

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adam Clark, a prisoner at HMP Hewell, on 1 December 2024

A report by the Prisons and Probation Ombudsman

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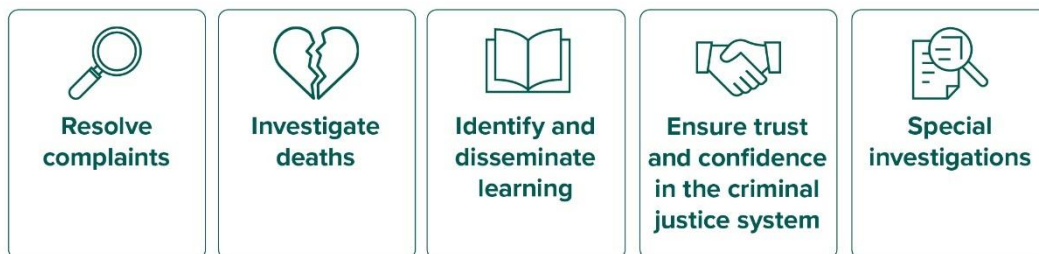
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OUR VISION

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



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

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 Adam Clark was found hanged in his cell at HMP Hewell on 1 December 2024. He was 36 years old. I offer my condolences to Mr Clark's family and friends.

Mr Clark was the fourth prisoner to take his life at Hewell since December 2021.

Mr Clark died after just over a month at Hewell, having arrived with several risk factors for suicide and self-harm including a recent overdose. Despite recommendations we made in previous investigations, not everyone involved in the reception process had access to important documentation which helped identify risk and the process was confused and insufficiently robust.

Mr Clark's mental health clearly deteriorated in the lead up to his death, and he was markedly paranoid. While staff took positive steps to support him, including moving him onto the wellbeing unit, they were less aware that his paranoia could increase his risk of suicide and self-harm.

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

September 2025

Contents

Summary	1
The Investigation Process.....	5
Background Information.....	6
Key Events.....	10
Findings	20

Summary

Events

1. On 30 October 2024, Mr Adam Clark was remanded in prison for threats to kill, criminal damage and attempted arson and sent to HMP Hewell.
2. Mr Clark had a history of self-harm and attempted suicide in the community and in police custody and had taken a deliberate overdose seven weeks before arriving at Hewell. Mr Clark had a history of anxiety and depression and reported that he had post traumatic stress disorder (PTSD) and emotionally unstable personality disorder (EUPD). He also reported that he had been admitted to a psychiatric hospital in 2016. Mr Clark had an extensive history of substance misuse.
3. Mr Clark's Person Escort Record (PER – a document that accompanies prisoners between police custody, court and prison setting out information about the prisoner and the risks they pose) included a suicide and self-harm warning, information about his history of self-harm and his mental health diagnoses.
4. On his arrival to Hewell, prison and healthcare staff assessed that there were no factors to indicate that Mr Clark was at increased risk of suicide and self-harm and did not start suicide and self-harm procedures (known as ACCT). The reception nurse referred Mr Clark to the mental health team.
5. In November, Mr Clark spoke to staff about his mental health on several occasions. He said his mental health was poorly controlled and spoke about increasing paranoia. He told an education tutor that he had previously tried to take his own life. No one started ACCT procedures.
6. On 29 November, Mr Clark threatened a prison officer and shortly after threw hot water through his door, injuring another prisoner. His comments around this time indicated continuing paranoia and deteriorating mental health.
7. On 30 November, a custodial manager (CM) and supervising officer (SO) spoke to Mr Clark, who said that staff were constantly talking about him and that he wanted to be in his own cell. The CM made Mr Clark temporarily high risk to share a cell, moved him to the wellbeing unit and contacted healthcare to check that Mr Clark was being supported with his mental health.
8. At around 11.50am on 1 December, prison staff went into Mr Clark's cell. He appeared angry and distressed and told them to stop talking about him and to leave him alone.
9. At 3.54pm, two officers went to Mr Clark's cell and found he had barricaded the door. A minute later, they were able to enter the cell and found Mr Clark hanged. Officers started CPR and radioed a medical emergency code.
10. At 4.14pm, paramedics arrived and, at 4.20pm, pronounced life extinct.

Findings

11. When he arrived at Hewell, Mr Clark had a number of risk factors for suicide and self-harm, including a recent deliberate overdose, that were recorded on paperwork accompanying him. Not all staff who interviewed him as part of the reception process were aware of his risk factors, with some appearing to rely on his presentation to determine whether to start ACCT procedures. We found that not all reception and first night staff saw the PER, which clearly identified Mr Clark's risk factors.
12. We found that not all non-operational staff members in contact with prisoners had received ACCT training, including Mr Clark's maths tutor, with whom he shared concerns about his deteriorating mental health.
13. Mr Clark's mental health clearly deteriorated in the time before his death and he became increasingly paranoid. Although staff offered support, they did not recognise that this might mean he was at increased risk of suicide or self-harm.
14. The clinical reviewer found that the healthcare Mr Clark received was not equivalent to that which would have been received in the community. Mr Clark should have been referred to the clinical substance misuse team and the mental health team should have contacted his community team to establish more details about his diagnosis and the reason for prescribed medication.

Recommendations

- The Governor should review the provision of training to non-operational staff to ensure that they are competent in identifying increased risk of suicide and self-harm and understand how to start ACCT procedures when required.
- The Governor should amend local policy to provide staff with clear instructions about the actions they should take when they discover a blocked observation panel and follow this up with a clear quality assurance process to ensure that staff understand their responsibilities.
- The Head of Healthcare should ensure that mental health staff understand the circumstances in which they should request a prisoner's history from community mental health services and that there are clear roles and responsibilities for requesting this information.
- The Head of Healthcare should ensure that patients with a complex history of substance misuse, including those prescribed opiate substitution medication before their arrival in prison, are referred to the clinical substance misuse team for an assessment of their needs.

