Investigation into the circumstances surrounding the death of a man at HMP Shrewsbury on 22 August 2009

Report by the Prisons and Probation Ombudsman for England and Wales

October 2010

This is a report into the circumstances surrounding the death by hanging of a man who was a licence recall prisoner at HMP Shrewsbury, on 22 August 2009. The man was 34 years old. Suicide monitoring procedures were in place until three days before he died.

I offer my sincere sympathy and condolences to the man's family and friends for their loss. I apologise for the delay in issuing this report and any distress this may have caused.

The investigation was carried out on my behalf by one of my colleagues. A clinical review of the man's healthcare at Shrewsbury was undertaken by Mr A on behalf of Shropshire County Primary Care Trust (PCT). I am grateful for the review. I would also like to thank the Governor of Shrewsbury, Mr B, and the Director of Dovegate, Mr C and their staff for their co-operation and assistance with this investigation. Particular thanks go to Ms A, who was a very efficient liaison officer.

Throughout his sentence, the man remained troubled by his crime and presented prison staff with a number of challenges. He became addicted to drugs in prison seemingly as a way of coping with his guilt about his offence. Several attempts at detoxification were unsuccessful. He had been recalled to Shrewsbury only hours after being released into the community on licence. Although staff at his previous prison had helped the man to prepare for his release, he nevertheless faced it with trepidation. Also, he had been unable to take part in some offending behaviour courses because of his personality disorder and social phobia. Consequently, he was unable to demonstrate that his risk to the public had reduced.

I am satisfied that the man was well supported by staff at both prisons. However, I make three recommendations, covering recording refusal to take medication; timely risk assessments for prisoners with significant mental health conditions and noting the reasons for moving prisoners at risk of suicide or self-harm to single cells. All three recommendations were accepted.

I have copied this report to the Director of Dovegate and the West Mercia Probation Trust.

Jane Webb
Acting Prisons and Probation Ombudsman **October 2010**

CONTENTS

Summary	4
The investigation process	6
HMP Dovegate and HMP Shrewsbury	7
Key findings	11
Issues	27
Conclusion	33
Recommendations	34

Annexes

SUMMARY

The man was born in 1975 and died on 22 August 2009 in his cell at HMP Shrewsbury. He was 34 years old. He had been recalled to prison five weeks earlier after breaking the terms of his licence. He had been in Shrewsbury several times before and many of the staff knew him.

In 2002, the man was sentenced to ten years imprisonment for the manslaughter of his mother's partner. A psychiatric report prepared for the court indicated that he had a personality disorder and social phobia. He therefore found it difficult to undertake the group work element of offending behaviour courses. As a consequence, he was not eligible for early release as he could not demonstrate that his level of risk had reduced. The man began using drugs in prison as a way of coping with the crime he had committed and became addicted to opiates.

The man was due to be released from prison on licence in July 2009. In April 2009, he told staff that he had suicidal thoughts as he was worried about being released as well as remaining addicted to drugs on release. Staff placed him on the suicide and self-harm prevention monitoring procedures and continued this additional support until he left prison on 17 July. The man initially disputed the condition of his licence which forbade alcohol and threatened to get drunk, not report to the hostel and to harm himself. However, staff calmed him and he eventually accepted the conditions.

On the day of his release, the man made his way to his home town, where he went to a pub and got drunk. At around 11.15pm that night, he went to the police station. He told the police he had been released from prison earlier that day and had contravened his licence conditions. Consequently, the Probation Service issued a licence recall. The police arrested him and took him to Shrewsbury prison the following day. Staff at Shrewsbury immediately placed him under the suicide and self-harm provisions, but they ended the following day as plans were put in place to address his issues. The man was again subject to these measures between 2 and 19 August, following his claim to have taken an overdose of his prescription drug, fluoxetine. During his time at Shrewsbury, the man also engaged with drug workers. He attempted to stop taking drugs by moving to a wing with minimal drug use. However, after a while he returned to a general wing, reportedly because of the greater availability of drugs.

Three days after the suicide monitoring ended, on 22 August, the man was found hanging in his cell by officers conducting the morning count of prisoners. As he appeared to have been dead for some time, they did not attempt resuscitation. The paramedics subsequently certified him dead at 6.17am. Support was provided for both prisoners and staff. The prison asked the police to contact the man's family as they held no next of kin details. Thereafter, the prison kept in touch with the family and was represented at the man's funeral.

The investigation has found that the man's refusal of medication was not recorded in his clinical record and therefore not communicated to relevant staff. Also, given he had been assessed as having complex needs, a detailed risk assessment should have been conducted as a priority. The man moved to a single cell while subject to self-harm monitoring, but the reasons were not recorded. I make three

recommendations regarding these matters.

