Investigation into the circumstances surrounding the death of a man at HMP Shrewsbury in June 2008

Report by the Prisons and Probation Ombudsman for England and Wales

July 2009

This is the report of an investigation into the death of a man who was discovered hanging in his cell at HMP Shrewsbury in June 2008. He had been in custody for just over three months and it was his first time in prison. The man was 47 years old when he died.

I extend my personal condolences to the family and friends of the man for their loss. I would also like to thank the family for their assistance with my investigation and I hope that I have addressed their concerns. I regret that my report is delayed and apologise for any additional distress this may have caused.

The investigation was undertaken by two investigators from my office.

An independent review of the man's medical care whilst in prison was commissioned by the local Primary Care Trust. I am grateful to the Joint Commissioner for Prison Healthcare and Substance Misuse for leading the panel review. Thanks are also due to the Governor of Shrewsbury and his staff for their help and cooperation throughout this investigation.

Given the inevitable constraints of a prison environment, I do not believe that staff at Shrewsbury could have prevented the man's death. However, while it seems the man derived considerable benefit from the psychotherapeutic counselling he received, I believe more could have been done to put in place supportive measures for his mental health problems. I endorse the recommendations of the clinical review and am pleased to note that many of these are reflected in the recent Service Review for Shropshire PCT, carried out by the West Midlands Care Services Improvement Partnership (the CSIP report).

In 2006, my office investigated another death at HMP Shrewsbury in which the clinical review recommended a review of the mental health referral process. Although the CSIP report will assist to address the problem, I am disappointed that no formal action plan was developed in response to my previous recommendation which I repeat here.

I make three further recommendations in respect of the suicide and self-harm management procedures and the personal officer scheme, two of which echo those made by Her Majesty's Chief Inspector of Prisons in her report of an inspection carried out in June 2006.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2009**

CONTENTS

Summary	4
The Investigation Process	7
HMP Shrewsbury	8
Key Findings	9
Issues	24
Recommendations	35

SUMMARY

The man was born in June 1960. He was 47 years old when he died in June 2008 in his cell at HMP Shrewsbury. It was his first time in prison.

Following an attempted overdose on 27 February 2008, the man had been arrested for an assault against a family member. After a brief return to hospital, he was remanded into custody at Shrewsbury on 1 March. He was assessed by prison healthcare staff and placed on a constant watch due to his high risk of suicide. His reception health screen concluded that he should have a mental health assessment and an appointment with the doctor. My investigators found no evidence that either took place. The man said he had suffered from depression for the last couple of years, but had never before tried to harm himself. He was initially deemed unsuitable to hold his own medication, which was administered to him at set times.

At a multidisciplinary Assessment Care in Custody and Teamwork (ACCT) review on 2 March, a registered mental health nurse concluded that the man was not actively suicidal and reduced his level of watch to intermittent. (The ACCT document is used to assess, observe and support prisoners who are at risk. It highlights the problems and possible trigger points of a prisoner at risk of self harm, and delivers a multidisciplinary plan to give support and help through a period of crisis.) Although no formal mental health assessment was carried out, the man was found to have no mental illness and was referred for counselling with a psychotherapist.

In March, the man appeared at Magistrates Court and was seen by a community psychiatric nurse who thought that he was at high risk of suicide. In her comprehensive assessment, she recommended an increased level of observation and mental health in-reach contact. The self-harm warning form she sent to the prison was not found on the man's clinical record and there was no evidence of any action as a result.

A week later, on 10 March, the weekly joint meeting between in-reach and primary care mental health confirmed that the man was unsuitable for in-reach support and he was referred back to the primary care team. However, no primary care interventions were put in place, save for the counselling, and no formal mental health assessment was carried out.

The man was a religious man who received regular chaplaincy support throughout his time in prison. He also had regular visits from his family. The man was remorseful about his offence from the start and remained depressed about its seriousness, and its effect on those close to him, throughout his time in prison.

The man was regularly monitored under the ACCT process, and the level of observations was reduced. Although he continued to be low in mood at times, his demeanour improved and the ACCT procedures were closed on 7 April. They were re-opened briefly later that month after a letter from the man to his wife was read by security staff at the prison.

On 10 April, a month after the referral, the man attended his first counselling session with a counsellor. He benefited from the sessions and slowly started to work through his problems. Citalopram was prescribed, under supervision, to manage his depression although it is unclear whether or not he saw a doctor. On 20 April, a doctor signed off a repeat prescription without sight of his medical records, and his medication was given to him in possession.

The man continued to see the counsellor each week and she encouraged him to write a personal log to externalise his feelings. By mid May, the man had become very anxious and propanolol was prescribed to manage his symptoms. Due to her concerns, the counsellor invited a mental health nurse to join three of her sessions with the man in an attempt to secure primary care support. None of these interactions was recorded or planned actions written down as a result.

On 19 May, the man pleaded guilty to his offence.

The man was said to find it difficult to communicate with male authority figures. On 26 May, he refused a mental health assessment with a male nurse, and asked to see the female nurse. No further assessment was scheduled. He did not show his emotions to staff and prisoners on the wing where he was seen as a quiet man, although popular with other prisoners.

By 3 June, the man had been prescribed his 70th day of medication in possession but without a review taking place. The counsellor noticed the next day that the man was calmer, although he kept pushing his eye which was a symptom of anxiety. She concluded that he was distressed but did not think that he was suicidal. Over the next few days the man made regular telephone calls to his wife and sister, at times appearing emotional and overwrought.

On the morning of 8 June, the man attended chapel and was described as buoyant and happy. Later that afternoon, he made what was to be his last telephone call to a friend. He then settled down for the night to watch a film with his cellmate, before going to sleep. At about 1.30am the following morning, the man's cellmate found him hanging from a ligature attached to the window. Officers and medical staff quickly attended and gave cardio-pulmonary resuscitation until the paramedics arrived. Sadly, the man's life could not be saved and his death was pronounced at 2.11am.

My investigators found a stark contrast between the distress which the man wrote about in his log and the way that he presented on the wing. With the benefit of hindsight, it is clear from the log (the contents of which he did not show to the counsellor) that he became very confused and distressed. However, he gave wing staff no reason to believe he was about to take his own life.

Although the man was regularly reviewed under the ACCT regime and appropriate decisions about risk were made, my investigators found flaws in the management of the ACCT processes. Amongst them were a lack of continuity in case management and a lack of staff and multidisciplinary input into case reviews.

I endorse the findings of the clinical review in this report. There was a lack of primary mental healthcare provision, unclear referral processes and a dilution of mental health nursing services due to a shortage of staff. Information and communication with prisoners was unrecorded, and well documented treatment plans were absent.

THE INVESTIGATION PROCESS

1. The investigation was opened at Shrewsbury on 12 June 2008 when my investigator visited the prison. My investigator met the Governor and other staff and was briefed on the circumstances surrounding the man's death. My investigator took away the man's core record and all other relevant documentation for examination. Notices were distributed around the prison notifying staff and prisoners of the investigation and inviting anyone with information about the man's death to contact the investigation team.

2. My investigator and another of my investigators returned to the prison in late July to interview staff and prisoners. An independent review of the man's medical care whilst in prison was commissioned by the local Primary Care Trust. The clinical reviewer, Joint Commissioner for Prison Healthcare and Substance Misuse, led the panel review and carried out joint interviews with my investigators.

3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.

4. One of my family liaison officers contacted both the man's wife and his sister. She gave them the opportunity to discuss the purpose of the investigation and raise any concerns or questions they wished to be addressed. The man's family raised a number of concerns:

    - Did the man make any other attempts to take his own life whilst in prison custody?
    - What medication was the man prescribed in prison and what were the likely side effects?
    - Did the man hold his medication in-possession?
    - What was used as a ligature?
    - Did the man receive any mental health assessment?
    - Why was the man not on suicide watch, given a previous attempt to take his own life?

    I have done my best to address these issues within my report. I hope that the report helps the man's family better understand the events leading to his death.

The man's sister asked why he had been permitted to contact his wife on their home telephone, given that the victim of his offence also lived there. His sister expressed concern about the emotional and psychological impact that the man's contact with home would have had upon him. The nature of his offence meant that the man's communications were restricted, including reading his mail and monitoring and recording telephone conversations. The man also signed a compact agreeing that he would not make contact with the victim. I judge that the prison's monitoring appears to have been appropriate in this case.

HMP SHREWSBURY

5. HMP Shrewsbury is a category B local prison housing adult male prisoners, unconvicted and convicted, mainly from the courts in Shrewsbury, mid-Wales and Stoke on Trent. The prison has an operational capacity of up to 340 prisoners.

6. The cells are divided between A and C wing. C wing, where the man lived during his time at Shrewsbury, is the smaller wing and normally holds around 22 vulnerable prisoners. It is a self-contained wing with direct access to the workshops, kitchen and classrooms. A wing has two gated, constant watch cells. The cells have the normal door and an additional barred door which allows staff to observe a prisoner unhindered. The man was held in one of these cells during his first few days in the prison.