The Investigation Process

15. HMPPS notified us of Mr Clark's death on 1 December 2024.
16. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
17. The investigator obtained copies of relevant extracts from Mr Clark's prison and medical records. She also obtained CCTV footage, body worn video camera footage of the emergency response, the HMPPS Early Learning Review and West Midlands Ambulance Service records.
18. NHS England commissioned a Clinical Reviewer to review Mr Clark's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed seven members of prison and healthcare staff in January 2025.
19. The investigator interviewed an additional eleven members of prison staff and two prisoners in January and February 2025.
20. We informed HM Coroner for Worcestershire of the investigation. The Coroner gave us the results of the post-mortem examination and toxicology. We have sent the Coroner a copy of this report.
21. The Ombudsman's office contacted Mr Clark's mother to explain the investigation and ask if she had any matters she wanted us to consider. Mr Clark's mother explained that he was very clearly mentally unwell and had multiple risk factors and regularly communicated that he was struggling. She wanted to know why he was not managed under ACCT procedures. She also asked why he was in a cell on his own. Mr Clark's mother asked what triggered him throwing water at another prisoner/member of staff and whether this was another sign he was in crisis.
22. Mr Clark's mother, father and other family members went on to ask the following additional questions which we have answered in this report, in the clinical review and in separate correspondence:
 - How long was Mr Clark in the cell in which he took his life and why was he moved to that cell? Was he allowed to leave the cell after the incident throwing water?
 - What were the events of the day Mr Clark died and how often was he checked?
 - How did Mr Clark get on with staff and other prisoners? Did he have any contact with chaplaincy?
 - Did Mr Clark eat all of his meals?
 - Was Mr Clark's mental health properly assessed, supported and medicated in prison?
 - What were the barriers preventing Mr Clark contacting his family from prison?

23. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report.
24. We also shared the initial report with Mr Clark's family. They did not make any comments.

Background Information

HMP Hewell

25. HMP Hewell is a large category B local prison in Worcestershire, holding adult male prisoners. It has six residential houseblocks. Healthcare services are provided by Practice Plus Group (PPG) and mental health and substance misuse services are sub-commissioned to Midlands Partnership NHS Foundation Trust (MPFT).
26. MPFT provide an integrated mental health and substance misuse service known as 'Inclusion' and are commissioned to be on site at Hewell between 9.00am and 5.00pm Monday to Friday, with regional on-call cover available at the weekends. MPFT also provide a Targeted Care Pathway (TCP) at Hewell which is covered by two mental health nurses, seven days a week. The TCP is for people who have been deemed to require increased mental health support due to their needs and who are seen for daily reviews.

HM Inspectorate of Prisons

27. The most recent inspection of HMP Hewell was in June 2025. The full report of this inspection was not available at the time of writing. The previous inspection of HMP Hewell was in November 2023 and was an independent review of progress following their inspection in December 2022. Inspectors reported that early days in custody arrangements were not good enough. They identified that since their last inspection there had been around a 40% increase in new arrivals at the prison each month. They noted that despite efforts of leaders to streamline reception and induction processes, the management of risk for this vulnerable cohort remained too weak.
28. Inspectors noted that the initial safety interviews for new arrivals remained cursory and lacked sufficient depth when exploring potential vulnerabilities. They also found a few instances where new arrivals had received no interview at all. They noted that some prisoners continued to wait far too long to have numbers added to their telephone accounts so they could phone their families.
29. Inspectors identified that healthcare delivery had improved since their previous inspection and that waiting times to see a GP or for a mental health assessment had reduced. They noted that managers had introduced a dedicated nurse to clinically triage all applications which they said worked well.

Independent Monitoring Board

30. 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 September 2024, the IMB reported that the reception and induction process was strengthened by additional staffing from NHS England to complete assessments within timescales. They noted though that the high number of arrivals and departures every day put unsustainable pressure on assessment and screening.

31. The Board found that incidents of self-harm had increased by more than 50 per cent in the previous year. They noted that despite quality assurance, ACCT documents still lacked depth and analysis. They noted that the highest number of ACCTs were opened in reception and the induction block.
32. The Board found that the use of force incidents they witnessed were proportionate. They noted that men sometimes were not able to make a phone call on arrival because the required phone number was stored on their phone and retained in reception. They noted that while there was a process for retrieving these numbers, it relied on staff being available. The Board suggested that allowing prisoners to note down one or two essential numbers during the reception process would help reduce anxiety and frustration.

Previous deaths at HMP Hewell

33. Mr Clark was the tenth prisoner to die at Hewell since December 2021, and the fourth to take his own life. To the end of June 2025, there have not been any further deaths at Hewell. In a previous investigation into a self-inflicted death, we made recommendations that (i) the prison should examine reception practices to ensure that all relevant staff read the Person Escort Record (PER) when processing prisoners, and (ii) that the Head of Healthcare ensure that all staff, including agency staff, were trained to access PERs.
34. Hewell responded that healthcare staff would be given access to the prison system to be able to review a prisoner's PER. They also told us that a process had been introduced which ensured that all PERs were seen by the reception supervising officer. Where the PER identified any suicide or self-harm concerns, they noted that a welfare conversation would take place to establish any potential risks and triggers, and any information obtained would be recorded on the induction paperwork.

Assessment, Care in Custody and Teamwork (ACCT)

35. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.
36. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. When Mr Clark was at Hewell, guidance on ACCT procedures was set out in the Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody). From January 2025, this was superseded by the Prison Safety Policy Framework, in which the principles of how an ACCT is managed remain largely unchanged.

Person Escort Record (PER)

37. A PER must be completed for all prisoners before any escorted movement or transfer. They provide escort staff and receiving prisons with relevant information on a prisoner and the risks they may pose during and after the movement. The PER is not itself a risk assessment, however it conveys information about a prisoner's assessed risks to those who may need to know about them. Prisoner Escort Custody Services (PECS) generally use a digital PER to transfer prisoners from police custody or court to prison.