THE INVESTIGATION PROCESS

1. The man died on 22 August 2009. 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. No one responded.

2. My investigator visited the prison to open the investigation four days later. During the visit, she met the Governor, a representative of the Prison Officers' Association and the Independent Monitoring Board. She also visited A wing and looked at the man's cell. The prison provided the man's prison records for examination as well as his medical record. My investigator later returned twice to interview staff and a prisoner.

3. In the early part of the investigation it became clear that the investigator needed to interview staff at HMP Dovegate. The Director appointed a liaison officer who arranged for my investigator and a colleague to speak to the staff.

4. One of my family liaison officers, contacted the man's family and gave them the opportunity to raise their concerns. The family appreciated the efforts of prison staff who were respectful and welcoming towards them when they visited. However, they also raised a number of issues:

   - How was the man able to take an overdose in prison?
   - Why was he allowed to be in a single cell?
   - What mental health assessments were carried out?
   - The length of time before the man was found.
   - How long was the man at the approved premises?
   - His family was not told of his whereabouts, or his release to an approved premises.
   - What were the conditions of his release on licence and which did he breach?
   - Did the prison help him to deal with his guilt about the offence?
   - How was the ligature attached to the window bars?

   I hope that this report and additional correspondence from the investigator goes some way towards addressing the family's concerns.

5. Mr A undertook a clinical review of the man's healthcare at Shrewsbury on behalf of Shropshire County PCT. He reviewed the man's clinical record and the transcripts of the interviews with staff. He and colleagues met as a panel to discuss the issues and their findings. His review is at annex 2.

HMP DOVEGATE AND HMP SHREWSBURY

HMP Dovegate

6. Opened in 2001, Dovegate is a category B prison for adult male prisoners sentenced to over four years and local remand prisoners. New prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D, with category A prisoners being the most dangerous. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult.

7. Dovegate is managed by Serco under contract to the National Offender Management Service (NOMS). It currently holds up to 1,146 prisoners. There are 946 in the main prison and 200 in the therapeutic community (TC). (TCs provide a long term, residential, offending behaviour intervention for prisoners who have a range of offending behaviour risk areas, including emotional and psychological needs.) Healthcare services in Dovegate are provided by Serco Health.

8. The former Chief Inspector of Prisons last reported on Dovegate following an announced inspection in October 2008. She said:

> "On our last two visits to the main prison, we noted serious weaknesses in safety and control and a lack of progress between inspections. To the credit of the Director and his staff, this full announced inspection found a safer and more controlled prison with reasonable purposeful activity, although resettlement remained weak.
>
> "The establishment was now much better ordered and considerable efforts had been made to tackle bullying. A strong emphasis had been placed on security, and this was not disproportionately affecting the regime for prisoners. Staff appeared more confident and there had been a substantial reduction in the use of force."

9. Regarding the healthcare services at Dovegate, the Chief Inspector made the following comment:

> "Primary health services were reasonable, but were compromised by shortages of staff and accommodation, which needed a substantial increase in funding for healthcare to move forward. …Mental health services were good and developing, and prisoners were well supported by the primary and secondary services."

10. The Independent Monitoring Board (IMB) comprises lay people from the community who monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained. The IMB Annual Report, for the period 2007-08, made the following comments regarding healthcare services:

> "Serco Healthcare has a contract to provide healthcare at HMP Dovegate. Unlike Home Office prisons the local Primary Care Trust is not responsible for delivering healthcare at HMP Dovegate, but does provide support for clinical guidance.
>
> "There has always been a high turnover of staff in healthcare, nurses and GPs, as well as managers. This unit needs some stability particularly at this time. As part of the ongoing extensions to HMP Dovegate the healthcare unit is to be increased in size, extra facilities and more single rooms are to be provided."

HMP Shrewsbury

11. 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. In January 2010 it became a Category C training prison. (Category C prisoners cannot be trusted in open prison conditions but would not have the ability or resources to make a determined escape.) However, at the time of the man's death, it held both sentenced and unconvicted men from the courts in Shrewsbury, Mid Wales and Stoke-on-Trent. The information below describes the prison as it was when the man was there.

12. The prison has an operational capacity of 340 adult male prisoners who occupied mainly double cells within two wings, 'C' and 'A' wing. 'A' wing cells are located on four galleried landings, known as A1 (ground floor), A2, A3 and A4 landings.

13. 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 In-reach Team provides services for prisoners with mental health issues.

