Investigation into the circumstances surrounding the death of a man at HMP Shrewsbury on 11 September 2008

Report by the Prisons and Probation Ombudsman for England and Wales

February 2010

This is a report into the circumstances surrounding the death by hanging of a man who was a remand prisoner at HMP Shrewsbury, on 11 September 2008. He was 43 years old.

I offer my sincere sympathy and condolences to his family and friends for their loss. I apologise for the length of time it has taken to produce this report and any additional distress the delay may have caused.

The investigation was carried out on my behalf by a colleague. A clinical review of the man's healthcare at Shrewsbury was undertaken by Shropshire County Primary Care Trust. I am grateful for the review. I would also like to thank the Governor of Shrewsbury and his staff for their co-operation and assistance with this investigation.

The man had been put on suicide and self-harm monitoring procedures three days before his death, after a previous self-harm attempt. He was detoxing from heroin and alcohol and complained that back pain was keeping him awake. I am satisfied that the detox process was conducted according to the guidelines. The suicide monitoring procedures were carried out satisfactorily but the support, as set out in the form, was not as good as it should have been.

Officers found the man suspended in his cell after lunch on a day when his cellmate had gone to court. Letters were found in his cell after his death addressed to his family, along with a note to officers. They reflect a sense of weariness and hopelessness about the future.

I make two recommendations, covering the prison's suicide monitoring procedures and the completion of the forms. It is disappointing that one of the recommendations focuses on part of the suicide monitoring form that was discussed in the Ombudsman's report into a previous death at Shrewsbury.

Jane Webb
Deputy Prisons and Probation Ombudsman **February 2010**

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SUMMARY

The man was born on 16 July 1965 and died on 11 September 2008 in his cell at HMP Shrewsbury. He had been remanded into custody eight days earlier. He had been in Shrewsbury several times before and many of the staff knew him.

A nurse in reception interviewed the man and assessed his health needs. The man told her that he drank heavily and was on a Subutex maintenance programme to manage his heroin addiction. The nurse carried out a brief mental health assessment and concluded that the man was depressed. She referred him to the doctor, prison drugs services and the mental health in-reach team.

The man returned to court the following day, and was remanded until 10 September. On his return to prison, he was assessed by a nurse who put him back on a Subutex detox programme. A doctor then examined the man and prescribed the same anti-depressant medication and pain killers that he had been receiving in the community.

In the early hours of 8 September, the man attempted to hang himself. However, the sheet broke and he fell to the floor. Later that morning, his cell mate informed staff, who opened an Assessment, Care in Custody and Teamwork (ACCT) plan. (The ACCT document describes the problems facing a prisoner at risk of harming himself and implements a plan to give him the support he needs to help him through a period of crisis.) The following day, during an ACCT assessment, the man said that it had been “a spur of the moment act”. The ACCT case manager then held a case review meeting and completed a Care Map, setting out the actions to be taken to support the man. However, these goals and actions set out did not actually give the man additional support to help him through the crisis.

The man appeared in court the following day via a video link and was again remanded in custody. Later, the man discussed accommodation and community based drug programmes for his release with a prison drugs worker. After attending chapel and association, he told an officer that he was “fed up because he didn’t get bail”.

On 11 September the man’s cell mate went to court. The man spent most of the morning out of his cell, asking various people to lend him tobacco. At 12.30pm, the prisoners were locked in their cells as usual while the staff went to lunch. As his cellmate was at court, the man was on his own.

An hour later, as staff were unlocking the cells, they found the man hanging from the window bars by a sheet. The first two staff who entered the cell were not carrying anti-ligature knives, but used a cigarette lighter to burn through the ligature. A third officer then used his anti-ligature knife to cut the ligature from the man.

Staff began cardio-pulmonary resuscitation (CPR) and health care staff took over when they arrived. The prison doctor administered medications to aid resuscitation. Paramedics arrived and took over the man's treatment. Sadly, they were unable to resuscitate him and the doctor certified his death at 2.12pm.

THE INVESTIGATION PROCESS

1. The man died on 11 September 2008. Notices were issued to staff and prisoners at the prison to inform them of the investigation process and give them the opportunity to speak with the investigator. An Assistant Ombudsman, visited the prison to open the investigation on 15 September. During the visit, she met the Governor, a representative of the Prison Officers' Association and the chaplain. She also spoke informally with staff who knew the man and had attended when he was found. The prison provided the man prison records for examination as well as his medical record.

