The death in custody of a man at HMP Shrewsbury in May 2004

Report by the Prisons and Probation Ombudsman for England and Wales

July 2005

This is the report of an investigation into the circumstances of the death of a man who hung himself at HMP Shrewsbury in May 2004. The sad death of the man occurred in only the second month in which I took responsibility for investigating all deaths in custody. I would like to offer my sincere condolences to the man's family on their loss.

Under transitional arrangements agreed with the Prison Service at the time, a Senior Investigating Officer (SIO) was appointed by the service to conduct the investigation. The SIO works to me for the duration of the investigation and submits a draft report that I review and amend as necessary. This final report is my independent examination of the circumstances leading to the man's death.

In this case the SIO was the Governor of HMYOI Stoke Heath. I appointed one of my investigators as the liaison officer. The SIO and one of my family liaison officers, met the man's mother and sisters at his mother's home during the course of the investigation. The family liaison officer remained in telephone contact with them throughout the investigation.

A clinical review into the man's care and treatment was commissioned from the Director of Quality and Nursing at the Primary Care Trust (PCT). The review was undertaken by a Consultant Forensic Psychiatrist.

I am grateful for the assistance offered to the investigation team by the staff at HMP Shrewsbury, the Police and the staff at the Crown Court during the course of this investigation.
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Stephen Shaw
Prisons and Probation Ombudsman

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Summary

The man was a 61 year old. He was no stranger to prison and had served 19 previous custodial sentences. He was released on license from a 10 year sentence for supplying class A drugs in May 2003.

The man was arrested again in October 2003, along with his co-accused, and charged with conspiracy to supply class A drugs. He was taken to HMP Shrewsbury on 17 October 2003.

The man's trial began in April 2004. He attended court daily between 27 April and 30 April and 4 May to 7 May. Prisoner escort record forms (PER forms) were completed on each day he was at court. On 5 May an entry on the PER form stated that there had been 'problems in court' and described the fact that the man had attempted to throw water across the dock, resulting in the dock screen being broken. He was held in contempt of court by the judge following this incident.

The man attended court and gave evidence on 6 May and 7 May. On the evening of 6 May he allegedly told a fellow prisoner that he was going to 'do himself in'. The prisoner stated that he had known the man for some time and did not consider this to be a serious threat. He did not inform staff at Shrewsbury prison of this conversation.

During court proceedings on 7 May the man objected to other evidence given and in the afternoon he left the dock and refused to return. He had a short legal visit and then returned to the prison.

A member of reception staff at Shrewsbury prison received a telephone call from the courts that afternoon, requesting that the man be informed that if he refused to attend court on Monday 10 May, the hearing would continue in his absence. He was told of this upon his return to Shrewsbury but staff said he seemed unconcerned by it.

The man was seen by two Samaritan trained prisoners, known as 'listeners' in reception that evening. They too said they had no concerns about him.

The man occupied a single cell at Shrewsbury prison and returned to it at 8.00pm on 7 May. Following lock up, a prisoner in a neighbouring cell said he asked if the man was alright. The prisoner said that he replied that he was Ok and there was no further conversation between them.

At approximately 6.00am on 8 May during morning roll check the man was found hanging in his cell from the window bars. He had laid out his glasses, and watch, and had left a note.

Assistance was called for, but it quickly became evident that there were no signs of life. Paramedics arrived on scene and pronounced the man dead at 6.17am.

Background

HMP Shrewsbury

Shrewsbury is a local prison, opened in 1783. It holds both sentenced and unconvicted prisoners, and has an operational capacity of 350. On the morning of 8 May 2004, the unlock figure was 335. Shrewsbury prison had two deaths in custody in the six months before the man died. Prior to these the last death in custody had been some three and a half years ago.

The age and size of the prison has resulted in a limited regime for prisoners. The gymnasium building has been declared unsafe and is due to be demolished. No decision has yet been taken about whether to rebuild the facility.

Investigation process

Terms of Reference were issued by the Prisons and Probation Ombudsman and a liaison officer from the Ombudsman's office was appointed to the investigation. Upon arrival at the establishment, the investigation team met with the acting Governor. The team then met with the local Prison Officer's Association, a member of the Independent Monitoring Board and the Police Liaison Officer.

The senior investigating officer a family liaison officer from Shrewsbury prison and police officers met with the man's two nephews and niece on 13 May 2004. The family was concerned about two notes that he had written prior to his death. One note was addressed to a family member and a copy of this note was given to them during the meeting. The other note was addressed to the man's co-accused. This was not given to the family.

During the course of the investigation a total of 14 prison staff were interviewed. The Chairman of the Independent Monitoring Board (IMB) was interviewed, as was a Senior Custody Officer from the courts. A total of six prisoners were also interviewed. The interviews were tape recorded and a transcript was made of each interview.

The man's cell was visited during the course of the investigation. This had previously been searched by the Police and nothing of significance was found.

The last two deaths in custody at Shrewsbury prison were examined for any similarities, or action points that had not been addressed.