Key Events

38. On 30 October 2024, Mr Adam Clark was charged with threats to kill, criminal damage and attempted arson. He was remanded to HMP Hewell. Mr Clark was last in prison in 2016, for four months.
39. Mr Clark had a history of depression and anxiety. He also reported that he had emotionally unstable personality disorder (EUPD), post traumatic stress disorder (PTSD) and ADHD (these diagnoses were not confirmed). Mr Clark was prescribed medication for both his physical and mental health including mirtazapine and venlafaxine (both antidepressants) and quetiapine (an antipsychotic).
40. Mr Clark had a history of self-harm and attempted suicide in the community and in police custody. Around seven weeks before he was sent to Hewell, he took a deliberate drugs overdose.
41. Mr Clark had an extensive history of drug and alcohol misuse. He also had a history of diazepam (prescribed medication) dependency.

HMP Hewell

42. Mr Clark's PER identified a suicide and self-harm warning and recorded that he was observed at least every 30 minutes in police custody. The PER noted Mr Clark's history of self-harm, including that he had taken an overdose in September 2024, that he had tied a ligature around his neck in a police van in July 2022, and that he had made a noose out of his clothing in police custody in 2018.
43. The PER noted that Mr Clark had depression, anxiety, EUPD, ADHD and PTSD. It listed the medication which Mr Clark was prescribed and noted that he had been seen by a healthcare practitioner in police custody and referred to Liaison and Diversion Services. (Liaison and Diversion Services are specialised mental health support programmes designed to help people with mental ill health, substance misuse or other vulnerabilities who are in contact with the criminal justice system.)
44. Supervising Officer (SO) A saw Mr Clark in reception. (SO A is not a permanent reception SO. He said that he has worked various shifts there but has not had any specific reception training.) He told the investigator that he could not remember his interaction with Mr Clark but that he would have seen the PER.
45. SO A recorded in Mr Clark's prison record that Mr Clark said he felt fine, had no thoughts of suicide or self-harm and that there were no concerns to raise.
46. Officer A completed the custodial part of Mr Clark's cell sharing risk assessment (CSRA, to identify the risk of violence that a prisoner poses to a cell mate). Officer A concluded that Mr Clark was standard risk and therefore could be allocated a shared cell. (We have not reviewed this document as the prison could not locate the paperwork.)
47. Nurse A completed Mr Clark's initial health screening. Nurse A told us that he did not have access to the PER. (Nurse A was an agency nurse on one of his first shifts at Hewell and said that he did not have a log-in to access the PER.)

48. Nurse A recorded that Mr Clark had taken an overdose six weeks earlier and had been admitted to hospital for nine days. He also noted that Mr Clark had previously had a week-long stay in a psychiatric hospital and had been under the care of community psychiatric services. Nurse A noted Mr Clark's prescribed medication and referred him to the mental health team.
49. Mr Clark tested positive for buprenorphine (an opioid analgesic used in treatment of opioid dependence), cocaine and benzodiazepines. Mr Clark explained that he was prescribed Buvidal (an injection of buprenorphine) in the community but he had missed a dose when he was arrested and said that he no longer wished to take it. He said that it had been two months since his last dose and he was coping well.
50. Nurse A completed two assessments which indicated mild withdrawal symptoms for opiates and benzodiazepines. Mr Clark declined a referral to the substance misuse service and Nurse A did not refer him.
51. Officer B, an induction officer, carried out Mr Clark's first night in custody interview. Officer B told the investigator that staff do not see the digital PER as part of this interview process. She said that she sees the CSRA document and that any suicide and self-harm warnings about the prisoner should be written in the comments box at the bottom of this document. (At Hewell there is also a Reception Staff Handover to First Night Centre document which includes questions about self-harm warnings, mental health issues and substance issues. The prison was unable to locate Mr Clark's and we do not therefore know what was written on it.)
52. Officer B could not remember Mr Clark's induction interview or recall what was on the CSRA document. She noted in Mr Clark's prison record that he had no thoughts of suicide or self-harm.
53. Mr Clark was not offered a phone call on his first night in custody as he was subject to public protection measures, but was given £2 credit the following day. Mr Clark did not make any calls during his time at Hewell.
54. At around 6.30pm, Mr Clark moved into a shared cell on House Block 2 (the induction wing, where all new prisoners initially live).
55. On 31 October, Nurse B, a mental health nurse, saw Mr Clark. Nurse B recorded that Mr Clark was irritable about being in custody. She noted that she had no access to Mr Clark's community records and could not therefore confirm his diagnoses but that he reported EUPD, anxiety, depression, PTSD and ADHD.
56. Nurse B discussed Mr Clark's recent overdose and recorded that he denied any plans or wish to end his life. Nurse B assessed that Mr Clark would benefit from psychosocial support and referred him to the substance misuse service.
57. That day, Mr Clark's sister's number was added to his prison phone account. He did not try to call this number during his time in prison. (Sometime between 11 and 23 November, Mr Clark wrote to his sister to ask for her telephone number so he could add it to his account. (Mr Clark's family provided a copy of this letter to the investigator.) We do not know exactly why he did this, given that the number had previously been added. In the letter, Mr Clark also asked for his mother and father's

numbers. Mr Clark's mother and sister attempted to contact Mr Clark via the Find a Prisoner Service, but they did not receive a response before he died.)