2. The investigation was initially assigned to an investigator. However, in December 2008, she left the Fatal Incidents Team, and a colleague took over the investigation. She visited the prison twice in April 2009 to interview staff. On the second occasion she briefed the Governor on her findings. She also met with the police investigator to share information.

3. One of the family liaison officers contacted the man's family and gave them the opportunity to raise their concerns. The family did not respond but will be given another opportunity to be involved in the investigation with the issue of this draft report.

4. A clinical review of the man's healthcare at Shrewsbury was undertaken by Shropshire County Primary Care Trust. The reviewer and the clinical review panel reviewed the man's clinical record and transcripts of the interviews of staff conducted by the investigator.

HMP SHREWSBURY

5. Shrewsbury is one of the oldest prisons in England and there has been a jail on the site since 1793. The present prison was built in 1877. It holds both sentenced and unconvicted men from the courts in Shrewsbury, Mid Wales and Stoke-on-Trent. It currently has an operational capacity of 340 adult male prisoners who occupy mainly double cells within two wings, 'C' wing and 'A' wing. 'A' wing cells are located on four galleried landings, known as A1 (ground floor), A2, A3 and A4 landings.

6. The local Primary Care Trust is responsible for healthcare provision within the prison. The Primary Care Centre is staffed by a multi-disciplinary team under the management of a doctor and a healthcare manager. It is currently open from 7.30am to 9.00pm daily and provides primary healthcare as well as a number of services - substance misuse, dental, psychiatric, optical, chiropody and counselling. In addition, there are clinics for sexually transmitted infection (STI), blood borne virus (BBV), Well Man, asthma and diabetes. A Mental Health Inrreach Team provides services for prisoners with mental health issues.

7. The prison's strategy links both the Prison Service's and Government's initiative in combating the illicit use of drugs and offers treatment to those using drugs. Rehabilitation is offered to those requiring detoxification using a Subutex based treatment programme. Subsequent treatment programmes cover a wide range of issues, including: drug awareness and education, individual and group counselling.

8. There is a system of emergency radio calls in place to ensure that staff are aware of the type of healthcare emergency. 'Code blue' is a local procedure used to alert the communications room staff that someone is experiencing breathing difficulty. The radio operator in turn alerts healthcare staff, who can then attend with the correct emergency equipment.

Previous deaths at Shrewsbury

9. There have been five deaths at HMP Shrewsbury since April 2004 and there are several themes running through them that link with the man's death. The requirement for staff to carry anti-ligature knives has been highlighted in previous reports but was still not routine at the time of the man's death. Several reports discuss healthcare procedures and assessments and make recommendations to improve them. I am pleased to note that the improvements were in place when the man arrived at Shrewsbury. Finally, several previous recommendations have focussed on ACCT procedures, many of which have been implemented. However, in the Ombudsman's report into the death of a man in 2008, he highlighted deficiencies in the Care Map section. The

Care Map drawn up for the man was not sufficiently focussed on supporting him and, again, I make a recommendation about this part of the ACCT process.

Her Majesty's Inspectorate of Prisons

10. HM Chief Inspector of Prisons, Dame Anne Owers, made a full announced inspection of Shrewsbury in June 2006. In the report of the inspection, the Chief Inspector said, "Communication and joint working between healthcare and the prison regime were good, and healthcare was well supported by Shropshire Primary Care Trust". She also judged that healthcare services had improved over the previous two years.

11. Dame Anne said the quality of ACCT entries and the Care Map actions were good. However, as discussed above, the Care Map prepared for the man fell below this standard.

12. The quality of staff/prisoner relationships at Shrewsbury was higher than average. Dame Anne said:

> "Many prisoners were well known to staff and a degree of familiarity and mutual tolerance had developed. In an overcrowded and relatively impoverished environment … there was evidence of real care and thought for and about prisoners."

Independent Monitoring Board (IMB) report

13. Each prison is monitored by an Independent Monitoring Board, members of which are volunteers drawn from the local community. They have full access to prisoners and every part of the establishment. In its latest annual report, for the year ending 30 April 2009, Shrewsbury's IMB concluded:

> "The Board feels it essential that prisoners are provided with surroundings that are at all times safe and humane and appreciate that this is being achieved to a high level by all concerned."