The investigation team examined a number of policies and procedures at HMP Shrewsbury, contingency plans and local procedures for incident response.

The investigation team received full co-operation from the local POA and local management throughout the investigation.

In May, the senior investigating officer, the principal officer and my family liaison officer visited the man’s mother and his sister, to update them on progress in the investigation and to attempt to answer any questions they had.

The death of the man and the events leading up to it

The man was arrested by the police, along with his co-accused, following a period of observation on 15 October 2003. The next day he was charged by the police with conspiracy to supply Class A drugs. On 17 October he was remanded into custody at HMP Shrewsbury. He requested, and was granted, a single cell, following a cell sharing risk assessment.

The man's trial began on 27 October at the Crown Court. He attended court daily between 27 April and 30 April 2004 and again between 4 May and 7 May. A prison escort record form (PER form) was completed each day that he travelled to court.

Nothing of note was recorded on the PER forms prior to 5 May when an entry states "10:48 problems in court 5. Attempted to throw water across court, dock screen broken during incident. [the man] handcuffed and returned to cells." Following this incident the Judge held [the man] in contempt of court. An officer employed by Premier at the Crown Court, said that the man was calm when he returned to the cell area after this incident and had a cup of tea.

A prisoner said that he had travelled to court with the man on 5 May. He said that the man had told him that he thought he was going to be found guilty and receive a life sentence. He said he thought that the man was depressed and scared at this prospect. Later that evening the man made a phone call at 7.10pm.

In a telephone conversation, the man's barrister told the senior investigating officer that the man had said at court on 5 May that "If he went down he would do himself in." The barrister stated that he did not believe that the man would actually harm himself and therefore did not report the conversation to the Prison Service.

On 6 May the man returned to court. The man's next door neighbour stated that the man had come to his cell that evening and told him that he was going "to do himself in". The man's next door neighbour had known him for several years, and said he spoke to him for some time that evening. He said that the man was worried that he was about to get a substantial sentence and told him that he would not be able to cope with that. He said that he had been his usual cheerful self until the Wednesday and Thursday of that week when he began to look distressed. The man's next door neighbour said that only someone who knew the man well would have been able to see his change in mood. He said he thought that the man's threat to kill himself was 'prison talk' and was shocked to find on the Saturday morning that he had killed himself. The man's next door neighbour did not therefore tell any members of staff about his conversation with the man.

The man made his last telephone call from the prison on Thursday 6 May to a friend. He gave no indication that he intended to take his own life and indeed does not speak about his feelings at all.

On Friday 7 May the man returned to court and again gave evidence. A prisoner from Shrewsbury was with the man in the holding cell that morning. He said that he was in good spirits and they shared a laugh and a joke. During the course of the day, the man made a statement in evidence which allowed the judge to take the decision to recall him to the witness stand to be cross examined on his previous convictions. He became upset and asked to be removed from the dock, refusing to return. The officer employed by Premier said that, prior to his removal from the dock, the man shouted out "I might as well go down then!" The officer employed by Premier said that the man was again calm in the cell area and described him as "a perfect gentleman." He said later that he and the other staff in the court were very shocked to learn of his death. The man had a short legal visit prior to returning to the prison.

At 4.30pm that day a reception officer at Shrewsbury received a telephone call from the Crown Court to inform the prison that the man had refused to attend court and that should he again refuse to attend on Monday 10 May the court would continue in his absence.

The man arrived back at the prison at 5.45pm and was told about the message from court. His response to a member of staff was “fuck ‘em”.

The man was seen by reception staff upon his return, who had no concerns about his welfare. He also spoke to two prisoners trained as Listeners. He did not specifically ask to speak to the Listeners, it is Shrewsbury's policy to employ Listeners in reception as prisoners are often in reception at a vulnerable time. Both prisoners remembered the man as quite "upbeat" and talkative when they had spoken with him earlier that week. They said there was a distinct change in his demeanour when he returned from court on Friday 7 May, when he was obviously very angry.

The man stated that he was angry and felt that the Judge in the case was against him. One of the Listeners stated that the man said at this time “That’s me pensioned off. I’m fucked.” They had a conversation in which he explained what had happened in court that day and how his previous record was to be revealed to the jury. They also said that he complained about the size of his meal and talked to them about needing to get to the gym to correct a problem with his leg. By the time he left reception the prisoners said that he seemed in quite good spirits and told them that he would see them on Monday. Neither listener said there was any indication that the man was going to take his own life and both were very surprised to learn of his death.

The man returned to his cell and, along with all other prisoners, was checked at evening lock up, which was at 8.00pm. Following lock up, the man’s next door neighbour banged his cup on the wall as a recognised signal to talk. The

man was asked if he was alright. He stated that he was Ok and there was no further conversation.

On 8 May at 5.45am an officer on night duty commenced his roll check of the wing. During this roll check he stated that he checked cell A2-31. The officer saw the man hanging from his cell window bars.

The night duty officer said that even from outside the cell he could see that the man was rigid.