7. Healthcare is provided by the local Primary Care Trust. The primary care centre is staffed by a multi-disciplinary team under the management of a general practitioner and a healthcare manager. It has no in-patient facilities but does have nursing staff on duty at night giving 24 hour healthcare cover.

8. In June 2006, Her Majesty's Chief Inspector of Prisons carried out a full announced inspection of the prison. She reported that suicide and self-harm prevention was managed under the remit of a safer custody principal officer. Some innovative ideas to promote awareness and care had been developed. The quality of ACCT documents was good, showing good levels of interaction with prisoners and insight into individual cases. However Her Majesty's Chief Inspector of Prisons found a lack of consistency in case managers, which meant that continuity of care was not guaranteed. I refer to this issue in my report and, along with repeating Her Majesty's Chief Inspector of Prisons' recommendation with regard to the lack of consistency in case managers attending ACCT reviews, I also repeat her recommendation with respect to the implementation of the personal officer scheme at the prison.

9. The Independent Monitoring Board's (IMB's) report for the year ending 20 April 2008 states that, "Healthcare within the prison is continually striving to improve" and that improvement and change remains the theme within the primary care centre at the prison. With regard to issues of safer custody, the IMB reports:

    > "ACCT procedures at the prison are of a high quality with excellent communication between staff and those at risk from self harm. There are 24 ACCT assessors and every manager is trained as a case manager to carry out daily review with multi-disciplinary team departments."

    I regret to report that my own findings appear to be at odds with those of the IMB.

10. Since my office took over responsibility for investigating deaths in prisons in April 2004, there have been five deaths at Shrewsbury prior to that of the man. All of those deaths were apparently self-inflicted.

KEY FINDINGS

Events leading up to the man's death

11. The man took an overdose of tablets on 27 February 2008. He was arrested by police in the early hours of 28 February and taken to hospital. During his stay he seems to have considered suicide a second time by climbing onto scaffolding outside his window, but changed his mind. On 29 February, he was assessed by the police medical officer as fit for custody. His medical form noted his hospital treatment and that he felt depressed and suicidal.

12. In March, the man was taken to Magistrates Court and charged with assault against a female member of his family. His prisoner escort risk record, (used to communicate information between police, court and prison staff) indicated that he was a very high suicide risk. The man was therefore placed under constant supervision.

13. At 10.48am, the man transferred to HMP Shrewsbury on remand on an open Assessment, Care in Custody and Treatment (ACCT) document, which is used to monitor and support prisoners judged to be at risk of self-harm or suicide. It was the man's first time in prison. Shortly afterwards at 11.05 am, the senior officer in charge of reception, read on the suicide and self harm warning that the man had taken an overdose and intended to kill himself as he had nothing to live for any more. The form noted that he was very depressed due to the seriousness of his offence.

14. An ACCT document was opened by a prison officer at 11.20 am. The officer and senior officer and a registered mental health nurse (RMN), carried out the routine Cell Sharing Risk Assessment. The RMN advised that the man should be placed on a constant watch, and so the senior officer concluded that he should be placed in a single cell until the constant watch ended, when he could share a cell.

15. The officer also completed a First Night Care and Induction interview which dealt with the practical issues of being received into prison. The officer recorded the interview in the First Night Care and Induction booklet and again noted the man's low mood and thoughts of killing himself.

16. At 12.30pm, the RMN carried out a First Reception Health Screen in line with routine practice in prisons. The man told the nurse that he had no physical health problems, but mentioned his recent stay in hospital due to the overdose. When asked about his mental health, the man said he had never received psychiatric care but had suffered depression and been prescribed anti-depressants, although he had not taken the medication. He described being unhappy for the last couple of years but said that he had never before tried to harm himself. The man told the RMN that he would consider harming himself again, wished that he had died from the overdose, and still wanted to die as he felt there was no way forward. The nurse noted that he was upset and talking about different ways he could end his life. She recorded that the planned

17. The RMN later completed the mental health referral form, giving the reason as the man's overdose and noting a diagnosis of anxiety and depression. (The clinical review established that this was not a referral to the in-reach secondary mental health service, but to the mental health clinics run by the primary care mental health team.) The nurse made a note of the health screen in the man's medical record, although without detailing any of the planned actions. There is no record of the doctor's appointment. The man's medical records from his community general practitioner were not requested as they should have been.

18. At 12.45pm, the senior officer completed an Immediate Action Plan as part of the ACCT process. The man was present. The senior officer explained the cell arrangements and the constant watch. The man was also given access to the telephone and offered support from the Samaritans.

19. A second RMN was on duty on A wing where she was giving out medication to prisoners. She noticed that the risk assessment for having medication in his own possession had not been completed and went to reception to interview the man. On the basis of the open ACCT and his recent overdose, she concluded that his medication should be taken under supervision. She wrote this information on the prescription chart in the man's medical record in order to alert other staff.

20. The man was placed in a gated single cell on A wing under the constant watch of an officer. An ACCT assessment interview was carried out at 4.30pm with a second officer. The man was still depressed, and distressed about his family and how they would cope. However, he said that he would not kill himself. After reassuring the man, the second officer thought that his mental state might change and so they agreed that he would remain on constant watch.

21. At 10.30pm, 11 hours after being placed on the constant ACCT watch, the man went to his first ACCT case review. An acting senior officer led the review. No one else was present but she and the man. The acting senior officer spoke to the man at length. He was very tearful, low in mood and extremely worried about his family. He said that he felt he had no one to talk to, and the acting senior officer suggested the support of the prison counsellor, the Listeners (prisoners trained by the Samaritans to provide support and a listening ear, but not counselling), Samaritans and the chaplaincy.

22. In line with the normal practice, the man was seen during his first 24 hours in prison by the Church of England chaplain and offered pastoral support. In interview, the prison chaplain described the man as extremely distressed and concerned about his offence and his family. Throughout the man's time at Shrewsbury, he received regular support from the chaplaincy. Prisoners can access the service 24 hours a day, although the man never asked for help out of hours.

23. On 2 March, the man's second ACCT case review was carried out by the acting senior officer and on this occasion a third prison officer and the second RMN were also present. (The nurse was there in line with the prison's policy that reviews of prisoners on a constant watch should be attended by an RMN. Healthcare staff did not attend subsequent reviews.)

24. The man was quite tearful but composed and willing to talk about his feelings. He spoke of his marriage and family relationships. He admitted to fleeting thoughts of self-harm, but said that he had no plans to harm himself as his preferred method (of overdose) was unavailable to him. He was glad to be in prison where he could get the support he needed and was happy to be referred to the prison counsellor. Although the man was tearful, the second RMN did not believe him to be actively suicidal as he was positive and looking to the future. The level of observation was therefore reduced from constant to intermittent (five times per hour). No formal plan of action was recorded in the man's clinical record regarding ongoing primary care mental health provision, and no primary care mental health assessment was carried out. The second RMN concluded that the man did not fulfil the criteria for in-reach mental health, and that his problems were of a psychological nature rather than linked to mental illness.

25. The second RMN summarised the case review in the man's clinical record. She referred the man to a counsellor at Axis Counselling (commissioned by the PCT to provide a counselling service in the prison), although without retaining a copy of the referral on his medical record. The referral said that the man had no mental health issues.

26. At 12.30pm the same day, the man saw a prison chaplain who described him as talkative, tearful but stable. A fourth prison officer noted on his ACCT observations that the man was calmer and more settled and it appeared that he had found prisoners to talk to on the wing. They talked about his court appearance the following day, after which he hoped to return to Shrewsbury and obtain help to address his problems.

27. In March, the man appeared at Magistrates Court and was remanded at Shrewsbury until 10 March. He was seen at court by the Community Psychiatric Nurse of the court's mentally disordered offenders team. She completed a full assessment, noting that the man presented in a very anxious, nervy, tearful manner, and considered that his risk of suicide was high. (The comprehensive assessment was sent to the prison but was not found in the medical record.) As a result, she completed a Possible Risk of Self Harm or Suicide Form, advising the need for an increased observation level and mental health in-reach contact, and sent it to the prison. (The clinical review found that there was no mention of the referral having been received in the man's medical record, nor evidence of any planned action as a result of the risks highlighted.)

28. The man returned to the prison at 4.00pm, and was seen in reception by the reception nurse. She commented on his Return from Court document that he was "fine", and recorded no change in status. (This contact was not documented in his medical record either.)

29. Later that evening, at 6.30pm, the man took part in a further ACCT case review with a second senior officer and fifth prison officer. The man was very tearful and wanted to talk about his case and his children. He said he did not have much to live for, although the second senior officer noted that he appeared a little more settled by the end of the meeting. The level of observations remained intermittent, five times an hour, and another case review was planned for the next day (although it did not in fact take place). The man returned to his cell and his ACCT record showed that he was feeling quiet, a little emotional but a lot more settled than when he first came to prison.