14. The prison's drug strategy links the initiatives of both the National Offender Management Service and the Government to combat the illicit use of drugs and offer treatment to those using drugs. Rehabilitation is offered to those requiring detoxification using a Subutex based treatment programme. (Subutex prevents withdrawal symptoms.) Subsequent treatment programmes cover a wide range of issues, including drug awareness and education, individual and group counselling.

15. 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 bring the correct emergency equipment.

Previous deaths at Shrewsbury

16. There have been six deaths at HMP Shrewsbury since April 2004, when the Prisons and Probation Ombudsman was given responsibility for investigating deaths in prison custody. There are several themes running through them that link with the man’s’ death. Several recommendations have covered suicide and self-harm monitoring procedures, which I again address in this report.

Her Majesty’s Inspectorate of Prisons

17. The former Chief Inspector of Prisons made a full announced inspection of Shrewsbury in June 2006. In the report of the inspection, the former 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.

18. The former Chief Inspector of Prisons said the quality of ACCT entries and the Care Map actions were good. (The ACCT procedure provides additional monitoring and personalised support for prisoners considered to be at risk of harming themselves or suicide.) The quality of staff/prisoner relationships at Shrewsbury was higher than average. The former Chief Inspector of Prisons 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

19. 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.”

20. 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

21. The man was remanded into custody on 7 November 2002 and taken to HMP Blakenhurst. This was not his first time in prison. On 2 October 2003, he was sentenced to ten years imprisonment for the manslaughter of his mother's partner. After serving the early part of his sentence in HMP Blakenhurst and Shrewsbury, he moved to Dovegate on 12 January 2004.

Dovegate

22. Throughout his sentence, the man refused to take part in offending behaviour courses. The psychiatric report prepared for the court before sentencing had concluded that the man suffered from a personality disorder and a social phobia. Staff tried to persuade him to complete courses, such as Enhanced Thinking Skills. However, the courses all involved group work and his social phobia meant he was very uncomfortable in groups. As the man could not show that his level of risk to the public had reduced, he was not released on parole or Home Detention Curfew (HDC). (HDC allows certain prisoners early release from prison to serve the remainder of their custodial sentence in the community wearing an electronic tag, which must not be removed, while subject to a curfew.)

23. The man settled into life in prison and was employed in the workshops. Staff described him to the investigator as, "a hard worker … he would work like mad." When he was not at work, he spent a lot of time in his cell. Prison Custody Officer (PCO) A told the investigator:

> "He tended to spend a lot of time on his own or with a select couple of prisoners on the wing. Most of the time though, he was a fairly quiet guy."

24. Whilst at Dovegate, the man began using drugs and other prisoners' medication, becoming addicted to opiates. He told staff in 2005 that he had been using heroin for 18 months. For the next two years he was prescribed a number of detox programmes using Subutex, an opiate substitute that lessens the effects of withdrawal. However, at other times, he was prescribed methadone, a substitute for heroin, as part of a maintenance programme. From 2005, the man was prescribed fluoxetine, an anti-depressant.

25. Mr D, a prisoner in Shrewsbury who was an old friend, said that the man spoke to him of his life in Dovegate. The man told Mr D that he had started using drugs:

> "... to get all the bad things he had done in his life, he wanted to forget them all. But where most people will talk to Samaritans or officers or In-reach [staff], he didn't want that … He didn't want to be a burden to anybody."

Mr D described the man's daily life at Dovegate as, "… doing a bit of work, come back, take a bit of heroin, go to sleep." The man told Mr D that he was

"so remorseful for what he did". G wing Unit Manager, Ms A, told my investigator that the man had spoken to her about his offence. She said,

> "He struggled to cope with what he'd done, that was his biggest [issue] … He was worried about being released, facing his mother and coping with what he'd done."

26. During his time at Dovegate, the man sometimes became very low in mood and occasionally he harmed himself. A PCO said that when he did so, he usually told the staff. He cut himself, used ligatures and, on one occasion, stockpiled his medication and then took an overdose. Staff opened ACCT plans to give him additional support while he worked through his problems. Other prisoners with whom he was friendly also looked after him. Custody Officer A said that the prisoners used to tell staff how the man was feeling and sometimes advised them to "keep an eye on" him.

27. The man had a re-categorisation board in January 2008. Staff prepared reports about his behaviour and readiness (or otherwise) to move to a lower category of prison to assist him progress through his sentence. The board's decision was to change the man to category C to enable him to move to a training prison where the necessary offending behaviour courses were available. The man should then have applied to transfer to a category C prison but he did not do so. His offender supervisor, Custody Officer B, noted in her records,

> "Received his cat C. Seems happy at the moment. Not bothered about a transfer. Happy here".

Staff considered that to force the man to move prisons against his will would be counter-productive and so they did not insist that he had to transfer.