14. The report also highlighted a recent survey of prisoners being released from Shrewsbury which found that it:

> "…did not throw up any negative criticisms of the prison. Health Care; treatment by staff; food; all rated highly but the most significant item to come out of the survey was that they all felt safe while in the prison."

KEY FINDINGS

15. The man who died was arrested on 2 September 2008. He was charged with criminal damage and breach of a non-molestation order, obtained by his partner. He appeared at North Staffordshire Magistrates Court the following day and was remanded in custody to HMP Shrewsbury. The man had been imprisoned in Shrewsbury several times before and many of the staff knew him.

16. In reception, an officer interviewed the man and completed the first two sections of the Cell Sharing Risk Assessment (CSRA). (A cell sharing risk assessment is completed when a prisoner is received into prison in order to make sure that unsuitable prisoners do not share cells, eg a racist prisoner and one from a visible ethnic minority or a mentally disturbed prisoner with a violent one.) The man answered "Yes" to the questions about past and current misuse of alcohol and drugs. He told the officer that he had previously been on an ACCT plan. When the officer asked the man whether he had any concerns about sharing a cell and if he tended to become angry quickly, the man said yes to both. The officer assessed him as a medium risk, which meant that he and his cellmate would be regularly reviewed.

17. The duty reception nurse, a Registered Mental Nurse (RMN), then interviewed the man. She assessed his health needs and completed the First Reception Health Screen form. When asked about his physical health, the man said he had no concerns.

18. The nurse then asked him about his use of alcohol and drugs. The man said that his use of alcohol had gradually increased since October 2007 and he was currently drinking "14 pints daily". (The Department of Health currently recommends a daily maximum of three to four units for men and the man was drinking 28 units per day.) The man told the nurse that he used heroin three to four times a week and had last taken some the previous day. He said that he injected the drug but the nurse noted that there were no needle marks on his hands. He also said that he was currently prescribed 18 milligrams (mgs) per day of Subutex, an opiate substitute used to treat heroin addiction. A urine test showed that the man was positive for both heroin and benzodiazepine, a tranquiliser. She therefore referred him to the doctor, the prison drugs service and the mental health in-reach team.

19. The next section of the health screen focuses on mental health. The man told the nurse that he had never seen a psychiatrist but he had been treated for depression and anxiety. His doctor had prescribed diazepam, a tranquiliser, but he was not currently taking it. He then said that, after his wife's death in 2002, he had tried to hang himself. However, he told the nurse that he had no thoughts of harming himself. The nurse completed a "mental state examination" form which highlighted that the man was depressed. She made a further referral, this time to the Mental Health team (MHIT). The MHIT referral was not

marked as urgent and the man was still waiting to be seen when he died. The clinical reviewer discusses this in his report at annex 2. Finally, the nurse completed the healthcare section of the CSRA. She assessed the man's risk of harm to others as low and also noted that there were no self-harm concerns.

20. From reception, the man went to A wing, where he was allocated a shared cell on the ground floor (A1-20). The officer who had been in reception again interviewed him, this time to complete the "First Night Care and Induction Booklet". (This booklet was produced by staff at Shrewsbury and is designed to identify any problems a new prisoner has. It must be completed on the prisoner's initial day of reception.) When asked about any previous self-harm, the man said he had never harmed himself. The officer wrote on the form that the man was withdrawing from drugs but there were no other concerns.

21. As the man was charged with breaching a non-molestation order, the officer also completed a "Communications Restrictions" form. This set out the special restrictions on the man, who was not to contact his partner. The man signed the form to show that he was aware of the restrictions.

22. The following day, 4 September, the man returned to court, where he was remanded in custody until 10 September. The man's next appearance was arranged to be by video-link from the prison. He returned to Shrewsbury at 5.00pm. In reception, a nurse examined him and completed a "Return from court" form. On it she wrote, "Req Zop? Detox? D/W Dr." The nurse no longer works at the prison, so the investigator was unable to ask her what the note meant. However, it would appear that she was questioning whether the man needed to be prescribed Zopliclone, a sleeping pill, as he was detoxing and that she would discuss the matter with the doctor.

23. The man attended the healthcare centre for appointments with both a nurse and the doctor. The nurse completed a detox assessment and then started the man on a Subutex detox. This consisted of a Mirtazapine, an anti-depressant, and Buscopan, which counteracts stomach and bowel cramps. The doctor examined the man and prescribed diazepam and co-codamol (a pain killer), the medications that the community general practitioner had been prescribing.