Post Incident Response

Upon discovering the man hanging, the night duty officer stated that he broke his sealed pack containing a cell key, and entered the cell. The night duty officer shouted for the assistance of the Night Orderly Officer, who quickly joined him in the cell. Between them, the staff supported the man's body, and cut the ligature from which he was hanging. The man was laid on the cell floor, medical assistance was called for and this quickly arrived. The nurses on scene checked his airways, breathing and circulation but there were no signs of life. The man's pupils were fixed and dilated and rigor mortis was evident. The nurse applied the de-fibulator, which demonstrated no electrical activity from the heart.

Contingency plans were implemented. An ambulance was requested at 5:58am, paramedics arrived on scene at 06:10am and, following their assessment, they confirmed his death at 06:17am.

The Duty Governor was contacted at 06:05am, and arrived at the prison at 06:25am. The police were contacted at 06:10am, they also arrived at 06:25am. The cell was sealed at 06:30am by an officer and senior officer (SO). The police contacted the man's family and broke the sad news to them. Scenes of crime Officers arrived at the prison at 07:52am and left at 11:15am. The Coroner attended the prison at 08:05am, and left the prison at 09:00am.

All staff were seen and debriefed prior to going off duty. Several staff commented at interview that they were very happy with the hot debrief and the level of care that was offered to them.

The Family

The man's sister was contacted by my family liaison officer. She, the senior investigating officer and the principal officer visited the man's sister and mother, at their home. The family said they were happy with the manner in which the news of the man's death had been broken to them. A letter of condolence had also been sent by the acting governor. They were concerned that no one had noticed how upset the man had been when he returned from court on Friday 7 May. The senior investigating officer told them what the two listeners, staff and other prisoners had said about the man's demeanour on that day. The family accepted that only someone who knew him well would have been able to tell how he was feeling.

Level of compliance with authorised procedures

Local contingency plans were activated and adhered to. These appear to be adequate for such an incident.

The local suicide prevention policy was examined. The prison was found to be compliant with this policy. Trained Listeners are on duty in reception every evening as part of the establishment's suicide prevention policy.

A selection of F2052SH documentation was sampled. These were found to be in good order.

Action points from one of the previous deaths in custody at Shrewsbury were examined. There were 2 recommendations. One was that a safer cell be built in the Segregation Unit. A bid for this has been submitted. The other recommendation called for increased use of the crisis suite. The investigation team found that the suite had been used during the course of this investigation.

Findings

The man gave no indication to either prison staff or fellow prisoners that he would take his life. He apparently told his barrister and his next door neighbour that he would take his own life but neither person thought that there was any likelihood of this happening. Both parties were so unconcerned that they did not feel it necessary to tell anyone else about their conversations with the man. Indeed the man's next door neighbour observed that only someone who knew him very well would have been able to tell that he was upset. The trained listeners in reception simply thought that the man was angry and saw no cause for concern.

The response to the incident by staff was appropriate. Upon being found, the man was quickly tended to by healthcare staff. Paramedics were on scene very quickly, and this would have given the best chance of saving him. Sadly it appears that he had been dead for some time before he was found.

There was a lack of entries in the man's personal history sheet at Shrewsbury prison. Personal Officers knew him well and had clearly interacted with him, but this was not evidenced in the history sheet.

There was a lack of information on the PER forms completed daily during the man's trial. The incident on 5 May was recorded, but there were no indications of incidents on 7 May, when he requested to be removed from the court and later refused to return.

In both of the previous two deaths in custody at Shrewsbury both prisoners had also requested a single cell. I can draw no particular conclusion from this as the circumstances were very different in each case. I am satisfied that the man's allocation was sensibly and properly dealt with and can see nothing to criticise in the decision to put him in a cell on his own. There was no indication that he was at risk of suicide or self harm. However, interviews with wing staff showed that there is little awareness of the procedures for and reasons behind allocating prisoners to single cells.

In her clinical review of the man's medical care the doctor notes that several mental health professionals at Shrewsbury prison chose to refer to the man by his surname. I would like to endorse her view that, when in contact with health professionals, patients should be afforded respect and should be addressed by their title or alternatively their full name.

Conclusions

Staff at HMP Shrewsbury acted appropriately throughout the man's time in custody.

The man's death could not have been foreseen by staff at Shrewsbury prison.

The post incident response by staff was appropriate.

There was a lack of evidence of the interaction between the man and staff at HMP Shrewsbury documented in his history sheet.

There was a lack of information in the PER forms completed upon the man.

The decision to place the man in a single cell was properly assessed and was appropriate.

There is confusion among staff about the procedures for allocating single cells.

Recommendations

Entries in history sheets for prisoners by Personal Officers need to be improved.

Recording of events on PER forms needs to be more comprehensive and relevant information needs to be shared with all parties.

A review of local procedures should be undertaken to assess vulnerability of prisoners requesting single cell status.

Staff should be made aware of the reasons why prisoners are allocated single cells and the procedure for applying for one.

Relevant staff at Shrewsbury note the clinical reviewers report and in particular her comments in paragraph 17.