February 2009

28. In February 2009, staff from various departments at Dovegate began preparing for the man's release. As mentioned earlier, he was not eligible for parole or HDC, and so his release date was the 'non-parole date'. This date is when the person has served three-quarters of their sentence which, in the man's case, was after seven and a half years. The person is then released from prison 'on licence' for a further period. The licence sets out certain conditions that the person must observe, otherwise they can be recalled to custody. The person must be released from prison on their non-parole date.

29. Custody Officer C was the man's resettlement officer, and responsible for "liaising with [prisoners] to gain accommodation, employment, education, training and any other needs they might have". She told the investigator that she first met the man on 10 February and assessed his needs using the 'seven resettlement pathways' guide. This is a set of areas that might be problematic for a person leaving prison and covers accommodation, work, education, attitudes, thinking and behaviour, finance and debt, substance misuse and health.

30. The man's main issue was accommodation and his worry that he would have to sleep rough on release. Custody Officer C told my investigator that she contacted various housing agencies but none could accommodate him at the time of his release.

31. On 16 April, Custody Officer A opened an ACCT plan to provide additional monitoring as the man said that he had suicidal thoughts because he was so concerned about his forthcoming release. He was also worried about being addicted to drugs when leaving prison. Staff noticed that his mood had changed and he was not eating or socialising with other prisoners.

32. The following day, an ACCT assessor interviewed the man to ask about his thoughts of self-harm, the reasons for his actions and possible coping mechanisms. She and the man discussed his drug use and the man said that he felt it would be helpful to detoxify before release. Unit Manager, Ms A, then completed the Care Map section of the ACCT. It lists the prisoner's problems and identifies actions to resolve them. In relation to his drugs problem, Ms A wrote that the man would contact the Counselling, Assessment, Referral, Advice and Throughcare service (CARATs) team. (CARATs workers are based in prisons and specialise in the treatment of substance abuse. They run programs, offer counselling, support and referral to rehabilitation centres to prisoners and on release.) Given his worries about being released, Ms A advised him to work with his offender supervisor and offender manager to plan his release. She also encouraged him to contact his mother before leaving prison as the man had said that he was worried about how to re-establish his relationship with her.

33. Later that day, Ms A held an ACCT case review meeting, attended by staff and the man. A member of the CARATs team was present, together with the legal services officer, Custody Officer B and a G wing officer who knew the man well. (ACCT case reviews are supposed to be multi disciplinary meetings but this is not always the case. I am pleased that staff of different disciplines who knew the man were at the meeting.) The man was concerned about being unsupported on release. The staff noted that he now appeared more positive and was less withdrawn. They discussed starting a detox programme to deal with his drug addiction.

34. The next review was held a week later, when staff described the man as "despondent". He was unhappy because his drugs treatment had not started immediately. However, he told them that he had no intention of harming himself.

35. The clinical reviewer notes that rather than a detox programme:

> "Following a case conference in April it was decided that stabilisation for opiate use was necessary prior to his release, due to chaotic drug use. There is no account of drug use in the IMR [medical record], we would presume that he was purchasing illicitly. Naltrexone was

discussed but the decision was to retoxify with methadone. This was administered in increasing doses."

36. On 30 April, the man attended an Offender Assessment System (OASys) review board, chaired by Ms B, his offender manager, with Custody Officer C, Custody Officer B and two other members of staff. (OASys is a sentence planning tool to inform decisions on release and interventions.) They discussed the man's recent months and set targets for the next three months to stay out of trouble on the wing and continue his education.

37. Custody Officer B noted in the Supervision and Sentence Plan, "To complete victim awareness and to engage with CARATs workers." The man had applied for a victim awareness course in 2007 but had not completed it because he was on the Vulnerable Prisoners Unit (VPU). (The VPU accommodates prisoners who ask to be segregated, for example if they are vulnerable to bullying or have committed an offence of which other prisoners disapprove. Prisoners within the unit can mix with other vulnerable prisoners.) The man also agreed to complete an Enhanced Thinking Skills (ETS) course after release if he could do it in a one-to-one setting rather than in a group. He had been allocated a place on a course during his time at Dovegate but had refused to participate. He also considered working part-time while attending college to gain some qualifications that would improve his employment prospects. (He had gained a level 2 NVQ in Performing Manufacturing and Operations and level 1 literacy and numeracy certificates at Dovegate.)

38. Custody Officer B also wrote:

"The man seems scared of leaving his comfort zone, which is the prison. He has been in a very low mood lately and because of this he has not been engaging with the CARAT team, RMN [registered mental health nurse] etc".