24. At some point during the next day, the man referred himself to the Counselling Assessment Referral Advice Throughcare (CARATs) team who help prisoners with substance misuse problems. On 6 September, the man telephoned his uncle to tell him he was in prison. His uncle later told the police that the man had sounded upbeat and said that his solicitor was going to "sort things out" for him.

25. One of the CARATs workers interviewed the man on the morning of 8 September and completed an assessment. The man said that he had

started to use drugs in his teens and then used alcohol as well. He had taken cocaine in the past but now only used heroin and alcohol. The drugs worker then completed a harm reduction checklist with the man as a means of discussing the risks associated with his substance misuse. They also decided to refer the man to a community based drug interventions team on his release from prison.

26. In the afternoon, the drugs worker interviewed the man's cellmate. At the end of the conversation, the cellmate said that the man had tried to hang himself during the night. He had been woken up during the early hours of the morning by a noise in the cell and found the man on the floor. The man had a sheet round his neck and had apparently fallen off a chair which was under the window. Neither he nor the man had told any other members of staff what had happened.

27. The drugs worker reported the information to wing staff and opened an ACCT plan. He recorded the information from the cellmate in the booklet and then passed it to the duty Senior Officer (SO). The SO completed the Immediate Action Plan, listing the support the staff would give the man. This included putting him on intermittent watch of five observations an hour until the ACCT assessment had been completed. As the ACCT was opened after staff learned that the man had attempted to harm himself, an Injury to Inmate form (F213SH) should have been completed. However, there was no record of this being done and no form in his records.

28. Later that afternoon, the man collected his PIN phone card, which allowed him to make telephone calls. An officer wrote in the observation section of the ACCT, "Had a call to his family. States he is feeling better." An entry at 6.30pm noted, "Said he felt a lot better."

29. At 8.25am the following morning, the man asked for three application forms, relating to the PIN phone, medical and Job Centre Plus. An officer gave him the relevant forms and explained how to make an application. Shortly afterwards, another officer interviewed the man and completed the ACCT assessment. He told the investigator that he knew him from previous times in Shrewsbury and the man spoke quite freely to him.

30. The man told the officer about the problems in his relationship with his partner and the events that led to him being in prison. He said that he had been feeling frustrated about the situation he was in and that harming himself had been a "spur of the moment act". He said that he was feeling "a little low" and was having trouble sleeping because of back problems. However, he had no current thoughts of self-harm. The officer set out the next steps for the man who would speak to Listeners if he needed to talk to someone, find employment while in prison and speak to healthcare staff about his back pain. (Listeners are prisoners who have volunteered for the role and have been trained

by the Samaritans to listen to prisoners who are in distress or crisis and need to talk in confidence.)

31. Shortly afterwards, the man and the officer met with the Suicide Prevention Co-ordinator (SPC) for the ACCT case review meeting. During the meeting, the SPC completed the Care Map, which sets out the prisoner's problems and ways for them to be resolved. She identified the man's issues as being family problems, his detoxing from heroin and being remanded in custody. The columns for goals and action should contain ways to improve the man's situation but they do not - the entries merely expand on his problems. The SPC noted that the man was due to appear in front of magistrates the following day, via a video link. She also noted that he would speak to healthcare staff about pain relief for his back problems. Finally, she reduced the observations to hourly and set the date of the next case review meeting for 12 September.

32. Immediately after the meeting, the man had an appointment with a staff nurse. The man asked to speak to a doctor and the nurse explained the appointment process to him. He asked her for sleeping pills because he was could not sleep because of his back pain. The nurse told him that, because of the detox medications, sleeping pills are not usually prescribed.

33. Later that morning, the man talked to one of the prison chaplains. He told the chaplain that he had put in an application to healthcare to discuss his back pain and that he was appearing in court the following day. The chaplain wrote in the ACCT document, "Encouraged to focus on those two issues before trying to look beyond. The man says that he … will try to do so."

34. Later, a community chaplain visited the man. The community chaplain had known the man for a number of years and had helped him find accommodation several times after release from previous prison sentences. The community chaplain was interviewed during the police investigation into the man's death. He said that the man had told him that he firmly believed that he had damaged the relationship with his partner for good. The community chaplain also noted that the man did not discuss his housing needs on release as he had done on previous occasions and in fact, had not discussed any plans for his future.