58. A member of chaplaincy staff delivered Mr Clark's chaplaincy induction. (Mr Clark did not have any further contact with chaplaincy staff.)
59. On 1 November, healthcare staff discussed Mr Clark and allocated him a mental health care coordinator.
60. On 5 November, Mr Clark met a drug recovery worker, to explore psychosocial support, which he declined. Mr Clark shared that his problem was his mental health. Mr Clark said he wanted a diazepam prescription as he said this was the only medication to help with his anxiety.
61. On 11 November, Nurse C, a mental health nurse and Mr Clark's care coordinator, reviewed him. He recorded that Mr Clark felt anxious and said that he needed a medication review. Nurse C told the investigator that Mr Clark's main concern on that day was wanting to move off House Block 2, so he rebooked an appointment to discuss Mr Clark's care plan.
62. On the same day, Mr Clark moved to House Block 1, a standard residential wing. Officer C took him to his cell. Officer C said that over the following days, Mr Clark said that he struggled with his mental health. Officer C told us that he thought he had contacted the mental health team by phone but that he was unable to say the exact dates he had done so. (He did not record this contact and there is no mention of it in Mr Clark's prison or medical records.)
63. On 14 November, Nurse C saw Mr Clark. He recorded that Mr Clark was more settled and said that he wanted a review of his medication. Mr Clark explained that he was previously prescribed diazepam, and he felt that his anxiety had increased. Nurse C explained that Mr Clark was on the waiting list for the psychiatrist and noted that Mr Clark was happy about this. (Mr Clark had been referred for a routine appointment with the psychiatrist, for which the waiting time could be up to 18 weeks.)
64. Nurse C said in interview that he did not observe any evidence of paranoia or psychosis and was not aware of the reason that Mr Clark was prescribed quetiapine. He did not contact the Community Mental health Team as he said it would usually be the Early Days in Custody Team who would find that information. They discussed that Mr Clark was due in court on 27 November and that he was expecting a custodial sentence.
65. Nurse C told the investigator that he found Mr Clark to be settled and did not consider that ACCT procedures were required. Nurse C recorded that Mr Clark was RAG rated "amber" because of his anxiety and history and that he planned to see him again on 2 December. (RAG rating is a red, amber, green system identifying a prisoner's risk, to inform the frequency of reviews. The expectation at Hewell is that prisoners rated as "amber" would be seen every two or three weeks.)
66. On 20 November, Mr Clark submitted an application to the healthcare department. He ticked that he needed the following services: (i) nurse/doctor (ii) mental health and (iii) medications/pharmacy. He wrote on the application that he needed

medication for constant headaches due to a broken eye socket and that he had severe anxiety. He ticked that this was a long-term need and wrote that he had had anxiety for the last eight to ten years. An appointment was later arranged for the 11 December. (We do not know if Mr Clark was made aware of this appointment.)

67. On 21 November, Mr Clark's maths tutor had a discussion with Mr Clark to complete an Individual Learning Plan (ILP). The tutor recorded that he experienced extreme mental health and had been diagnosed with PTSD and EUPD, and had ADHD, anxiety and depression. She recorded that he experienced night terrors and that he said that his mental health had deteriorated rapidly and he had a lot of challenges.
68. At interview, the tutor said that she told her manager about this discussion. She explained that her first impression of Mr Clark was that his mental ill health was more severe than she was used to dealing with. They decided to monitor Mr Clark to see if he settled down.
69. The tutor told us that Mr Clark was very paranoid about officers coming into or walking past the classroom, and about other learners. He made comments such as "where are the cameras in the room" and that he felt that he was being watched throughout.
70. Officer C told us that, over the next few days, Mr Clark started saying things like, "My head's all over the place, I need to be high risk". Officer C said to Mr Clark that until healthcare accepted that he was high risk, he would have to share a cell with someone. (The Head of Safety told us that the duty operational manager can authorise temporary high risk for cell sharing, without the input of healthcare staff.) Officer C told the investigator that Mr Clark seemed on edge, was talking fast and seemed to be completely different to before.
71. On the morning of 23 November, Mr Clark was angry and refused to go in his cell. He repeated that he wanted to be high risk. Mr Clark said, "I'm not banging up, my mental health's all over the place". Officer C said that he tried to calm him down.
72. Officers then took each of Mr Clark's arms and restrained him on the floor. They noted in statements that they believed force was necessary because Mr Clark was refusing an order and was holding onto bars and refusing to let go. Officer C also said that he believed that force was appropriate as he was concerned that Mr Clark was going to get onto the netting (which spans across the landings between floors as a safety feature to prevent falls) next to him.
73. Around a minute later, officers lifted Mr Clark up off the floor and SO B and Officer C escorted him back to his cell. Mr Clark told SO B that he was having night terrors and that it was "bad for him and for whoever shares with him".
74. That afternoon, Mr Clark moved to House Block 3, a standard residential wing. An intelligence report noted that staff moved Mr Clark due to possibly being under threat from his former cell mate.
75. On 25 and 26 November, Mr Clark missed his daily dose of venlafaxine. On one occasion, the record states he did not attend and on the other it notes that prison officers asked him twice but he declined. (Mr Clark took some of his other

medication at a different time of the day. There is no evidence that he missed doses of his other prescribed medication.)

76. On 26 November, Mr Clark spoke to the tutor and said that he was not good. The tutor told the investigator that he went on to say that he wanted to complain about some officers and asked how to do it. The tutor explained that she would find out for him. Mr Clark told her that “they’re watching me in my cell” and that they “want rid of me”. He explained that he had the officers’ names and numbers and that he had them written in his cell.
77. Following this, the tutor spoke to the tutor’s manager and they completed an intelligence report. In the report, the tutor wrote that Mr Clark felt unsupported, extremely paranoid and did not trust anyone in the prison. She recorded that he had alleged that he had previously attempted to take his own life and she suggested in the report that if he were pushed further he may cause harm to himself, his cellmate or officers. The tutor and the tutor’s manager did not share the information further and did not discuss starting ACCT procedures. We have not seen evidence that this intelligence report was shared with Safer Custody or wing staff.
78. On 27 October, Mr Clark attended court. He pleaded guilty to two charges and not guilty to one charge and was remanded to face trial.
79. On 28 October, Mr Clark did not attend an appointment for an asthma review.
80. That afternoon, Mr Clark moved to a different, shared, cell on House Block 3. (The reason for the cell move was not recorded in his prison record.)

Events of 29 November

81. On 29 November, Mr Clark asked Officer D about his prison shop purchases and when these were going to be delivered. (Due to Mr Clark’s recent move onto the houseblock, his purchases had not been delivered straight to House Block 3.) She explained at interview that she told Mr Clark that they would be delivered later that day and that he seemed happy with this response.
82. At around 6.00pm, Officer D gave Mr Clark his prison shop purchases which she said contained a pack of vapes and a greetings card. Mr Clark became agitated and said that he had not ordered any cards and that staff were “taking the piss” out of him. Officer D said that he was standing at the door with a kettle in his hand.
83. Officer D asked Mr Clark to put the kettle down and closed the door. She explained at interview that Mr Clark seemed very angry and she was concerned that he was going to throw water over her.
84. Mr Clark shouted through the door that he could “hear them all” and that they were taking the piss out of him and that one day her face would be “burnt off”. He started shouting loudly and said to leave him alone.
85. Around 15 minutes later, Mr Clark assaulted another prisoner by throwing hot water through the crack in his door and scalding the prisoner’s forehead. He said afterwards that he did not mean to harm the prisoner and that this was intended for an officer.