30. A referral made by a Healthcare Nurse (primary care) for the man to be assessed by the in-reach team was received the same day by South Staffordshire and Shropshire Foundation Trust, the secondary mental health service provider at the prison. (A copy of the referral was not held on the man's medical record.) The reason for the referral was the man's "high suicide risk", and he was allocated to a third RMN.

31. On the afternoon of the next day, 4 March, the man saw the second prison chaplain. They both came from where the man lived and the second prison chaplain felt that this helped establish some trust between them. He said that the man was very quiet at first, although he spoke openly about his situation. He felt under some pressure and was in quite a low mood.

32. On 5 March, the counsellor received the man's referral for counselling and his name was added to the lengthy waiting list for the counselling service. The second prison chaplain visited the man twice during the day, noting that he was still emotional. The man received two letters from his family, which pleased him.

33. The next day (6 March), the man was moved out of the gated cell into a shared cell on A wing where he appeared to get on well with his cellmate. He received another chaplaincy visit in which he admitted thoughts about dying, but said he would not do anything in prison. His sister visited in the afternoon, which he found supportive. (The man received visits from his family regularly throughout his time in prison.) The second RMN noted that he was viewing the future more positively and was remorseful about his offence. He found comfort in his religion and hoped to attend church services regularly. The second RMN recommended that the ACCT observations be reduced to hourly, due to the man's improved frame of mind.

34. On the morning of 7 March, the man attended a further ACCT case review. On this occasion only the third senior officer was present. The review concluded that, although still very low, the man had improved dramatically since his reception and was coming to terms with his situation. The observations were reduced to hourly and the man was relocated to C wing, the vulnerable prisoners unit. The records suggest that he seemed happy there, settled in well and socialised with the other prisoners.

35. A prison officer was assigned as the man's personal officer and he introduced himself, noting no problems on his wing history sheet. (The personal officer did not remain the man's personal officer throughout his time on C wing as personal officers are allocated certain cells and so his personal officer changed whenever the man moved cells.) The personal officer carried out the man's introductory interview and completed the Personal Officer Compact. (The Compact records basic information about the prisoner, their attendance at induction boards regarding support and welfare, and agreements about expected behaviour. It reviews progress for the Incentives and Earned Privileges scheme which is intended to encourage and reward good behaviour by allowing access to privileges such as in-cell television, wearing of own clothes and more time out of cell.) The man's Compact is completed on the first page of basic information and the section regarding IEP reviews, but the remainder was left blank. A chaplain who visited the man noted that he was much happier and found it helpful that his new cellmate also had a religious faith.

36. The weekly meeting between the primary care mental health services and the in-reach team took place on 10 March and discussed potential referrals, issues of concern, and feedback on the in-reach allocation meeting. The third RMN discussed the man's referral with the second RMN and, on the basis of the in-reach referral criteria, the nurse felt that it was an inappropriate referral. (He had not been in contact with mental health services in the community, he had not been on anti-psychotic medication and he had never been compulsorily admitted to hospital.) The second RMN considered that initially the man should be managed within primary care, and she agreed with the third RMN that the initial plan would be to refer him to counselling. He would then be monitored and treated in primary care and referred back if he deteriorated. The third RMNnoted their decision in the man's clinical record. (In fact, no primary care interventions were put in place except for the counselling which began a month later, and no formal primary care assessment was carried out or recorded in the man's medical record.)

37. At 9.40am, the man appeared at court via video link and no causes for concern were noted on his ACCT record. He received a visit later that afternoon, after which he saw the chaplain who noted that he was reasonably settled but had some major decisions to make.

38. The weekly in-reach allocation meeting took place on 13 March and the third RMN informed the team of the decision to hand the man's case back to primary care.

39. Later that morning, at 9.30am, the fourth senior officer carried out an ACCT review with the man. No other staff were present. The man appeared very low in mood, very tearful and upset. He spoke of concerns about his son. The review noted his constant thoughts of suicide and, as a consequence, he was advised to ask for counselling or make contact with the in-reach team. The hourly observations remained in place. (There is no evidence that the senior officer's suggestions of a mental health referral were followed up by either the

40. The man spoke at length later to the chaplain about his family relationships, but stated he had no intentions of harming himself. He was considering asking for a special visit with his wife with a chaplain present. He was quite emotional but left the meeting more positively and still appeared to be in good spirits the next day.

41. The man's IEP review on 15 March noted that he was quiet on the wing but appeared to have settled well. He mixed to a point with other prisoners, but generally stayed in his cell.

42. On 18 March, in line with the standard healthcare practice when a patient is transferred back to primary care, the third RMN wrote to primary care confirming this. (The letter was not found on the man's medical record, and was only held on the in-reach team's own records which are kept outside the prison.) The man continued to receive ongoing chaplaincy support. His general demeanour seemed settled over the next few days and he was said to be in good spirits after a visit on 19 March.

43. The next ACCT case review took place on 20 March, with only the man and the fifth prison officer present. The very brief review noted that he was still tearful and unsettled, his thought process was poor and he had had little contact with his wife. He remained on hourly observations.

44. On 25 March, the man had a further ACCT case review, attended solely by the man and the acting senior officer as his Case Manager. The acting senior officer spoke to the man at length and he told her he was feeling much better, although he was a little nervous about a visit planned for the next day. She noted that he was awaiting an appointment for counselling. She agreed with the man that the ACCT should remain open, because he was still very nervous, although the observations were reduced to three times daily.

45. The man received a visit from his wife the following day. A wing officer noted that he looked a little glassy eyed, but the man said that it was her first visit and was feeling emotional. A chaplain visiting him the next morning noted that he was feeling quite talkative and positive about the visit.

46. On 29 March, the sixth prison officer spoke to the man who told him that sometimes he felt he wanted to harm himself but he tried to get over it. The next day the chaplain saw him and he was in good spirits. The man appeared very concerned about issues relating to his son over the next few days, but was reasonably settled on the wing. His ACCT case review on 1 April with the fifth senior officer and seventh prison officer reflected those concerns, and so the observations were kept at the same level.

47. The man received some good news about his son on 2 April and the second prison chaplain, said this lifted his spirits. Notes in his ACCT document show that he felt he could now concentrate on his own problems. However, that

48. Over the next few days the man was noted as being both positive and generally improving, although struggling at times. On 4 April, the chaplain talked to the man and thought that his outlook was very encouraging. He noted that the man had made good progress and was sorting through his issues. The chaplain felt the man was gaining in confidence and could resolve his own problems.

49. The fourth senior officer and an eighth prison officer held an ACCT case review on 7 April. They concluded that the man appeared fine, talkative, and that his attitude was positive. Issues which had been worrying him had been resolved, counselling had been arranged, and he was seeing the chaplaincy regularly. The man's ACCT was therefore closed and a post closure interview was planned for 17 April.

50. On 10 April, over a month after his referral, the prison counsellor saw the man for around 15 minutes for an initial counselling assessment. (The counsellor is a qualified psychotherapist. She works with prisoners who are suffering from depression and deals with issues such as relationships, anger and bereavement.) The counsellor documented all her sessions with the man in his Axis Clinical Record and his prison medical record. The man presented as an anxious person and it was clear to her that he wanted to talk, but he was afraid to open up. He was described by the counsellor as very vulnerable and the work with him would need to be carried out slowly.

51. After the meeting with the counsellor, the prison doctor prescribed 20 milligrams of citalopram per day to be given under medical supervision for 56 days. (Citalopram is used to treat depression, is well tolerated and has few side effects.) It is unclear from the records whether the man was seen in person by the doctor or whether he was medically assessed.

52. Two days later, on 12 April, the personal officer reviewed the man's IEP record. He wrote that the man's ACCT had been closed and that he appeared to have settled down well. He gave staff no cause for concern about self-harm and the officer recorded that he was "quite confident the worst is over". The post closure ACCT review took place as scheduled on 17 April and no further problems were recorded. On 19 April, the man's IEP review shows that he was coping very well following his ACCT closure and was regarded as a 'model prisoner'.

53. On 20 April, the prison's security department read a letter from the man to his wife. It contained various comments that staff thought indicated possible suicidal ideas. Given the man's self-harm history, the ACCT was re-opened the next day (21 April). In the case review, led solely by the fourth senior officer, the man was described as being low in mood, tearful but with no current thoughts of self-harm. Hourly ACCT observations were resumed. A chaplain saw him later that day and recorded that, although there was a lot on his mind, the man was reasonably settled.

54. Although there is no entry in his medical record save on the prescription chart, on 21 April a second prison doctor signed a repeat prescription for 20 milligrams of citalopram to be issued “in possession” to the man initially for 28 days. The chart shows two repeats of the prescription to be given and reviewed in two months time.

55. In interview it was established that a nurse had asked the second prison doctor to issue the repeat prescription, but that the doctor did not see the man in person to review or assess him. EMIS (a computerised healthcare record system operating in many prisons) does not operate at Shrewsbury, and the doctor did not have sight of the man’s medical record or the medication protocol concluding that he should not be given his medication in his own possession. (Although the instruction about in possession medication was written on part of the prescription chart, the doctor only saw what was written on the repeat page prescription page.)

