of a prisoner. When prisoners pass through reception on their return from court, prisons are required to have protocols in place for risk assessing them to identify any potential suicide and self-harm issues. Prison Service Instruction (PSI) 07/2015, *Early days in custody*, states that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance by video link.

91. As these prisoners do not leave the prison, they are not always subject to the standard screening procedures that they would receive when returning to the prison and passing through reception.

92. Several PPO investigations in 2020, when the Covid-19 pandemic meant all court appearances were remote, found that prisoners were not being risk assessed after attending court by video link. We made a national recommendation to HMPPS to review their guidance. In March 2021, the Director General wrote to all Governors and Directors requiring them to review local processes to ensure that similar health screening arrangements, and the same processes for assessing risk of suicide or self-harm, were followed after video link appearances, as in reception following a physical appearance in court.

93. Also in March 2021, HMPPS issued a safety briefing on assessing the risk of harm in prisoners attending court by video link. In April 2021, they followed this up with another safety bulletin containing early learning review analysis of several issues including video court appearances. Both documents advised that it was vital that staff engage with prisoners after a video court appearance, and that they assess the prisoner's risk on the basis of official information, as well as the individual's presentation. They also advised that a verbal handover of key information should be given to wing staff and any new risk information should be recorded and shared on

the prisoner's record (NOMIS) and the wing observation book. If necessary, concerns should be escalated, including starting ACCT procedures where appropriate.

94. When Mr Donnelly died there was no standard procedure at Cardiff for prison staff to risk assess prisoners after video link court appearances. Aside from an officer telling a member of staff in the wing office that he had been sentenced, none of the measures required across HMPPS guidance were taken. This was a significant missed opportunity to identify that Mr Donnelly's risk to himself had increased.

95. After Mr Donnelly died, Cardiff immediately introduced a procedure requiring the officer present in the video court to tell wing staff about changes in a prisoner's status and write entries on NOMIS and in the wing observation book. While we welcome this and commend the speed with which it was brought in, it does not fully comply with the Director General's instruction and Safety Briefing advice that prisoners receive the same standard of risk assessment following a court appearance of any type, including being seen by healthcare.

96. Mr Donnelly's death is the fifth self-inflicted death since March 2021 in which we have found that the relevant prison did not have the required procedure to risk assess prisoners following a video link court appearance. We are concerned that despite previous national guidance, prisons still do not have the required local procedures in place and therefore are not robustly risk assessing prisoners after they have appeared in court via video link. We make the following recommendation:

The Director General of HMPPS should issue guidance to ensure that prisons are clear about their responsibilities to ensure that prisoners who attend court by video link are assessed for their risk of suicide and self-harm and seen by healthcare staff in the same way as prisoners attending court in person. Prison Group Directors should monitor compliance with this guidance.

The emergency response

97. PSI 03/2013, *Medical Emergency Response Codes*, requires governors to have a two-code medical emergency response system. As is usual, Cardiff use code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance.

98. CCTV showed that the wing was very crowded and the first staff to respond were confronted by several prisoners including Mr Donnelly's two friends, one of whom was clearly distressed and angry about what had happened. The situation was further confused by a nurse pressing the general alarm. In the evident confusion, no one radioed a code blue emergency. Despite this, Mr Donnelly received prompt CPR from officers and nurses.

99. The absence of a code meant the control room officer did not automatically ring for an ambulance. This caused a delay of four minutes, and it was only requested after a manager had radioed asking for one. There was a further delay of seven minutes between this initial call and the ambulance service dispatching an ambulance. This

was mostly due to the failure of the prison's mobile phone which would not work in the laundry.

100. However, some of the delay was due to control room staff not having sufficient information to answer the 999 operator's questions for them to dispatch an ambulance. Both times they called they could not tell ambulance staff whether Mr Donnelly was breathing. The first time this resulted in the 999 operator unsuccessfully trying to call the allocated prison mobile phone. The second time, they dispatched the ambulance two minutes into the call. 999 operators need to know whether the patient is breathing before they can send an ambulance. In October 2023, we made a recommendation to the Director General of HMPPS that they review the emergency response policy to provide clarity about this issue. This is currently being considered by HMPPS, so we make no further recommendation.

101. It is extremely unlikely that this delay affected the outcome for Mr Donnelly. He had been fully suspended by the neck for up to 15 minutes when he was found, which is long time for the brain to be deprived of oxygen. We did not identify delays in calling a code blue or inefficient communication with the ambulance service as an issue in any of the self-inflicted deaths at Cardiff in the three years before Mr Donnelly died. The CM said the mobile phone (which in other circumstances might well have been highlighted as an example of good practice) had worked well in other emergencies and its failure in this case appears to have been a result of the unusual location of Mr Donnelly's death, rather than a systemic problem. We therefore make no recommendation. However, the Governor will want to consider the learning from Mr Donnelly's death.

Clinical care

102. The clinical reviewer concluded that Mr Donnelly's clinical care was equivalent to that he would have expected in the community. They have made several recommendations, not related to Mr Donnelly's death, which the Head of Healthcare will wish to consider.

Governor to note

103. As a domestic violence perpetrator, Mr Donnelly's telephone contacts should have been checked by staff, but he was able to contact his partner by adding her under a different name.

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