86. Following this, Officer D charged Mr Clark with offences against prison rules for using threatening behaviour and for assaulting a prisoner. (The disciplinary hearings did not take place as there was insufficient information in the reports.) Officer D recorded the incident in Mr Clark's prison record and in the wing observation book. She also submitted an intelligence report.
87. Officer D phoned Custodial Manager (CM) A (the duty manager) due to concerns about Mr Clark sharing a cell. CM A said that he would have a conversation with Mr Clark. Officer D said in interview that her plan was to complete a mental health referral when she was next on duty.
88. Later that evening, CM A spoke to Mr Clark in his cell. (He turned on his body worn video camera, so we were able to watch the recording of the conversation.) Initially, Mr Clark said he would not take a seat on his bed as he didn't know what CM A was going to do. Mr Clark said that the whole time he had been at Hewell "these lot" were taking the piss out of him. (From the context we believe that this is referring to staff rather than prisoners.)
89. CM A asked Mr Clark if he would have any issues with other prisoners, given what had happened with the prisoner earlier, and offered him the opportunity to move to the segregation unit for protection if required. Mr Clark said it did not matter where he went and it did not make a difference. He said that he probably would have issues but that he would have to face these. Mr Clark asked CM A to tell staff to "stop taking the piss out of him". CM A asked Mr Clark how they were doing this and Mr Clark responded that he "wasn't going to go there".
90. CM A told Mr Clark that they would bring his cell mate back into the cell and that he was on shift the next day if Mr Clark wanted to speak to him. CM A told the investigator that Mr Clark presented as very paranoid.
91. Mr Clark's cell mate at the time, said that it was clear Mr Clark had things on his mind. He said that Mr Clark had night terrors and used to shout in his sleep, including about officers. He said that Mr Clark told him that he had tried speaking to a few officers but that he was very stressed that they weren't doing the things he asked for. Mr Clark said he did not want to be in a cell with someone else and that staff were laughing at him. The cell mate said that they spoke together to Officer D and tried to get Mr Clark in a single cell. (Officer D said in interview that she did not recall any interactions with Mr Clark before 29 November.)
92. The cell mate said that Mr Clark did not show any signs that he intended to take his life. He said he thought Mr Clark also had concerns about medication.

Events of 30 November

93. In the morning of 30 November, CM A and SO B spoke to Mr Clark about the incident the evening before. CM A said at interview that Mr Clark seemed much calmer and more settled than the day before. He told Mr Clark that he would have to see an operational manager to discuss throwing water at the prisoner the day before. (This would be as part of the disciplinary process in prison.)
94. In this conversation, Mr Clark spoke about his mental health struggles and waiting for an ADHD diagnosis, his history of substance misuse and said that he needed a

medication review. Mr Clark said that he felt he had not been supported by the mental health team and that he was not in a good place. He explained that he needed help but was not receiving it. Mr Clark said that staff were constantly talking about him on the landing, but did not name any particular staff. SO C recorded that she was not sure if Mr Clark was hearing things or whether staff were actually talking about him. (SO C explained that there was an officer called Clark on the landing, which might have led to some confusion for Mr Clark.)

95. Mr Clark said he had apologised to the prisoner he had assaulted but he was concerned that there were going to be some reprisals. CM A said that Mr Clark said that he wanted some help and support. CM A told Mr Clark he would contact the mental health team. He also said that they would look to move him to House Block 4 and make him temporary high risk for cell sharing, so that he could get some sleep and did not have to worry about his night terrors. They did not discuss whether Mr Clark had any thoughts of suicide or self-harm and CM A was not aware of Mr Clark's history of attempted suicide and self-harm. CM A said that Mr Clark seemed positive at the end of this interaction.
96. At 9.50am, CM A sent an email to the psychosocial cluster manager. He wrote that he had spoken with Mr Clark and that he was a complex individual with an extensive history of poor mental health. He asked the manager to check that Mr Clark was on their radar and being supported.
97. That afternoon, Mr Clark moved to B1 landing on House Block 4 and was allocated a single cell. (House Block 4 is a wellbeing unit which houses men with substance misuse issues. B1 landing is for those with mental health issues.) CM A spoke to SO C and explained the incident from the day before and that this was a fresh start for Mr Clark.
98. At 8.26pm, the manager responded to CM A's email and copied in the Head of the Mental Health Team and Nurse C. She wrote that Mr Clark was currently under the mental health team and asked Nurse C to look at CM A's email. (The Head of Mental Health and Nurse C were not on duty that weekend and did not therefore see the email until after Mr Clark had died.)

Events of 1 December

99. The following account has been drawn from staff statements, interviews, body worn video camera (BWVC) footage, CCTV footage and ambulance service records.
100. SO D told us that wing staff had discussed Mr Clark at the morning briefing. He said that he told them that Mr Clark had attempted to throw water on officers. He told us that anyone who was located on the B1 landing would have some kind of mental health issue, but he did not know about Mr Clark's diagnoses or history.
101. At around 9.00am, an officer unlocked Mr Clark's cell. (Mr Clark did not leave the cell.) Around a minute later, Officer E and Officer F spoke to Mr Clark at his cell for around a minute. They went back a minute later and stayed for around three minutes. Officer E told us that when he was first unlocked, Mr Clark was screaming and shouting that she had been talking about him and saying things through his door. Mr Clark said that House Block 3 staff had worked with him and knew what he needed and shouted for them to get SO C.