56. The man’s ACCT record shows that on 22 April he seemed fairly relaxed and was clearly benefitting from the friendship of his cellmate. In a conversation with the chaplain on 23 April, the man discussed how his letter to his wife had been misinterpreted. He said that he had not meant to give an indication that he was thinking about suicide, although he could see why the ACCT had been re-opened. There appear to be no further concerns about the man on his ACCT records from this time.

57. The man had his first full counselling session with the counsellor on 24 April. She noted that, although on an open ACCT again, he appeared to be steadier and was not so tearful. She confirmed that he had no suicidal thoughts and, “… he had a busy mind – all over the place …” and needed to talk. The counsellor asked the man to keep a daily log of his feelings to externalise them, rather than suppress them. The man used this private log in his counselling sessions as a basis for their discussions. He would read out sections, although he did not give the log to the counsellor to read herself.

58. During an ACCT case review with the acting senior officer on 25 April, the man discussed the misinterpretation of the letter with his wife and said that everything was fine. The acting senior officer said in interview that the man made good eye contact, was bubbly, laughed and made jokes. He discussed the counselling and how it was helping him. He felt that he was moving forward and was positive. He had no thoughts of self-harm or suicide and the acting senior officer decided that the ACCT should be closed. The man’s IEP review on 27 April shows that he continued to be positive on the wing. On 30 April, the man’s log (read after his death) indicates that he received a letter which had made him very tearful, with feelings of guilt and remorse, and that he had a very restless night.

59. On 1 May, the man had his second session with the counsellor. She knew that his ACCT was closed, and he was able to open up a bit more with her. The next day (2 May), the man wrote in his log that he had been given a new cellmate and he was worried about others finding out the details of his offence.

60. In her session with the man on 8 May, the counsellor spent a significant period on coming to terms with his offence and noted that his memories had come flooding back. She commented on his low self-esteem and vulnerabilities and helped him to work through issues with family boundaries. The man also recalled the session in his log, saying how safe he felt in that environment. He had woken that morning in a terrible state and had been comforted by his cellmate who had offered to contact the Samaritans. The following day (9 May), the man's log indicates that he felt very panicky and guilty about his past. He said that he had tried to watch television but went off to bed wishing that he had died.

61. On 10 May, the man's personal officer recommended him for a position of trust. Two days afterwards, on 12 May, the second prison officer carried out the ACCT post closure review, concluding that the man felt safe in prison, had adapted to prison life and was receiving counselling. He had no thoughts of suicide and just wanted to be sentenced so that he could put the past behind him.

62. The man disclosed in his session with the counsellor on 14 May that he was feeling anxious and shaky. Due to her concerns, the counsellor invited the reception nurse (RMN) into the meeting to discuss the possibility of further medication to help manage his anxiety. The reception nurse agreed to organise this and the man's prescription chart shows that the second prison doctor prescribed 40 milligrams of propanolol (commonly prescribed for anxiety type symptoms) three times a day, to be administered by the nurses. There is no evidence to show that the doctor saw the man in person.

63. On 16 May, the man wrote in his log:

> "…Spoke to a third prison chaplain about how I was having thoughts of killing myself when I get out as I would panic about being on my own again."

The man said he hated himself and wrote, "I just knew I'll do it when I get out. I'm afraid of the future, not now." The man's IEP review noted that he was quiet and respectful and there were no issues. On 17 May, the man's log indicates that he was extremely worried about court and appearing in front of a male judge, and also about facing the future.

In response to the draft report the man's wife asked my investigator if he had spoken with the third prison chaplain about the entry written by the man on 16 May. My investigator had not directly done so and as a consequence spoke

64. The man appeared by video link at court on 19 May. He was convicted after pleading guilty to the charges against him. His log shows that he was very distressed by the court experience. He had not slept well, and could only think about killing himself. However, he told his barrister that he liked being in prison and, if let out, would kill himself. Afterwards he asked to return to his cell with the door open (as he felt safer from himself that way) and to see a chaplain.

    In response to the draft report the man's wife said that during his appearance at court, on the video link, the man appeared distressed and was showing extreme signs of anxiety. The man's wife expressed concern that this was not recorded in his prison record.

65. On 21 May, as a consequence of the man's distress during his session with the counsellor, she again invited the reception nurse to join them. The counsellor did not think that the man was responding appropriately to his medication and she agreed with the nurse to ask the doctor to increase the anti-depressant dosage. It was decided that the reception nurse would arrange for the man to be seen in the primary care mental health clinic. The counsellor noted in the Axis clinical record that an agreement had been made for the reception nurse, "to support the man in between the counselling sessions, and that the reception nurse would keep an eye on him where possible".

66. Following the session, the dose was increased to 60 milligrams daily and a further repeat prescription was given to him in possession for 14 days. Again the man was not seen in person by the doctor. The plan to refer the man to the clinic was not documented in his clinical record. In interview, the reception nurse confirmed that she had arranged for the man to be seen at the next available clinic on 26 May and had put this in the clinic diary. However, this was not recorded on the man's medical record and the clinic diary could not be produced.

67. The man's own log recalled that he "was falling apart and crying a lot" in the session on 21 May. He discussed how his actions hurt everybody, he truly hated himself, saying "the chapel says God forgives me but I can't forgive myself. I wish I had a gun." On 23 May, the man wrote about planning a suicide or farewell letter:

    > "I'm cracking up. It isn't a coward's way out I'm after … I just can't face the future … I just want out … I know I'm going to do it. I don't know when, it'll just happen."

He wrote on 25 May of his continual worry about sharing out visit cards to his family. He described how he pretended to be asleep when others approached his cell as he did not want to talk to them. He wrote, "I'm not going to have a future, my past will be wiped out and in the present I worry about them both." On 25 May, the man's IEP review recorded another positive week without any problems.

68. In interview, the reception nurse clarified that she had intended to see the man over the weekend of 24 and 25 May as planned, but due to an incident on the wing her contact with him had been brief. She explained to the man that she could not see him at length but would arrange for him to be seen the following week. (None of these interactions was recorded in the man's medical record.)

69. The Healthcare Nurse went to see the man for a mental health assessment on 26 May. The nurse noted in the medical record that the man declined the meeting, saying that he would prefer to see the counsellor. The man's log, however, indicates that he apologised and asked instead to wait to see the reception nurse, a female nurse, when she was next free. The man wrote in his log that he had seen the reception nurse after dinner. He had explained what had happened and hoped she did not think he was being awkward. She said she understood and would see him as soon as possible.

70. When the man saw the counsellor on 29 May, they talked further about his family and marriage and his low self-esteem. That afternoon, the personal officer allowed the man to use the prison telephone as he urgently wanted to make a call. The personal officer did not know the reason for the man's urgency but recorded their interaction in his wing history sheet. In his log, the man discussed how he felt he had let everyone down and needed to resolve unfinished issues before he could move on.

71. On 30 May, the man's writing in his log appears stronger and more positive, but he still had many worries about how his actions affected others. His IEP review noted a good week with no problems. On 1 June, the man received a visit from his sister and friend and wrote that he felt happy afterwards. The next day, 2 June, the man tried to call his home a number of times. At 3.30pm, officers carried out a routine search of the man's cell and a ninth prison officer agreed not to look at his log. In the afternoon and evening, the man had a difficult conversation with his wife that upset him. He appeared to be concerned about the length of his forthcoming sentence, but the calls were mainly related to personal issues.

72. The man was prescribed a further 28 days of citalopram on 3 June. This was the 70th day of medication being prescribed in possession without a face-to-face review. In what was to be his last log entry, written later that day, the man described his head "arguing" with him. He was worried about his visit the following day with his wife, but thought that the counselling session would help him. He spoke of his cellmate moving to a different prison and that it would be strange not having him around. At 6.44pm that evening, the man called his sister. Again, he discussed his concerns about his sentence. He said he had experienced blackouts and was forgetting lots of things.

73. The man gave his log to the counsellor for safekeeping on 4 June. The counsellor noted that the man felt calmer that week, but noticed that he became distressed during discussions and was pushing his eye. He said that he pushed his eye in order to feel the pain, which meant that he could concentrate. He was anxious about his wife's visit later that day, and the counsellor agreed to see him briefly afterwards. She concluded that he was distressed but did not think that he had any suicidal thoughts. She again brought the reception nurse into the session although the clinical review does not suggest that any action was taken by primary care staff as a result.

74. On 5 June, the counsellor saw the man as scheduled and he told her that the visit had gone well. He said he felt stronger and had asked for some money to be sent in the following week. This was the last time the counsellor saw the man. In interview, she said that she did not think that he had any suicidal thoughts and she noticed that he was brighter and seemed to be lifted by his wife's visit.