35. Staff made several entries during the afternoon about the man's back pain and a wing officer asked for a member of the healthcare staff to visit the man on the wing. A staff nurse came to see him in his cell. He asked for painkillers for his back pain but the nurse said that she could not give him any because he was on a Subutex detox. The man then refused to continue the detox. However, an officer noted at 8.30pm that the man wanted to know what time he would receive his medication. The prescription charts in his medical records show that

he continued to take his detox medication. A later entry in the ACCT said that the man "appears to have slept well through the night".

36. The following morning, via a video link, the man spoke to his lawyer and then appeared in front of North Staffordshire magistrates. They remanded him in custody until his next court appearance on 1 October. He telephoned his uncle afterwards and, although he had not been given bail, he still sounded "upbeat". He then told his uncle that he had made him the executor to his will. (This information came from his uncle after death, and the prison staff were not aware of it at the time.)

37. During the morning, the drugs worker spoke to the man about accommodation when he was released and about a community based drug interventions programme. In the afternoon, the man attended communion in the chapel and in the evening he had association, when he mixed with the other prisoners on the wing. Later, he told an officer that he was "so-so … fed up because he didn't get bail". The officer on duty at night wrote in the ACCT that the man "was settled all night".

11 September

38. On 11 September, the man was awake at 7.00am and asking officers for tobacco as he had none left. His cellmate then went to court. The man went to collect his medication with a friend who was also a prisoner. The friend told the police that they had spoken about past times and had laughed. He said that he felt the man appeared to be in "very good spirits", more cheerful than he had been over the previous few days. The friend said that they "were in hysterics with laughter". The man also spent about an hour talking to a relative who was also in the prison. The relative later told a chaplain that he had given the man some tobacco.

39. Throughout the morning the man asked a number of people for tobacco and items to make tea and coffee as he was waiting for his canteen order to arrive. (Prisoners are able to order items such as tobacco, stationery, food, drinks, and toiletries once a week from the "canteen". The orders are delivered on a set day each week.) The man also spoke to the duty wing officer and told him about his plans for release. Shortly before lunch, the officer gave the man enough tobacco and papers to make eight or nine cigarettes. At 12.30pm, the prisoners were served lunch. The man collected his lunch with the other prisoners and took it back to his cell where he appears to have eaten it. The prisoners were then locked in their cells while staff went to have their lunch. Staff returned to the wing at 1.30pm and the wing officer and a colleague began unlocking the men for the afternoon activities.

40. Before opening the man's cell, the wing officer looked through the observation hatch. He saw the man slumped under the window and realised that something was wrong. As he opened the door, he called

"Code Blue, A1-37" over the radio to request healthcare assistance at the cell. He then saw that the man was suspended from the window bars by what appeared to be a torn pillow case. He shouted to his colleagues to help him, went in and lifted the man up. An Operational Support Grade officer (OSG) ran in and tried, but failed, to untie the ligature. He then helped the wing officer support the man. Neither of the staff were carrying anti-ligature knives, but the OSG used his cigarette lighter to burn through the pillow case and the shoelace round the man's neck. As they laid the man on the floor, another officer came in. The OSG left the cell and the second officer used his anti-ligature knife to cut the ligature from the man.

41. The two officers felt for a pulse but could not find one, so they began cardio-pulmonary resuscitation (CPR). Both officers had been given first-aid training as part of their basic officer training. The second officer used a mask given to him by a colleague and started mouth-to-mouth resuscitation and the wing officer carried out the chest compressions. Healthcare staff then arrived carrying the bag of emergency equipment and took over the man's treatment. The officers moved furniture out of the nurses' way and then left the cell. One of the prison doctors arrived and examined the man. The man had no pulse, he was not breathing and his pupils were dilated. Another member of staff brought additional equipment and the nurses used an ambu-bag (a face mask attached to an oxygen cylinder) to provide oxygen to the man.

42. Staff set up a defibrillator (a machine that treats victims of sudden cardiac arrest by delivering a shock to the heart) and the doctor administered medication which is used to try to resuscitate patients. The paramedics arrived at 1.55pm and they too administered medications. After further CPR, the doctor, the healthcare staff and paramedics agreed that nothing more could be done for the man. The doctor therefore certified death at 2.12pm.