In the section on relationships, Custody Officer B noted that the man was in contact with his mother by letter but was worried about meeting her. He hoped to have contact with his sisters through his mother.

39. On the same day, there was an ACCT case review meeting. Ms A wrote:

> "Very positive as there are now measures in place for his release. Had a visit today from his outside probation and is having a phone call tomorrow via OMU (Offender Management Unit) regarding housing."

40. In May, unit managers held five ACCT case reviews. During the first, on 6 May, the man was noted to be:

> "low in mood, poor eye contact, became irate at times due to he thinks H/care [healthcare] are playing God with him. However, he again denied any thoughts of harming himself".

41. The next review was three days later. The man refused to talk to the staff. He became upset and told them that he would kill himself that night. Ms A raised the frequency of ACCT observations to five per hour and scheduled the next review for three days' time. However, a review was held the next day. The man said he felt much better and staff noted that he interacted well with them. The man told them that he was finding the very frequent ACCT observations "somewhat agitating". He said that he was not thinking about harming himself and would talk to staff if he needed to. The case manager reduced the observations to four per hour and warned that, if the man did not interact with staff, it could mean that his risk was rising.

42. At the review on 11 May, the man spoke about the methadone maintenance programme he had started. Staff recorded that he was "chatty" and "in good spirits not 100% though". The notes of the review held a week later stated that he was going to work and eating regularly. The manager reduced the observations to two per hour.

43. Because of the seriousness of his offence, the man was managed by the Multi-Agency Public Protection Arrangements (MAPPA) panel. This is the process through which the Police, Probation and Prison Services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public.

44. A MAPPA meeting took place on 23 May to manage the risk the man presented to the community. The panel members decided on a number of actions, one of which was to arrange to transfer the man to Shrewsbury prison. This was considered to be beneficial as the man would be closer to his home. Ms B and staff at Dovegate organised the transfer. However, the man refused to move and staff did not pursue the matter. The MAPPA co-ordinator agreed to contact the Community Mental Health Team (CMHT) to ensure that the man's mental health needs would be met after his release.

45. At the ACCT case review on 10 June, the man told staff that he was looking forward to his release, although he was still "a little worried" about it. Ms A set the date for the next review as 1 July and made a note to invite staff from the offender management unit (OMU), the CARATs team and the psychology department.

46. On 23 June, the MAPPA panel met again and the members discussed the licence conditions that the man would have to abide by in the community. They decided that he had to work with the CMHT and live in an approved premises (formerly probation hostel). As well as the normal morning and evening curfews, the man would have to report to approved premises staff at midday. The minutes noted:

> "Concerns are expressed about the length of time that NT [the man] has spent in a therapeutic community, apparently without engaging with any group work or therapy. He is known to be self-harming and his resistance to the prison move suggests that the transition from prison to the community will be even more stark."

47. The panel members agreed that, on his release, the man should be escorted from the prison to the hostel. They also arranged to transfer the man to the Worcester MAPPA panel which was where he would be living. When Custody Officer C told the man that he would be escorted to the approved premises, he refused to accept being accompanied.

48. On 1 July, the man did not attend the ACCT review because he had earache. The panel noted a continuing improvement in his outlook but, because of his impending release, decided to maintain the ACCT monitoring. The entries in the On-going Record of the ACCT plan show that the man began to spend a lot of time walking around the landing. When asked why he was doing this, he said that he was trying to get additional exercise to prepare himself for leaving prison. Often when he spoke to officers, he told them the number of days left until his release and the PCOs noted his excitement.

49. During the weeks leading up to his release, Custody Officer C, Custody Officer B, and Ms B, worked closely together to arrange accommodation for the man. On July 6, Custody Officer C learned that the approved premises in Worcester had agreed to take the man and she gave him the news. She told the investigator that he was very pleased that he now had somewhere to stay on his release. Custody Officer C also arranged an interview at Birmingham College for the week after his release, to discuss numeracy and literacy courses. The man had originally considered looking for a job but decided that collecting his methadone several times a day would be difficult to fit into a working day. Methadone had been prescribed as a way of stabilising the man's chaotic drug use.

50. At the ACCT case review on 9 July, the man was "in very good spirits, good sense of humour". The next review was set for 15 July, two days before his release.

51. On 13 July, the man asked to leave work early. Custody Officer D noted:

> "He said he feels paranoid and irritated. He says people are watching him. Really is not himself this afternoon … He did say he would not self-harm, but in a very low mood."

52. Later that afternoon, the man spoke to one of the CARATs workers. A PCO noted that he was restless and during association he walked around the landing. However, when a member of the night staff spoke to him, he said he was "fine". (Association is when prisoners are out of their cells and are able to associate with and speak to each other.)