75. The man's last IEP entry of 6 June read, "Another good week. No problems whatsoever to staff. Polite and respectful." That evening he had an emotional conversation with his wife in which he said he was not feeling alright. She was concerned about him, but he gave no impression of any suicidal ideation and she did not report any worries.

76. Later that evening the man rang his wife and apologised for their earlier conversation. He said that he would call her one last time to check she was okay and then never ring her again. He said that she would receive another letter, probably on the Monday, (9 June), setting out everything he wanted her to do for him. The man called his sister and discussed plans he was making for his finances. He referred to making a fresh start financially when he came out of prison. The man seemed confused and overwrought at times and his sister tried to calm him down. The man seemed concerned again about the length of his expected sentence.

Events surrounding the man's death

77. On Sunday 8 June, the man attended a chapel service led by the prison chaplain. In interview the prison chaplain said that the man was buoyant and seemed happy to be there. He had coffee and biscuits afterwards, chatted with the prison chaplain and gave him no concerns. He ate his lunch as usual and played pool with his cellmate and other prisoners between 2.00 and 4.00pm whilst they were on association.

78. During a conversation with his wife that afternoon, the man described two sides of his personality. One was the adult the man and the other was a little boy. He said that he could not sort his head out and was struggling with the concept of another six months of psychotherapy. He appeared concerned about his sentence and spoke of "going to pieces" in his probation meeting. He said that he had made his head bleed by scratching it and had been pulling at his eye

79. Later that afternoon the man called a male friend. it was the last telephone call he made. He spoke of arguing with himself all the time and how his tablets clouded everything. He discussed his sentence, which he felt was going to be very long, but said that his solicitor had given no advice as yet. The man ended the conversation by saying that he would be in touch soon. They laughed about cold beers and the weather in Spain.

80. After he collected his tea, the man's cell was locked up as usual for the night. The man's cellmate said in interview that the man got on with his customary routine, including constant letter writing, and was his normal chirpy self.

81. A tenth prison officer came on duty on C wing at about 8.15pm and checked that all the prisoners were in their cells. At around 11.00pm, the man and his cellmate settled down to watch a film. The man got up to make a cup of tea for them at about 11.15pm and they had a cigarette. The cellmate fell asleep soon afterwards.

82. The cellmate woke in the night to go to the toilet and tripped on a chair in the middle of the floor. He then saw the man hanging from the window. The cellmate jumped up immediately, rang the cell bell just before 1.30am and started shouting for help. On hearing the bell, the tenth prison officer immediately went to the cell. He saw the man hanging by a ligature from the window mesh at the back of the cell he asked the cellmate to support his weight until he got assistance to unlock the door.

83. At around 1.30am, the tenth prison officer radioed for immediate assistance on C wing. He did not specify a Code Blue (an emergency call that signifies to staff an incident such as a hanging or one involving obstruction of the airways has occurred) because he did not want to alert other prisoners and cause a panic. The tenth prison officer immediately ran to the office close to the cell, and telephoned A wing.

84. Three other prison officers' were on duty on A wing. The night orderly officer in charge of the wings that night, had been on A wing making his routine checks and was in the office when the alarm was raised. The radios take a few moments to activate after the button is pressed, but the tenth prison officer started talking immediately so the officers only heard "C wing" without the call for immediate assistance. They knew something was wrong because it is unusual for the radios to be used at that time of the night and so they began to make their way to C wing. Seconds later, the night orderly officer answered the tenth prison officer's call telling him there was a Code Blue on C wing and someone in cell 1/04 was hanging. The night orderly officer then radioed a Code Blue to staff for assistance. C wing was only a few yards away so the eleventh and twelfth prison officers were able to run there quickly with the night orderly officer unlocking the doors on the way. The eleventh prison officer brought his first aid bag.

85. The night duty nurse initially heard the muffled call for assistance on C wing and then heard the call for healthcare to attend C wing for a Code Blue emergency. He therefore brought his Code Blue bag containing emergency first line drugs, a defibrillator and an oxygen cylinder, and ran down to C wing. The doors had already been opened so the path was clear as he ran down the stairs at around 1.33am.

86. By the time the night orderly officer opened the door to C wing, the tenth prison officer had already broken the seal on his key pouch and placed it in the cell door in preparation for opening the cell door. He then went into the cell, followed by the eleventh prison officer who helped the cellmate take the man's weight whilst the tenth prison officer used his anti-ligature knife to cut the man down. The ligature (a shoelace) was too tight around the man's neck to cut off. He was blue in the face and the eleventh prison officer thought the man looked as though he was already dead. Having released the man the two officers carried him out of the cell and laid him on the floor of the landing to give themselves more room to carry out cardio pulmonary resuscitation (CPR). The eleventh prison officer then cut off the ligature with scissors from his first aid bag. The tenth prison officer immediately began mouth-to-mouth resuscitation.

87. The night duty nurse, who arrived as the man was being laid on the floor, checked for signs of life but could not find a pulse. The night duty nurse asked the officers to cut the man's shirt to expose his chest so that he could use the defibrillator, which instructed them to continue CPR (30 compressions to his chest and two ventilations to his mouth). The tenth prison officer continued with mouth-to-mouth resuscitation whilst the night duty nurse carried out chest compressions. The defibrillator did not advise staff to shock during the process and so they continued CPR. The night orderly officer and the twelfth prison officer ensured that an ambulance had been called. The eleventh prison officer went back into the cell to comfort the cellmate who was inconsolable. Having been relieved by the twelfth prison officer, the eleventh prison officer then went to help the night orderly officer ensure that the ambulance staff could enter the prison quickly.

88. The tenth prison officer and the night duty nurse continued CPR for about 20 minutes until paramedics arrived at around 1.50am and took over. The paramedics declared that the man had died at 2.11am.

Dealing with the aftermath of the man's death

89. At 2.15am, the night orderly officer contacted the duty governor to ask him to attend. Police officers arrived two minutes later at 2.17am. The night duty nurse asked for the man's body to be returned to a cell to give some privacy and dignity. The police officers wanted to preserve the cell for investigation and for the man's body to be placed in another cell. The eleventh prison officer arranged for the two prisoners (who were already awake) from the adjacent cell to be relocated to A wing, so that the man could be placed in their cell. At 2.45am, the duty Governor attended the prison and asked the prison chaplain to attend to support staff and prisoners together with the care team. The prison

90. The night duty nurse saw the cellmate in the wing office afterwards to reassure him, and contacted the emergency doctor to prescribe some medication to calm him. At 3.50am, the cellmate was taken across to a cell on A wing where he remained for the night and was offered a Listener and access to the chaplain. Staff made statements and a hot de-brief (a meeting at which the events surrounding the discovery of the man were discussed by staff) was held at around 8.00am.

91. Later that morning, at 9.10am, the duty governor and the prison chaplain visited the man's wife at her home. The man's wife was woken up as she had worked a night shift the previous night. The duty governor and the prison chaplain had not wanted to disturb her at work with the news and waited to visit in person the following morning. They told the man's family of his death and offered comfort and support as they were obviously distressed. The prison chaplain gave the man's wife his telephone number and encouraged her to make contact if she needed to. The man's wife agreed to inform the man's sister, his parents and son of his death. Both the duty governor and the prison chaplain made contact again with the family following this visit and the man's wife and sister were given the opportunity to visit the prison. They saw the chapel, where they lit candles, and the man's cell, where they prayed.

92. The duty governor and the prison chaplain attended the man's funeral on behalf of staff and the man's friends on C wing. The second prison chaplain held a small service at the prison on the same day for prisoners and staff who wanted to attend. Prisoners arranged a collection for the man and raised £70.

93. The police found a number of letters in the man's cell. They were addressed to the Governor, Coroner, the man's wife, his sister and friends, and stated his intention to end his life. He also left a handwritten will. The post mortem report concluded that the cause of death was hanging.

ISSUES

Clinical Review Findings and Recommendations

94. The local Primary Care Trust Clinical Review Panel carried out a review of the man's care and treatment whilst in prison. Their findings and recommendations are summarised below and the review itself is annexed to this report.

Mental health provision

95. The clinical review found that:

> "The paper based primary care mental health service records and referral systems in operation at times failed to provide a clear audit of where referrals had been made, how soon they would be dealt with, or a clear process for assessing risk."

96. This was evident in the absence of copy documentation held on the man's medical record in relation to the initial in-reach referral by the healthcare nurse and the letter of referral back to primary care from the third RMN on 18 March. Although the third RMN noted the outcome of the discussions in the clinical record, no records were kept by primary care colleagues or further actions planned for an assessment by primary care. It is unclear from the papers what process was used for assessing the man's risk and there was a clear delay in the assessment taking place.