43. The Governor chaired a hot debrief later that day. (A hot debrief is a meeting for staff to discuss emotive issues and any lessons learned following serious events such as deaths in custody.) The news was broken to the prisoners and those on ACCT plans had case reviews. The man's cellmate did not return from court, so no support was necessary for him.

44. A Governor and chaplain broke the news to the man's family and offered them support. The prison Family Liaison Officer, kept in touch with the family. A member of the chaplaincy team attended the man's funeral on 9 October.

45. After the man's death, staff found a number of letters in his cell. Most were to his relatives but one was addressed to the officers. Staff passed them to the police, who then made them available to the investigator. A number of the letters describe his life and feelings in

negative terms and express thoughts of his death. In the letter to the staff, he thanked them for their help during his time in Shrewsbury.

ISSUES

Health

46. The clinical reviewer completed a review of the clinical care the man received whilst at Shrewsbury. His full report is at annex 2. He concludes that there were no identifiable contributory factors or root causes relating to the man's death.

47. In respect of the man's mental health, the reviewer confirms that he was screened on reception by the duty nurse and referred for a mental health assessment as he was suffering from depression. The reviewer notes that the man was referred to the prison doctor and that there was no need for the mental health in-reach team referral. Referrals to the team are for prisoners with "severe and enduring mental illness", which depression is not. Patients who have failed to respond to treatment by the doctor can also be referred but there was no evidence that the man was not responding to the anti-depressant medication.

48. When the man was in Shrewsbury, prisoners could wait up to a month or more for a mental health referral because so many referrals were being made. The reviewer notes that the length of wait has since decreased as a result of new systems, a better referral process and prioritisation.

49. The man told prison and clinical staff that he had back pain and, on several occasions, asked for sleeping pills. Nurses explained to him that he could not have any because of the medications he was taking for the detox process. The man was waiting for a doctor's appointment to discuss this at the time of his death. He had told a nurse that he would stop the detox in order to be able to take sleeping pills. However, the prescription chart records show that he continued with the detox medications. The ACCT entries show that he slept well on most nights.

50. Finally, the reviewer considers whether "the man's thoughts about suicide could have been better identified and treated in his short stay in prison." His conclusion is that there is no evidence that he was considering harming himself.

Injury to Inmate form

51. After the man's cellmate told the drugs worker that the man had attempted to harm himself during the night, the drugs worker opened an ACCT plan. An Injury to Inmate form (F213SH) should also have been completed. This form is used to describe how a prisoner has been injured and what injuries he received. However, there is no such form in the man's records.

The Governor and Head of Healthcare should remind all staff to complete an Injury to Inmate form when a prisoner attempts to harm himself.

Assessment, Care in Custody and Teamwork

52. When the drugs worker learned of the man's attempted self-harm, he opened the ACCT procedures. Staff identified the three issues causing the man's distress and put actions in place to support him. This was done to a satisfactory standard and within the required timescales.

53. However, the Care Map completed by the SPC did not set out goals or actions that would help the man resolve his problems. For each of the three issues, the goal and action stipulated by the SPC merely repeated or expanded on the problem. For example:

> "Issue – further remand in custody
> Goals – Video link 10/9/08. Thinks he'll not go home
> Action required - to attend V/L and see the outcome of his court appearance."

54. The lack of focussed support for the man is disappointing. At the top of the Care Map page there is a list of the types of action to consider. Case managers should refer to this list to ensure that their actions meet the required standard. As a trained ACCT case manager the SPC should have been aware of this.

55. Nevertheless, the man was supported by the officers and other prisoners on the landing, many of whom knew him. He spent quite a lot of time out of his cell and spoke frequently to officers as well as having longer conversations with other prisoners. Staff also enabled him to telephone his uncle twice before his PIN phone card came through. In one of his final interactions with staff, the man asked the duty wing officer for tobacco. The officer gave him some of his own tobacco and papers, enough to make several cigarettes so that he could smoke during the lunch hour. As the man was observed every hour for the ACCT plan, being in the cell over lunch did not disrupt the process.

56. Prison Service Order (PSO) "Suicide Prevention and Self-harm Management", Annex 1b sets out areas to be covered by each prison's local suicide prevention and self-harm management strategy. It requires all ACCT case managers to receive refresher training at least every three years, although every two years is preferable. Such training is an ideal opportunity to highlight the aims of the Care Map and advice on how best to complete it.