102. Officer E told Mr Clark that they could discuss his care needs after he had calmed down. She told us that at this point he appeared extremely paranoid.
103. At 9.20am, Mr Clark went to the medication hatch. A medical technical officer administered him two paracetamol tablets. (The Head of Healthcare told us that the medical technical officer spoke to Mr Clark, who stated he had severe anxiety for eight to ten years. The medical technical officer did not escalate this further as Mr Clark already had an appointment booked with the GP.)
104. For the next hour and a half, Mr Clark went in and out of his cell several times, as well as going upstairs. He did not interact much with other prisoners except for very brief conversations.
105. Officer E told us that, during the morning, Mr Clark came to the office and asked her for vapes or phone credit. (She was unsure what exactly Mr Clark had asked for. Mr Clark still had £2 phone credit from when he arrived in prison as he had not made any calls.) She explained that he seemed fine at this time.
106. A prisoner living next door to Mr Clark, said that he spoke briefly to him on one occasion that morning. He said that Mr Clark asked him for a razor but he did not have one and that he would need to get one from the officers. He said that Mr Clark appeared to be upset and was angry and annoyed and said things like "I hate everyone" and that he didn't trust "them".
107. At 11.00am, Officer E locked Mr Clark in his cell along with the rest of the landing.
108. At 11.41am, Officer E unlocked Mr Clark for lunch. As she opened the door, Mr Clark shouted very loudly, "Why do you lot keep chatting shit about me, I've had enough, leave me alone". She immediately shut the door.
109. At 11.49am, SO D and Officer G went to Mr Clark's cell. As they entered the cell, Mr Clark shouted about the "shit" they had caused for him. SO D asked him to explain what was going on. Mr Clark continued to gesture outside and said that they were talking about him on the wing. Mr Clark was extremely angry and appeared distressed. SO D continued to try and get Mr Clark to sit down.
110. Mr Clark said he did not want to speak to SO D. He said it did not matter who he spoke to and told them to get out of the cell. The officers left the cell around three minutes later. (Mr Clark did not have lunch.)
111. At 1.48pm, Officer H spoke to the prisoner. He said that the prisoner told him that Mr Clark was "banging". (During the afternoon, the prisoner heard a lot of banging and told the investigator that it sounded like furniture. He said this lasted for around 20 or 30 minutes. He said he heard Mr Clark shouting but could not remember what he said.)
112. Officer H then went to Mr Clark's cell and looked through the observation panel. He told us that the observation panel was partially covered with paper, although he could still fully see Mr Clark, who was pacing up and down. He asked Mr Clark if he was alright and he nodded and carried on pacing. CCTV shows that Officer H then stepped back and crouched down slightly to look in the cell. (It appears from CCTV footage that Officer H was attempting to look through gaps in the cell door.) He told

us that he wanted to see if Mr Clark did anything different when his panel was shut. Officer H told the investigator that Mr Clark carried on pacing.

113. At 3.54pm, SO D and Officer E went to Mr Clark's cell. SO D said that he intended to have a conversation with Mr Clark and to bring him his food. SO D opened Mr Clark's observation panel but this was covered and when he tried to open the door, but he found that it was barricaded.
114. SO D attempted to move the barricade and managed to open the door slightly. A prisoner who was outside the door then went in the cell to remove the obstruction. (Officer E told the investigator that this prisoner was small enough to get through the gap and offered to help remove the obstruction to gain entry more quickly.)
115. At 3.55pm, SO D entered the cell and saw Mr Clark hanging from the toilet door. An officer radioed a medical emergency code blue, indicating a life-threatening situation. SO D and Officer E cut the ligature and shouted for prisoners to get some more staff and press the general alarm. SO D immediately started CPR.
116. At 3.58pm, healthcare staff arrived and officers continued CPR. At around 4.14pm, paramedics arrived and noted that rigor mortis and hypostasis were present (two conditions which are unequivocally associated with death). At 4.20pm, paramedics pronounced life extinct.

Contact with Mr Clark's family

117. At around 8.30pm on 1 December, the Governor at the time, and a member of the chaplaincy, arrived at an address they had for Mr Clark's mother. They found that this was not her current address. They phoned Mr Clark's sister but were not able to get through to her. They then phoned the control room who found a number for Mr Clark's mother in Mr Clark's records.
118. The Governor phoned Mr Clark's mother to ask where she lived. She explained that she lived on the Isle of Wight and the Governor therefore broke the news over the phone.
119. The following day, the prison appointed CM B as the family liaison officer.
120. The prison contributed toward the cost of Mr Clark's funeral in line with national policy.

Support for prisoners and staff

121. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

122. After Mr Clark's death, an Operational 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 also offered support.
123. The prison posted notices informing other prisoners of Mr Clark'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 by Mr Clark's death. Staff initiated postvention with the two prisoners who had helped in the emergency response. Postvention with other prisoners was carried out the following day.
124. Mr Clark's previous cell mate told us that he had not been provided any support.

Post-mortem report

125. A post-mortem examination found that Mr Clark died of a cardiac arrest as a result of hanging. Toxicology tests identified an elevated level of venlafaxine which suggested recent moderate excessive use before his death.
126. While Mr Clark was prescribed venlafaxine, he was required to take it front of healthcare staff (who are normally expected to check the prisoner's mouth to ensure they have swallowed it to prevent medication diversion), so we do not know how he came to obtain amounts of the medication over the levels prescribed to him.

Findings

Identifying the risk of suicide and self-harm

127. Prison Service Instruction (PSI) 64/2011, on safer custody, which was in place at the time of Mr Clark's death, required staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under suicide and self-harm procedures (known as ACCT). From January 2025, PSI 64/2011 was superseded by the Prison Safety Policy Framework, in which the principles of how risk is identified and the action that should be taken as a result remain largely unchanged.
128. PSI 07/2015 'Early Days in Custody' sets out guidance and mandatory actions for prison staff regarding reception, first night in custody and induction procedures. It sets out that the completed Person Escort Record (PER) and any other available documentation must be examined, and the prisoner interviewed in reception, to assess the risk of suicide and self-harm. Staff are required to be aware that particular groups are at a higher risk of suicide/self-harm. Annex D of PSI 07/2015 lists the categories of prisoners who may be especially vulnerable to suicide or self-harm.