97. In interview the Service Manager for the prison in-reach team, confirmed that the usual process for referral to in-reach mental health services would be via an assessment by the primary care team. In the man's case, he was referred direct to in-reach by the healthcare nurse due to his high suicide risk. As a result no primary care mental health assessment was carried out at this stage. The second RMN confirmed in interview that, at the man's ACCT case review on 2 March, she concluded that this was an inappropriate referral for the in-reach team according to the criteria they follow. However, her decision was not documented. The decision was confirmed during discussions at the joint meeting on 10 March, when the third and second RMN agreed that the man would be monitored and treated in primary care. Although I am satisfied that their conclusion was appropriate, the decision-making processes were unclear and not well documented. Staff are largely reliant on colleagues to discuss outcomes.

98. The clinical review found that:

> "… there was no primary care mental health assessment undertaken with the man, although this was indicated as a requirement from the First Night Reception Screening … and that there was "some confusion over who the man should be assessed by and a clear delay in the primary care mental health nurses responding to the original referral for him to be seen. There was a lack of clarity around the need for an assessment of the man to take place by the primary care mental health

service, despite a number of attempts made by the counsellor to ensure the man was seen by them."

99. Once the man had been referred back to primary care, there were no further planned actions made or documented, save for the counselling to which he had already been referred. Although the RMN had completed a referral for primary care mental health assessment on 1 March, there is no evidence that the man attended. In interview, the second RMN explained the referral process for a primary care mental health assessment. The referral forms are kept in a folder and, when a clinic is detailed, they are prioritised in order of urgency and an assessment is carried out. Due to the shortage of staff (three mental health nurses working in generic roles), the clinics do not run very regularly. A caseload is not generated, and so the clinics are run on a sessional basis. However, if someone is identified as needing follow up they will be reviewed. My investigators were unable to confirm why the man's case was not prioritised for assessment. His mental health assessment was not followed up until 26 May, after the counsellor's intervention. She told my investigators that she was concerned that he needed more support.

100. A number of events should have prompted a mental health assessment, including the self-harm warning form sent from the Magistrates Court to the prison by Community Psychiatric Nurse on 3 March. However, there was no mention of it having been received, nor any planned actions leading from it. On 13 March, in an ACCT case review, the fourth senior officer advised that the man should have contact with the in-reach team. There is no evidence to suggest that this was followed up.

101. On 26 May, the healthcare nurse recorded in the medical record that the man had declined an assessment, preferring to continue with counselling. This account conflicts with the man's own log that indicates that he was reluctant to see a male nurse and asked for the reception nurse. In interview, the reception nurse (who had handed over the assessment to the healthcare nurse to carry out) confirmed that she was aware of the man's preference, but did not realise that a male nurse would be on duty. She confirmed that she discovered this afterwards, but accepted the healthcare nurse's explanation that the man felt quite happy with the counselling service and did not feel he would benefit from mental health services. Without being able to interview the healthcare nurse, who has since left the service, the clinical review panel were unable to determine whether the man had declined or not.

102. In 2006 my office carried out an investigation into another death at Shrewsbury. In that case the clinical review recommended a review of the referral process and development of a protocol to manage urgent and non-urgent referrals from primary care to in-reach. My earlier investigation found that there were delays in assessment following referral, because of a lack of guidance or standards in relation to the timeframe for processing referrals not marked as urgent.

103. I am pleased to note from the Service Manager's interview that there are now clear guidelines and criteria in place based on the NICE (National Institute for Clinical Excellence) guidance which are well communicated to primary care

104. The clinical review found that

> "There was a lack of recording detailing when the man was planned to be seen. The clinical review team appreciate that some communications with patients will be ad hoc and in between other tasks. Nonetheless where a presentation had taken place between the man and the mental health nurse that related to his care and planned actions, the content of these discussions and the outcomes had not been documented."

105. On 1 March, the planned actions from the first reception health screen, including a referral to the doctor and a mental health assessment, were not recorded in the medical record. There is no evidence that the man saw a doctor. On 14 May, the reception nurse agreed to arrange medication for the man's anxiety at the counsellor's request. The reception nurse made no note of this intervention in the medical record. On 21 May, the counsellor asked the reception nurse to join the counselling session. She agreed to support and keep an eye on the man and arrange an appointment for a mental health clinic. Again the outcomes were not documented.

106. In interview, the reception nurse confirmed that she had seen the man and told him she would pop in and have a discussion with him over the weekend. Due to an incident on the wing on 24 May, she was unable to do this but briefly saw him to explain. The reception nurse said she did not record any of her interactions with the man because there was nothing to report. Although the reception nurse said she arranged a mental health clinic for 26 May and put this in the clinic diary, this cannot be confirmed. She said she thought there was already a mental health referral in place. On 4 June, the counsellor asked the reception nurse to join the session. Once more there was no record made of actions taken by primary care as a result.

107. The clinical review has:

> "… noted the absence of numerous important items of paperwork, such as the referral made from the community psychiatric nurse of the Mentally Disordered Offenders Team and the correspondence sent from the third RMN from the In-reach service."

In the Service Manager's interview, the panel learnt that the in-reach service considered the community psychiatric nurse to be a highly skilled and valued professional. Had they been aware of her assessment, in-reach would have taken her views very seriously.

108. The panel found, "… that the only intervention that the man was offered alongside prescribed medication was counselling through Axis". For over a

109. Through interviews, the panel learnt that primary care provision at the prison was very limited. There were no group sessions or cognitive behavioural interventions in place at the time of the man's death. Mental health nurses have a generic role that dilutes the quality of mental health care in primary care. As such, fewer clinics are run with nurses dedicating the majority of their time to clinical work. The second prison doctor raised concerns over the lack of regular review at primary care level for people with anxiety or depression. Assessments are not always followed up or reviewed with appropriate treatment. This is very difficult in the prison population due to the high levels of patients with those issues, in comparison with the community. Following her full announced inspection of Shrewsbury in June 2006, HM Chief Inspector of Prisons recommended that:

> "A wider range of mental health primary care therapies including options for group work should be available for prisoners with mild to moderate mental health problems."

110. The clinical review found:

> "The role of the Axis counselling service was clearly significant in providing much needed support to the man … However there is evidence of a high demand for this service with the therapist managing this demand and deciding who should be seen without consultation with the healthcare service."

111. Axis (the counsellor's company) is commissioned by the PCT to provide counselling services in primary care at the prison. The counsellor confirmed that the average waiting time for her service was a month. She had expedited the man's appointment due to his suicidal thoughts. Decisions about taking patients are based on need and judged by the counsellor, without liaison with primary care colleagues and with minimal formal information sharing. The Service Manager commented that, with hindsight, considering the man's suicidal ideation and previous attempts, some interaction between the counsellor, primary care and in-reach would have been helpful. Although the man clearly benefited from the counselling, it was quite separate from primary care provision in the prison. I therefore consider that the man's progress could not have been properly followed up in the absence of further interventions or communication and review between healthcare and the counsellor.

112. Although I consider that these issues had little bearing on the man's eventual death, I believe that better processes for referral, assessment and record keeping, and increased primary care mental health provision, could have improved the man's quality of life. I therefore endorse the following recommendations of the clinical review:

The Primary Care Mental Health Service should be a dedicated specialist team who exclusively work in a mental health role at this primary level, who complement existing secondary care provision. They should offer a wide range of mental health primary care therapies for prisoners with mild to moderate mental health problems including options for group work.

The formal risk assessment process carried out by the primary care mental health nurses needs to be reviewed and improved and should be based on best practice. The review should ensure there is a clear framework for the risk assessment to be completed to include timescales. This document should inform the need to carry out a full mental health assessment and the outcomes of the risk assessment should be documented in the continuous clinical record.

Following on from the primary care mental health service carrying out the mental health assessment, for those who are deemed as requiring intervention there should be a clear treatment plan formulated. This should include the lead primary care mental health nurse, the frequency of contact and the level of support offered. The treatment plans for patients should reflect national clinical guidance, such as that provided by NICE, National Service Frameworks and should be subject to clinical audit as part of the clinical governance arrangements.

The primary mental health nurses need to be skilled in providing mental health triage/rapid assessment, more detailed assessments and brief interventions. Skills in cognitive behavioural therapy, brief solution focus therapy, medication management and education, dual diagnosis … and group work are crucial.

There should be an emphasis on regular team meetings between primary and secondary mental health services to include the Axis counselling service. This meeting should be used to discuss new referrals and challenging cases with managers from identified services ensuring there are effective communication protocols for those members of the team who cannot attend and that the services are effective and integrated.

Medication and assessment

113. The clinical review found that, "the primary healthcare service does not routinely request the medical notes of patients that may provide valuable information about a patient's medical history".

114. The clinical review also found:

> "… that the man was prescribed citalopram for a period of seventy days without an initial medical assessment or subsequent review taking place which would involve him being seen by the doctor", and that "the lack of a computerised patient record and case management system posed difficulties in flagging up the need for medication reviews".

115. The clinical review note that each of the three times the man’s dose of citalopram was repeated or increased, it was initiated by the nurse who approached the doctor. This was also the case with the propanolol. In interview, the reception nurse confirmed she was not a nurse prescriber. The second prison doctor told my investigators that he has flagged up the issue of repeat prescriptions of psychotropic medicines. He said that there is a lack of manpower and information systems to facilitate reliable repeat prescribing and review. The doctors are reliant on manual records and the pressure of clinics means that reviews may not happen.