53. The following afternoon, Custody Officer C and a colleague met the man. They asked if he would like an appointment with a counsellor in the community and he replied that he would. They then discussed his licence conditions. When told that one of the conditions was that he could not drink alcohol without permission, the man was upset and walked out of the office. Wing staff contacted Custody Officer B who spoke to the man and they discussed the licence conditions. Custody Officer B wrote in the ACCT plan:

> "The man seemed overly cheerful and stated that he will not go to the hostel when released but will go to Bognor Regis [and] spend his money on drink and drugs … The man then stated that after a couple of nights when he is beginning to 'settle', he will get very drunk and kill himself. The man doesn't seem to want to listen to reason over this licence condition."

Custody Officer B told the investigators that, when he said this, he was very matter-of-fact and calm. She had no doubt that he was capable of doing what he said, that is taking his life.

54. The man repeated this assertion to one of the wing staff the following day. At 4.00pm, he attended an ACCT case review where the licence conditions were discussed. Ms B took part in the review by telephone. The man became very angry about the condition that he could not drink alcohol without permission. He said that he would get drunk and jump from a tall building in Telford. He would not report to the hostel or take his methadone.

55. The review meeting was suspended while staff tried to discuss the issue and calm him. After speaking to CARATs and resettlement staff and being told it was a normal licence condition, the man agreed to accept it. The review meeting discussed all the support networks that were in place for the man on his release. He told staff that he was looking forward to leaving prison, although he was a little nervous.

56. The entries in the ACCT plan on 16 July show that the man had a quiet day. One PCO wrote that he was in a very good mood and hopeful about the future, another noted that he "was joking on the wing".

Release from Dovegate on 17 July

57. The final ACCT case review was held in reception on the morning of the man's release. The reception duty manager chaired the review and Custody Officer B, Custody Officer C and a member of CARATs were there. Because the man was about to leave prison, the ACCT plan was closed. However, Custody Officer C had liaised with the approved premises staff and they had a self-harm care plan ready to put into place for him, which would include hourly observations and a care coordinator who would act as a mentor. They had also arranged twice-weekly appointments with a nurse from the CMHT. Custody Officer C had requested that during his journey to Worcester National Rail staff at each station would meet the man to assist him in get the correct train.

58. Mr D, the man's friend in Shrewsbury prison, told my investigator that the man had spoken to him about how he felt and what he did during the short time he was in the community. The man was unhappy at having to share a room in the hostel and because so many of the other residents were sex offenders. (Prisoners have an unofficial hierarchy based on their offence. Sex offenders are at the bottom and many serve their sentences in Vulnerable Prisoners Units.)

59. The man did not report to the approved premises. Instead he travelled from Worcester to Telford, his home town, intending to meet some of his friends there. However, he could not find any of his friends and so went to a pub in the town centre. He spent several hours drinking alcohol, in contravention of his licence conditions. At some point, he obtained drugs which he took. He told Mr D that he thought about harming himself (as he had told Dovegate staff he would) but did not do so.

60. At about 11.15pm, the man went to the nearby police station and gave an officer his name. He said that he had been released from prison that morning and had broken his licence conditions by drinking alcohol and missing the hostel's evening curfew. He sat in the reception area of the police station for about 90 minutes while the police checked his information. Once they confirmed that probation staff had taken the appropriate action to recall him to prison, they arrested him and took him to the cells and, the following day, to Shrewsbury.

HMP Shrewsbury

61. In reception at Shrewsbury on 18 July, the man told Officer E that he had cut both his wrists about a month earlier in Dovegate. He said that he now felt "low in mood" because his licence had been revoked. Officer E opened the ACCT suicide and self-harm prevention procedures to support him. The senior officer in reception, Senior Officer A interviewed the man, who said that he would not try to harm himself. Senior Officer A then completed the Immediate Action Plan, setting out the ways staff would help him over the following 24 hours.

62. The man had previously spent time in Shrewsbury. He asked for accommodation on the Vulnerable Prisoners Unit on C wing because of "trouble with people in the Dana (Shrewsbury prison) connected to drug dealers" and this was agreed. However, until a cell became available on C wing, he would be in a cell close to the wing office on A wing. Senior Officer A decided that, whilst subject to ACCT monitoring, the man would share a cell with another vulnerable prisoner. Staff were to observe him each hour and have a "meaningful conversation" with him several times a day.

63. Senior Officer A explained how to use the telephone to call friends and family and the special handset to talk to the Samaritans. He also spoke about the Listeners. (Listeners are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in

distress.) Finally, he referred the man to the Mental Health In-reach Team (MHIT).