57. As noted above, one of the man's concerns was his court appearance the following day. It would have been good practice for the next case

review to be arranged with this factor in mind. As it was, the SPC set the date for 12 September, two days after his court appearance. At interview, she stated that she now looks at forthcoming court dates before setting the date for case reviews.

The Governor and Safer Custody Manager should ensure that the refresher training for ACCT case managers includes:

- **advice and guidance on Care Map planning**
- **the need to consider significant events, such as forthcoming court dates when arranging case reviews.**

Anti-ligature knives

58. The staff who went to the man's aid had difficulty releasing the ligature from the window bars. They were not carrying anti-ligature knives, the OSG tried to untie the ligature before using his lighter to burn through it. When the second officer arrived, he was carrying a knife and used it to remove the ligature from the man's neck. At interview, the wing officer said that he did have an anti-ligature knife but that he was not carrying it on 11 September. The OSG said that anti-ligature knives were not routinely issued or carried at Shrewsbury.

59. Prison Service Instruction (PSI) 2006-32 "Cut-down Tools" which came into effect on 20 November 2006 stipulates that, "All unified and uniformed staff in closed and semi-open establishments must be provided with and carry on duty their own personal issue cut-down tool". In a report into a previous death at Shrewsbury the Ombudsman recommended that this PSI be implemented. It is disappointing that this had still not been done at the time of the man's death.

60. PSO 2700 "Suicide Prevention and Self-harm Management" states (in Annex 13b), "With help cut the ligature, saving the knot for evidence." The OSG, in his attempts to free the ligature from the window bars, tried to untie the knot. In the circumstances, I consider his actions justified, as he was attempting to release the man as quickly as possible. However, had the staff been carrying anti-ligature knives, it would not have been necessary to touch the knot.

61. After her interview with the OSG, the investigator raised these issues with the Governor, who took action. The following day, he issued a Governor's Order (Annex 4) making it a disciplinary offence for staff not to carry an anti-ligature knife. The same Order also reminded staff that, wherever possible, they should not cut the knots of the ligature. Whilst I am pleased that the Governor took this action, it is disappointing that it only happened as a result of the investigator's feedback. The Governor is responsible for safer custody and, I believe, should have taken the initiative straight after the man's death.

62. Sadly, there has recently been another death at Shrewsbury. However, it is satisfying to note that the officers who responded to that

emergency were carrying, and used, anti-ligature knives in compliance with the PSI and the Governor's Order. I therefore do not need to repeat the previous recommendation.

CONCLUSION

63. The man had been in prison several times and was known to staff and other prisoners in Shrewsbury. He was detoxing from heroin and alcohol and felt that his relationship with his partner was perhaps beyond repair. He also said that he had back pain that kept him from sleeping, although the ACCT entries by officers do not reflect this. He told staff that his attempted self-harm in the early hours of 8 September was “spur of the moment”. Staff opened an ACCT plan to put in place additional support, although elements of it were lacking.

64. Thereafter, the man showed no signs of wanting to harm himself. Prison officers described him chatting to them and other prisoners on the landing and appearing to be in good spirits. Two prisoners, one a long-standing friend and the other a relative, both said that he gave them no cause to be concerned.

65. However, after his death several factors emerged that appear to show that the man had been thinking about his death. The community chaplain noted that the man had not discussed his housing needs or any plans for his release from custody. The day before his death, the man told his uncle that he had appointed him as his executor. Finally, the letters the man wrote reflect a weariness with his life.

66. On 11 September, the hour alone in his cell at lunchtime provided the man with privacy. His ligature on 8 September had been a bed sheet, which broke. Three days later, he strengthened the ligature by twisting a shoelace into the sheet. Sadly, when staff found the man, he was beyond help, despite their efforts to resuscitate him.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should remind all staff to complete an Injury to Inmate form when a prisoner attempts to harm himself.

   The Prison Service accepted the recommendation, saying,

   "A Governor's Order has been issued to remind all staff to complete an injury to inmate form when a prisoner attempts to self harm."

2. The Governor and Safer Custody Manager should ensure that the refresher training for ACCT case managers includes:
   - advice and guidance on Care Map planning
   - the need to consider significant events, such as forthcoming court dates when arranging case reviews.

   The Prison Service accepted the recommendation, saying,
   "Locally the ACCT refresher training now includes this."