116. The clinical review panel found that the second prison doctor had not seen the man or his medical records before prescribing him citalopram “in possession”, against the advice of the medication protocol signed by the second RMN. The electronic medical information system (EMIS) does not operate in Shrewsbury and the doctor could not see the man’s records alongside the prescription charts and protocol. In interview, the second prison doctor said that EMIS would enable these documents to be linked. Although the second prison doctor could not remember the exact details of the repeat prescription, he said he would usually make a brief visual scan of the chart to see if the patient is on an ACCT so that he would know not to give in possession drugs. The doctor said that normally an ACCT patient would be barred from having medication in possession for 28 days. He was shown the second RMN’s note on the chart during the interview, but said he would only have been presented with the repeats page at the time. The second prison doctor thought it would have been a nurse’s decision to make an assessment of the man at this stage and allow medication in possession. The nurse would then have asked the doctor to prescribe it on that basis. I consider it would have been very helpful to have documented these decisions in the clinical record.

117. The clinical review panel said it, “… believed that the medication prescribed to the man was appropriate and given in the standard doses”. However, the lack of review and absence of records is disappointing. Therefore, I endorse the following recommendations from the clinical review:

The information systems should be addressed with immediacy to enable the easy access of relevant health information and postal correspondence.

There needs to be better use of the current resources and the nurse relationship with the GP to review the psychotropic medication prescribed within the recommended intervals. The Primary Care Trust provider arm should review the current practice of prison doctors prescribing medication without directly assessing the prisoner.

The process for initiating, reviewing and recording the decision to give in possession medication should be examined to ensure a clear decision making process.

There should be a formal process for all patient records and prescription charts to be audited in terms of legibility, whether they have been signed, and their accuracy and in particular whether they are able to be comprehended by other practitioners.

Further clinical review findings and recommendations

118. The clinical review found that, in the absence of a more specialist assessment of his mental state and the self-harm risk, it was difficult to estimate the man's risk of suicide. The panel was of the opinion that all reasonable attempts to resuscitate the man were made. The panel also recommended:

A robust system of clinical supervision and line management is required to support clinical activity for all nursing staff in the prison healthcare team that is based around the specific needs of the client group.

There is a need for ongoing training for the primary healthcare staff which takes into account the specialist training needs for the services they provide.

The need for a clear service specification for the primary mental health service that should be informed by the health needs assessment. This is echoed in the recommendations made by Care Standards Improvement Partnership in their review of HMP Shrewsbury Prison Healthcare.

The Axis counselling service should not continue to form part of a subcontracting arrangement held by the primary healthcare service but should have clear commissioning arrangements managed by the Prison Healthcare Commissioner which should include the level of service, joint working arrangements and managing the demands placed on the service.

119. In addressing these recommendations, the clinical review panel advised that the recommendations of the clinical reviews undertaken at Shrewsbury in 2006 be re-examined. I am pleased to learn that many of these recommendations are reflected in the recent Service Review for Shropshire PCT, carried out by the West Midlands Care Services Improvement Partnership, and are in the process of being implemented.

120. In particular, I note the development of a dedicated mental health team delivering a range of interventions and carrying a caseload in its own right. The assessment documentation and referral criteria are being reviewed. Training is to be improved to incorporate a wider range of primary care level interventions such as cognitive behavioural therapy.

I am also pleased to note the strengthening of links between primary and secondary mental health services to maximise joint working and information sharing. I am also encouraged by the attempts to ensure that reviews of medication for those patients on anti-depressants or other psychotropic

Suicide and self-harm management

121. Despite the man's high suicide risk when he arrived in prison, his demeanour and mood appear to have improved over time. I am satisfied that the ACCT was appropriately closed on 7 April, just prior to his counselling. He was regularly reviewed and his ACCT was re-opened, cautiously and correctly, following a letter to his wife on 21 April. Staff again ensured the man was reviewed before closing the ACCT the second time.

122. The man was a quiet man who kept his problems close to his heart and it was therefore difficult for staff to get a true picture of his feelings. He found solace in his work and in prayer, and received support from the chaplaincy and his cellmates. It was apparent that the man found it difficult to relate to male authority figures. This may have prevented his inner emotions being observed by prisoners or a predominantly male staff.

123. The counsellor said she was confident about the process for opening up an ACCT, but did not think it necessary after 25 April. She said she certainly would have done so if she had felt the man was at risk. The counsellor requested primary care nurse support and help with medication from 14 May, when she felt that the man's mood was not lifting. About two weeks before he died, she thought the man was feeling more relaxed and getting better. On 4 June, she was aware he was still distressed, but in her opinion he had no suicidal ideation. On her last meeting with the man on 5 June, he was a lot brighter and seemed lifted by his wife's visit. The counsellor was not aware of the content of his log or his suicidal thoughts. I consider that her judgement was appropriate, based on her knowledge and observations.

124. In interview personal officer said that the man was always very quiet. He was liked by the majority of prisoners and respected. Although the man was quite traumatised on arrival in the prison, the personal officer did not observe a significant change in his mood over time and described him as being pretty constant. He gave no further indications of suicidal intent to prompt the opening of an ACCT. The prison chaplain felt that there was a marked positive change in the man over time as he became more confident dealing with people. He saw the man at chapel on the Sunday before he died and said he behaved normally, chatting and showing no outward signs whatsoever that would have given him cause to open an ACCT.

125. The man's previous cellmate, who knew him from outside prison, provided emotional support and friendship. The previous cellmate said that the man was low in mood on 2 June and had seen the chaplain. When the previous cellmate was transferred to another prison on 3 June, he felt this might have been a trigger to the man's death. Although it is clear that the man valued this friendship greatly, it is not apparent from his log that the previous cellmate's transfer caused him particular upset. The previous cellmate said that the man never talked to him of harming himself. He was stressed, but his death came

126. To staff and other prisoners, the man appeared low in mood at times but otherwise well. His counselling appeared to be providing him with support, but was also making emotional demands that he had to deal with. By mid May however, the man's log provide an insight into his real feelings which were in stark contrast to those emotions displayed externally. With the benefit of hindsight, it is easy for the reader to see that the man was in distress, particularly from the middle of May. However, he gave nothing away to staff and showed no particular outward signs. I therefore conclude that the man's suicide could not reasonably have been predicted or prevented.

ACCT information sharing

127. At the heart of the ACCT process is the notion that suicide and self-harm management is the responsibility of <u>all</u> staff in contact with the prisoner at risk. This implies information sharing between healthcare and discipline staff. Although healthcare staff owe a duty of confidentiality to patients, ACCT policy makes it clear when it is appropriate to share information with non healthcare staff. The ACCT document itself also asks the prisoner to agree to confidential health information being shared in the interests of preventing suicide or self-harm. Prison Service Order (PSO) 2700 (paragraph 1.11.2) states that healthcare managers must ensure that healthcare staff are aware of the importance of sharing information with staff from other disciplines, and that they do share such information.

128. My investigators found little evidence of information sharing or liaison, despite the fact that the man was on the primary care caseload. Despite the self-harm warning form completed by the community psychiatric nurse and received on 3 March, no record made its way from primary care to the ACCT. The man's personal officer was unaware of the counselling he was receiving. Although the ACCT records state that healthcare were informed of the ACCT being re-opened on 21 April, nothing was recorded in the medical record. Despite her considerable contact with the man, the counsellor was not formally involved in the closure of his ACCT. It would have been helpful if the counsellor had had greater liaison with the healthcare staff, who could in turn have shared risk pertinent information with wing staff working with the man daily. Since he was not receiving any mental health nursing support, no observations of his mental state of mind could be made. The reception nurse appeared not to have been aware of the man's ACCT. If she had been she could have alerted staff to the fact she was keeping an "eye out for him".

129. Although I consider that this would probably not have changed the outcome in the man's case, and I make no formal recommendation, I encourage the Governor and Healthcare Manager to remind healthcare staff of the importance of sharing risk pertinent information with discipline staff.

ACCT procedures

130. Although the content of most of the man's ACCT case reviews was adequate, there was a lack of continuity of care. PSO 2700 (paragraph 19 Annex 8G) states that, wherever possible, the case manager appointed to lead the case reviews should arrange subsequent reviews at a time that they can be present. This is to provide continuity of care for the prisoner. However, for most of the man's case reviews, a different case manager attended. This undermined the level of understanding of his needs. My investigators established that there was no individual allocation of managers for reviews, and no expectation for them to attend subsequent reviews, as managers were allocated on a day to day basis. HM Chief Inspector of Prison's 2006 report recommended:

    The case manager allocated to a prisoner at risk should remain the same for the duration of the ACCT document so that the prisoner at risk receives consistent support from familiar staff.