64. For the first 90 minutes, until a cellmate was found, staff kept the man on constant supervision, meaning that a member of staff was always with him. At 4.15pm, about two hours after arriving at Shrewsbury, he went to the healthcare centre where the doctor prescribed an opiate detoxification programme. On returning to the wing, another prisoner had moved into the man’s cell, so the staff observations were reduced to hourly. During the evening, staff checked on the man and noted in the ACCT plan that he was “getting on with his cellmate”.

65. The following morning, Senior Officer B interviewed the man and completed the ACCT assessment. He told the investigator that the man sounded quite positive and denied any wish to harm himself. He said:

> “His concern was that he had come out of prison with an addiction and he still had it and he stated he wanted to change basically, he needed help to change his life around. … He wanted to be drug free and to give himself a fighting chance when he got back out into the community.”

66. The man told Senior Officer B that he had been released from Dovegate with a drugs habit and “had problems at the hostel he was sent to”. Also, that he had “got drunk” on the day of his release and had been recalled the same evening. He said that he no longer felt miserable, had slept well and his appetite was good. He had a further appointment with the detoxification staff later that day.

67. An ACCT case review meeting was held immediately after the assessment interview. Senior Officer C, the duty wing manager, joined the man and Senior Officer B. They discussed the man’s issues and the way they were being resolved. All three decided there was no reason to keep the ACCT plan open,and so it was closed. After an ACCT plan is closed, a post-closure interview must be held to assess how well the person is coping without the extra support of the ACCT process. The man’s review was set for 24 July.

68. On 24 July, Senior Officer B interviewed the man during the ACCT post-closure review. The man said he had no thoughts of self-harm or suicide and that he was “feeling okay”. He was waiting to learn how long he would remain in prison before being released again. Meanwhile, the probation staff in the prison were trying to arrange accommodation for him in the community. He told Senior Officer B that he would speak to staff if he had any further problems.

Suspected overdose

69. On 2 August some time after 10.00pm, the man pressed his cell bell. (Each cell has a bell to be used if the prisoner requires urgent assistance.) The officer on night duty went to his cell. The man asked what would happen if he

" … had taken an overdose of his medication". The officer telephoned Nurse A in the healthcare centre and asked her for an answer.

70. Nurse A went to the wing and the officer opened the man's cell door. They stood at the door and spoke to him. The nurse asked him why he wanted the information. She told the investigator:

> "His intention was that he wanted to die. He didn't want anybody to be involved or blamed and he said it had nothing to do with anybody within the prison and it was a decision he had made himself."

71. The man said that he had written to his family saying that he wanted to die and showed the notes to Nurse A. When she questioned him further, he said he did not wish to die and was not going to harm himself. However, he then told Nurse A that he had taken 31 fluoxetine (Prozac) tablets after stockpiling them for a number of days.

72. Nurse A returned to the healthcare centre and telephoned the out-of-hours doctor to ask about the urgency of the situation. Acting on his advice, she told the senior officer on duty in the prison to send the man to the accident and emergency department at the local hospital. The hospital carried out blood tests and admitted him for observation.

73. At 8.30 am the following day, 3 August, the man returned to prison. The discharge letter from the hospital said that he had shown no symptoms of having taken the medication and asked the healthcare staff to arrange "psychiatric follow up as appropriate". After telling the duty nurse that he was, "ok no problems", the man was referred to the Mental Health In-Reach Team (MHIT) and returned to A wing.

74. Senior Officer B, one of the safer custody staff, opened an ACCT plan to give the man support. He completed the Immediate Action Plan that sets out the various means of help that were available straight away. He decided that staff should check on the man five times each hour and have at least one conversation with him each shift.

75. At 10.00am, Nurse C from the MHIT and Nurse D, a community psychiatric nurse (CPN) from the community forensic (mental health) team, visited the man in his cell. The visit had been arranged prior to the man saying that he had taken an overdose. The man had worked with Nurse D before and was described as comfortable talking to her. He said that he had taken the overdose to highlight that he felt he was still suffering the effects of detoxification. He told her that he felt the detoxification "had been too quick and that he is struggling". He was also feeling "low" after learning that he might have to remain in prison much longer than he had expected.

76. Nurse D said that she would contact the man's offender manager to clarify how long he would have to serve. He agreed to work with the prison MHIT and, on his release, with the community forensic team. Nurse C also encouraged him to work with the CARATs team as he had not yet done so.

However, the man said that he did not like the attitude of the CARATs staff. Nurse C put the man on the list of patients to be discussed at the team meeting the following day.