Reception

129. When Mr Clark arrived at Hewell he had several risk factors for suicide and self-harm. He reported a mental health diagnosis and a history of self-harm and suicidal behaviour. Mr Clark also had an extensive history of substance misuse and was on remand for offences that, if convicted, might lead to a longer sentence than he had previously served.
130. Mr Clark's PER noted a suicide and self-harm warning and that he had taken a deliberate overdose in September 2024, six weeks before he was sent to prison. It also included details about his previous history of suicide attempts in police custody. It recorded that he was observed every 30 minutes prior to arriving at Hewell. The PER also noted Mr Clark's mental health needs including that he had EUPD, PTSD, depression and anxiety.
131. SO A could not recall his interaction with Mr Clark, but said that his usual practice was to look through the PER. While he was aware of risk factors which would increase someone's risk of suicide and self-harm, he explained that when considering whether to start ACCT procedures, he looked at a prisoner's presentation, including body language, verbal communication and eye contact.
132. SO A made a case note on Mr Clark's record that he had no thoughts of suicide or self-harm, but did not mention his suicide and self-harm warning or any consideration for ACCT procedures. The Head of Safety explained that, where there was a suicide and self-harm warning, he would expect an entry to set out that there was a warning and the justification as to why an ACCT was not opened.
133. Nurse A was an agency nurse on one of his first shifts at Hewell and told the investigator he did not have access to Mr Clark's PER as he did not have a log-in.

(Following Mr Clark's screening, a colleague came to tell Nurse A that he could not do the reception screenings as he needed access to the system.) Nurse A did have access to some paperwork and did record that Mr Clark had taken an overdose six weeks before and had been in a psychiatric hospital in 2016. He explained that he did not start ACCT procedures as there were not any acute mental health issues at the time he saw Mr Clark and that he said he did not have any thoughts of suicide or self-harm at that time.

134. At interview, the investigator showed Nurse A the information contained in the PER. He explained that if he had seen this he would have started ACCT procedures for Mr Clark. The Head of Healthcare told us that there was a quality assurance system in place to ensure that all healthcare have seen and reviewed the PER. She explained that where there is an agency member of staff the PER should be printed out and that there are posters to highlight that healthcare staff need to review the PER. Where the PER has not been reviewed, healthcare staff must set out the reason. (Nevertheless, Nurse A told us that he did not see the PER and we note that he did not record a reason. This suggests that the quality assurance system did not work on this occasion.)
135. Officer A, who completed the CSRA, explained that she always tries to look through the PER but if it is a busy night she will not have the time to look through this thoroughly. Officer B, first night interviewing officer, explained that staff in that role do not see the PER as part of this process. She told the investigator that she would expect all mental health or suicide/self-harm warnings to be put in the comments box on the CSRA. (Officer A explained that she would not put anything in the comments box about previous history of self-harm.)
136. We found that not all staff interviewing Mr Clark as part of the reception and first night process were fully aware of his risk factors. Certain staff based their assessment of Mr Clark's risk based on he presented, rather than examining and considering all the relevant risk information. His recent overdose should have been a strong consideration for starting ACCT procedures and we found no record that staff had considered this as part of the reception process.
137. While Mr Clark took his life just over a month after arriving, had staff properly considered his risk and started ACCT procedures on arrival then they would have been in a better position to understand his risk factors and this would have given wing staff an opportunity to set a care plan to support him through his first weeks in prison.
138. Our investigation into the death of a prisoner in 2022, identified concerns about the reception process and identifying risk. In response to our recommendation, Hewell said that healthcare staff would be given access to the PER, that all PERs would be seen by the reception SO and where a PER identified any risk of suicide or self-harm there would be a welfare conversation to establish risks and triggers, and that this information would be recorded on the induction passport before being handed over to early days in custody staff. (Hewell could not locate Mr Clark's induction passport so we cannot say whether any risk information was recorded on it.)
139. We found the process for reviewing key information about arriving prisoners and recording and sharing information across the roles who had early contact with new prisoners was confused and not sufficiently robust. In April 2024, Hewell

commissioned a training needs analysis to assess the provision of care in the Early Days in Custody Unit for those at risk of suicide and self-harm. The analysis, completed in January 2025, made a number of training and non-training recommendations. (The non-training recommendations include a review of staffing levels in Early Days in Custody and the introduction of quality assurance checks of record keeping and defensible decisions.) The Head of Early Days and Wellbeing told the investigator that, as a result, Hewell have now run cohorts of training and that they are planning to establish regular meetings to consolidate this learning. Hewell are also in the process of implementing the non-training recommendations.

140. Given the work which Hewell are doing in this area we do not make a recommendation. However, experience tells us that this area requires maintained focus to effect genuine change. The Governor will wish to monitor this work and the implementation of the recommendations contained in the needs analysis to ensure that prisoners at risk of suicide and self-harm are properly identified and supported.

ACCT training

141. PSI 64/2011 says that all staff in contact with prisoners must be trained to at least ACCT Foundation level. The Prison Safety Policy Framework notes that Governors must ensure that all staff are aware of the ACCT process and know how to act on concerns they become aware of from any source (but no longer stipulates that all staff must be trained). It says that a member of staff must start ACCT procedures when a prisoner has self-harmed or where there are concerns regarding a prisoner's risk of suicide or self-harm.
142. On 26 November, the tutor identified that Mr Clark was paranoid, that he had previously attempted to take his own life and she suggested that if he was pushed further he may cause harm to himself, his cell mate or officers. She explained that she did not feel there was a risk of suicide or self-harm as Mr Clark's main issue was his complaints about staff members on the wing. (The tutor also told us that she did not consider handing the information over to the officers who escorted Mr Clark, as she wanted to follow a formal process due to her concerns for his extreme paranoia.)
143. Following the conversation, the tutor spoke with her manager but neither of them considered starting ACCT procedures or raising directly with safer custody or wing staff.
144. At interview, the tutor explained that she had not received ACCT training since starting at Hewell in June 2024. She said that she needed more training in ACCT procedures and was still reliant on the opinions of others. The tutor's manager has previously had ACCT training, but not while she has been at Hewell. During our investigation, the tutor's manager told Safer Custody staff that she had previously requested ACCT training for her staff, without any provision.
145. The Head of Safety said that non-operational staff should have a level of ACCT training in their induction and should know how to get support from the Safer Custody Team. He told the investigator that they offer non-operational staff a day at various intervals as required where they can train all staff in their department, but recognised that this could potentially mean that staff could go some time before being trained. The Head of Safety explained that the prison are working on

implementing assurance processes to ensure they properly capturing the non-operational staff who have completed the training. We make the following recommendation:

The Governor should review the provision of training to non-operational staff to ensure that they are competent in identifying increased risk of suicide and self-harm and understand how to start ACCT procedures when required.