131. I support and repeat this recommendation.

132. PSO 2700 (paragraphs 13 and 17 Annex 8G) says that a Unit Manager should chair the first case review, appointing a case manager who should also consider other staff who could positively contribute. In subsequent reviews, it should be possible for a wider range of staff and specialists to attend. One of the attendees must be the allocated case manager, one a residential officer and one an appropriate member of non-discipline staff. However, only four out of eleven case reviews were carried out with more than one person present other than the man. Only one of those was multi-disciplinary and included healthcare staff. The second RMN confirmed that healthcare staff are not normally invited to further reviews. Both ACCTs were closed by people who had not recently reviewed the man's case, the second by one person alone. There was no evidence of consultation with staff who had been in contact with the man recently. (When a prisoner is on constant watch, the case review should be chaired by the duty governor or head of healthcare and a mental health nurse should be present.)

133. Case managers should be trained to the appropriate level. The Acting Senior Officer, although confident with the ACCT process, was trained only to foundation level when she took charge of the first case review. Where a prisoner is on constant watch, as in the man's case, PSO 2700 (paragraph 9 Annex 8Y) states that the first case review must take place as soon as is practicable and certainly within four hours of the ACCT being opened. The man's first review was eleven hours after the ACCT form was opened.

134. A care and support plan or caremap should be drawn up, implemented and monitored. PSO 2700 (paragraph 31 Annex 8G) syas that the case manager should review and update the caremap after each case review. PSO 2700 (paragraph 50 Annex 8G) states that the ACCT can only be closed once all caremap actions have been completed and the review team judges it safe to do so. Whilst I do not disagree with the judgement to close the ACCT on 25 April, the care map was not sufficiently comprehensive, and was updated only once

135. While my investigators found that staff were confident in ACCT procedures, that reviews were well timed and regular, and that the content of the ACCT was on the whole well considered, I am concerned by the gaps and flaws described above.

I recommend that the Governor ensures that staff follow the ACCT procedures in accordance with PSO 2700 and local policy supporting it.

Personal Officer Scheme

136. PSO 2700 says that personal officer schemes can contribute to the care of at risk prisoners and help reduce self-harm. The Chief Inspectors 2006 report concluded that prisoners had assigned personal officers but they were not easily identifiable and prisoners would approach whichever member of staff was on duty. There was more emphasis on the personal officer scheme encouraging good order and discipline, than on supporting the requirements of the offender management model and prisoner welfare.

137. My investigators found that little progress has been made since the Chief Inspector's report. The Personal Officer Compact was only partially completed on 7 March. The sections geared towards prisoner welfare were left blank. This suggests that, as the Chief Inspector found, the emphasis is still geared towards good behaviour. The Compact is completed by whichever officer is on duty at the time, not necessarily the assigned personal officer. My investigators undertook a random review of the Compacts and found that many were incomplete, and that officers relied on the weekly IEP reviews in the Compact to record reflective entries normally contained in the wing history sheets. There was a lack of easily identifiable and consistent support. Personal officers were allocated cells rather than individuals, so they changed on a cell move. This happened in the man's case.

138. Although my investigators observed some improvements in the personal officer scheme, such as the allocation of officers to prisoners, rather than cells, I am not convinced that the scheme has yet been successfully implemented. I therefore repeat the recommendation in HM Chief Inspector's 2006 report:

There should be focused management attention to ensure implementation of the personal officer scheme and staff should have appropriate training and support.

RECOMMENDATIONS

Healthcare

1. The commissioned Primary Care Mental Health Service should be a dedicated specialist team who exclusively work in a mental health role at this primary level, who compliment existing secondary care provision. They should offer a wide range of mental health primary care therapies for prisoners with mild to moderate mental health problems including options for group work.

   Partially accepted – An RMN will undertake mental health assessments and have an on going case load of clients. However, their role will also include medication rounds and working night duty. They also commented that workforce planning for training in Short focused therapies have been submitted for consideration.

2. The formal risk assessment process carried out by the primary care mental health nurses needs to be reviewed and improved and should be based on best practice. The review should ensure there is a clear framework for the risk assessment to be completed to include timescales. This document should inform the need to carry out a full mental health assessment and the outcomes of the risk assessment should be documented in the continuous clinical record.

   Accepted – A formal assessment and referral documentation has been developed which includes timescales for assessments to be carried out. This will form part of the prisoners on going clinical records.

3. Following on from the primary care mental health service carrying out the mental health assessment, for those who are deemed as requiring intervention there should be a clear treatment plan formulated. This should include the lead primary care mental health nurse, the frequency of contact and the level of support offered. The treatment plans for patients should reflect national clinical guidance, such as that provided by NICE, National Service Frameworks and should be subject to clinical audit as part of the clinical governance arrangements.

   Accepted – Treatment plans will form part of the new mental health referral pathway. They said that the prison health service will have a lead mental health nurse who will ensure monitoring and audit of mental health referrals and progress to care pathways.

4. The primary mental health nurses need to be skilled in providing mental health triage/rapid assessment, more detailed assessments and brief interventions. Skills in cognitive behavioural therapy, brief solution focus therapy, medication management and education, dual diagnosis … and group work are crucial.

   Accepted – A triage assessment document is used at first reception which

5. There should be an emphasis on regular team meetings between primary and secondary mental health services to include the Axis counselling service. This meeting should be used to discuss new referrals and challenging cases with managers from identified services ensuring there are effective communication protocols for those members of the team who cannot attend and that the services are effective and integrated.

   Accepted – Regular meetings to discuss mental health referrals are already being undertaken. The care pathway is integrated within the new referral process. Work is being undertaken between primary and secondary mental health on the development of pathway protocols. AXIS counselling will form part of these multidisciplinary meetings.

6. The information systems should be addressed with immediacy to enable the easy access of relevant health information and postal correspondence.

   Accepted – The scoping of the introduction and implementation to be part of the first wave of System One IT has been undertaken and we have now been informed that this will not be available until 2010. To look at secure funding for staff training and the implementation of existing EMIS system from own budget.

7. There needs to be better use of the current resources and the nurse relationship with the GP to review the psychotropic medication prescribed within the recommended intervals. The primary care trust provider arm should review the current practice of prison doctors prescribing medication without directly assessing the prisoner.

   Accepted – The Prison Service said that an RMN in post whose primary role is to work with the GP in reviewing prisoners who are taking psychotropic medication which is in line with the NICE guidelines.

8. The process for initiating, reviewing and recording the decision to give in possession medication should be examined to ensure a clear decision making process.

   Accepted – The process of assessing prisoners for in possession medication and documentation has been reviewed and documentation ratified at the Drug and Therapeutic committee.

9. There should be a formal process for all patient records and prescription charts to be audited in terms of legibility, whether they have been signed, and their accuracy and in particular whether they are able to be comprehended by other practitioners.

10. A robust system of clinical supervision and line management is required to support clinical activity for all nursing staff in the prison healthcare team that is based around the specific needs of the client group.

    Accepted – Clinical supervision is available to all staff. The healthcare provider manager will ensure that all staff have dedicated time to undertake clinical supervision. Bi yearly audit on staff supervision will be undertaken by clinical nurse manager.

11. There is a need for ongoing training for the primary healthcare staff which takes in to account the specialist training needs for the services they provide.

    Accepted – To scope clinical areas of speciality and source specialist training/education and development and link to KSF review for PHC staff to attend.

12. The need for a clear service specification for the primary mental health service that should be informed by the health needs assessment. This is echoed in the recommendations made by Care Standards Improvement Partnership in their review of HMP Shrewsbury Prison Healthcare.

    Accepted – The Health Needs Assessment is completed and is being signed off by the Prison Health Partnership Board. A separate service level agreement will be drafted for primary mental health services.

13. The Axis counselling service should not continue to form part of a subcontracting arrangement held by the primary healthcare service but should have clear commissioning arrangements managed by the Prison Healthcare Commissioner which should include the level of service, joint working arrangements and managing the demands placed on the service.

    Accepted – A service level agreement has been drafted and is out for comment. Performance measures are to be agreed and incorporated into a service specification and reported quarterly to the commissioner.

Other recommendations

14. The case manager allocated to a prisoner at risk should remain the same for the duration of the ACCT document so that the prisoner at risk receives consistent support from familiar staff.

    Accepted in principle – The case manager will, where predictable, diary all future meetings, this will ensure that the continuity of the case management of

15. I recommend that the Governor ensures that staff follow the ACCT process in accordance with PSO 2700 and local policy supporting it.

    Accepted – All staff who work with prisoners should receive ACCT refresher training. All new employees who will be working with prisoners will need to complete an ACCT training course.

16. There should be focused management attention to ensure implementation of the personal officer scheme and staff should have appropriate training and support.

    Accepted – The personal officer scheme will be prioritised by the Residential PO. They will make sure that an updated scheme is implemented and monitored. Staff will have support and training via wing meetings chaired by the Residential Governor. New policy will need to be re-written when Prison NOMIS is introduced.