29-1 December

146. There is evidence that Mr Clark's mental health began to deteriorate in the time before his death, and particularly that he was growing increasingly paranoid. In the few days before he died, CM A recognised Mr Clark's mental health concerns. It was a positive decision to recognise that Mr Clark's aggressive behaviour might be caused by poor mental health and to move him to the wellbeing unit rather than placing him in segregation. However, CM A was not aware of Mr Clark's previous history of self-harm.
147. At lunchtime on 1 December, Mr Clark was clearly extremely agitated and distressed. SO D tried to positively engage with Mr Clark but was not able to at this time and there was no plan put in place to check on his wellbeing. While Officer H did check on Mr Clark, he did not have a conversation with him, which might have been an opportunity to identify increased risk.
148. Some staff recognised Mr Clark's deteriorating mental health and some positive action was taken. Broadly, we think that staff at Hewell responded to Mr Clark's challenging behaviour calmly and with empathy. However, wing staff were not aware of Mr Clark's history of suicide attempts and this, in combination with his increasing paranoia, could have led them to consider ACCT procedures. Our investigations into self-inflicted deaths indicate that there may be a link between increasing paranoia and increased risk of suicide and self-harm that merits further consideration and a more proactive approach. HMPPS may wish to consider this area further.

Blocked observation panels

149. An HMPPS Safety Briefing on Observation Panels, issued in February 2018, said that local safety measures should explain what staff should do if the occupant of a cell cannot be seen due to the panel being covered or blocked. It said that when staff discover that a panel has been blocked and the prisoner does not comply with instructions to remove the blockage, they must take immediate action to remove the obstruction and check on the prisoner's welfare.
150. Officer H told the investigator that when he went to Mr Clark's cell around two hours before he was found, the observation panel was "partially blocked". He said at interview that less than half of the panel was covered and that he still had a clear view of Mr Clark. When officers attended Mr Clark's cell later that afternoon, the observation panel was completely blocked.
151. Officer H explained that a lot of prisoners cover their observation panels and as long as he could see into the cell he would not do anything. SO D said that

prisoners often partially obstructed their panel, but that this was fine as long as there was a clear and unobstructed view of the cell.

152. Hewell has recently reissued their Clean and Decency Policy, to say that observation panels are “scratch and cover free at all times” It does not include any specific guidance or instruction for what staff should do if they find an observation panel blocked, in line with the expectations of the national briefing. We make the following recommendation:

The Governor should amend local policy to provide staff with clear instructions about the actions they should take when they discover a blocked observation panel and follow this up with a clear quality assurance process to ensure that staff understand their responsibilities.

Clinical care

153. The clinical reviewer concluded that the clinical care that Mr Clark received at Hewell was not equivalent to that which he could expect to receive in the community.
154. Upon arrival at Hewell, the reception nurse referred Mr Clark to the mental health team and he was also referred to the psychiatrist. Mr Clark acknowledged his own concerns about his anxiety through an application and healthcare staff had booked a GP appointment, which was due to take place on 11 December. The clinical reviewer was satisfied that Mr Clark’s risk was appropriately assessed at the amber level of the RAG rating.
155. However, neither the early days in custody team nor Mr Clark’s care co-ordinator made contact with his community mental health team and therefore did not have a full picture of his mental health history or the reasons for his prescribed medication. We make the following recommendation:

The Head of Healthcare should ensure that mental health staff understand the circumstances in which they should request a prisoner’s history from community mental health services and that there are clear roles and responsibilities for requesting this information.

156. The clinical reviewer also noted that given Mr Clark’s complex history of substance misuse and declining to continue his Buvidal prescription, he should have been referred to the clinical substance misuse service. This would have allowed them to monitor his withdrawal and associated symptoms and to provide any necessary additional support or referrals. We make the following recommendation:

The Head of Healthcare should ensure that patients with a complex history of substance misuse, including those prescribed opiate substitution medication before their arrival in prison, are referred to the clinical substance misuse team for an assessment of their needs.

Governor to note

157. PSI 64/2011 says that, wherever possible, the family liaison officer and another member of staff must visit the next of kin in person to break the news of the death. It notes that where face to face notification is not possible, a follow up visit must be arranged as soon as possible.
158. Prison staff broke the news of Mr Clark's death over the phone, having visited an old address for his mother. We appreciate that in this circumstance it was appropriate to tell her over the phone in order to get the information to her as soon as possible. However, if the prison had the right address initially, they might have been able to get another establishment to visit Mr Clark's next of kin in person.
159. There were no next of kin address details recorded for Mr Clark at reception. In Mr Clark's prison record, staff noted that no details were given. We do not know whether this means that Mr Clark refused or did not know the details for his next of kin or if he was not asked to provide these. We understand that at Hewell, apart from on the first and second day in custody, they do not follow this up further. The Governor will want to consider what more can be done to maximise opportunities for prisoners to provide correct next of kin details.

Governor and Head of Healthcare to note

160. The toxicology report identified higher than expected levels of venlafaxine in Mr Clark's body. Mr Clark was prescribed this medication but did not keep it in his cell, meaning he was expected to take it in front of the dispensing clinician, who should check that the medication has been swallowed so it cannot be diverted.
161. We cannot say how Mr Clark came to consume more venlafaxine than would be expected given his dose, but as it was medication prescribed to him, it seems most likely that he was not taking it as prescribed but instead was stockpiling it. (The alternative being that he had purchased additional quantities from another prisoner.) The Governor and Head of Healthcare will wish to consider whether the supervision of medication queues and process for ensuring prisoners take their medication as prescribed is sufficiently robust.

Inquest

162. The inquest into Mr Clark's death concluded on 23 July 2026, a returned a verdict of suicide.



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