77. Just over an hour later, a nurse from the healthcare team discussed the man's detoxification with him. The man said that when it had ended he continued to withdraw from drugs, but he had not told staff this. He felt that the detoxification had not helped as he was restless and his legs were twitching. The nurse referred him to the CARATs team and arranged to discuss further treatment with the doctor. At 2.00pm, the doctor prescribed a lofexidine detoxification (to reduce the symptoms of withdrawal from opiate addiction) for the man. The nurse who gave him the first medication at 8.00pm, noted that he was "pleased and calm".

78. However, at 7.45am the following morning, the man collapsed whilst queuing for his medication. He was not injured and a nurse visited him in his cell. She measured his blood pressure, which was low. She decided that staff should monitor his blood pressure before giving the lofexidine and discontinue it if the readings were too low.

79. Senior Officer B interviewed the man in his office to complete the ACCT assessment interview at 8.30am. When asked what his problems were, the man said that he was finding the detoxification process difficult. Also, after serving a ten year sentence, he had been recalled to prison just over 15 hours after being released and did not know how long he would have to serve. He continued to feel guilty about his offence.

80. Having discussed the problems, Senior Officer B completed the ACCT Care Map, setting out ways of tackling each problem. (Over the next few days, the actions Senior Officer B set out in the Care Map were completed. The man's medication was reviewed and he started another detoxification. Senior Officer B contacted the OMU to ask about the recall process and release plan. The man also applied for an interview with CARATs staff.)

81. Senior Officer B and the man were then joined by the duty wing manager and a healthcare nurse for the first case review meeting. The man told the staff that he did not intend to harm himself, although he felt "low". Staff again checked that he knew what help was available if and when he needed it. They decided to continue the same level of observations but supervise him constantly when he was alone in his cell. The next review was scheduled for two days later, 6 August. By the end of the meeting, the man was feeling unwell and asked to return to his cell.

82. The man collapsed for the second time that day at 5.30pm, but again was unhurt. Healthcare staff informed the prison doctor, who told them to stop the lofexidine detoxification. At 9.05pm, the duty nurse visited the man in his cell. He refused his anti-depressant medication but accepted paracetamol as he had a temperature.

83. Nurses continued to monitor the man throughout the following day (5 August). At 4.00pm, a nurse told him that, although he could not have lofexidine, he would be able to have other medication to ease the withdrawal symptoms. The doctor examined him the following day and reviewed the medications listed as alternatives to lofexidine. The doctor again prescribed fluoxetine, having stopped it after the alleged overdose. However, from then on, the man refused fluoxetine, although he accepted his other medication. (There is no record that staff took any action over his refusal of the anti-depressant.)

84. The second ACCT case review was held on 6 August. The man told staff that he was embarrassed at "his recent behaviour" and he now "wants to live more than he wants to die". He was getting on well with his cellmate and was due to start work the following day. The staff and the man decided to reduce the observations to hourly and scheduled the next review for 13 August.

85. Throughout this time, officers regularly spoke to the man about how he was feeling and his plans for the future, both short-term and long-term. On 12 August, the man spoke to Officer F about transferring back to Dovegate where he "felt safer". He said the same thing to a member of the chaplaincy team about an hour later. He also spoke about the events surrounding his recall to prison. The chaplain wrote in the ACCT document:

> "He stated that he was not prepared to do 3½ years simply having a drink whilst on probation. I questioned what he meant and he said 'he will take his life, rather than do this'."

That evening, the man told an officer that he was hoping that the ACCT would be closed at the next case review meeting as "he was not suicidal".

86. The third case review took place on 13 August. The man told staff that he wanted to move back to Dovegate as he thought that it was easier to obtain drugs there. Everyone discussed this and noted that the man was waiting for an appointment with the CARATs team. They also noted that arrangements were in place for the man and his cellmate to move to C wing shortly. The level of observations was left at the same level and the next review scheduled for 19 August. Senior Officer B, who chaired the review, told the investigator that the man would not have been transferred to Dovegate after admitting his reason was to obtain drugs.

87. After the meeting ended, the man asked to speak to a Listener. He spent some time in the interventions suite talking to the prisoner who was the duty Listener. (As Listeners are bound by the same confidentiality code as the Samaritans, I do not know what they discussed.)

88. Mr F, one of the drugs workers from the CARATs team, interviewed the man in the afternoon. The man said that he wanted to move to a prison with a methadone maintenance programme as he was finding it "difficult at the moment being without drugs".

89. After the meeting ended, he and his cellmate moved to C wing. An officer noted in the ACCT document that the man was “very cheerful and happy”. The entries for the next days noted that he continued to be “happy” and “content”. He began working in the C wing workshop and mixed well with the other prisoners during exercise and association.

90. However, on 17 August, the man asked for his vulnerable status to be removed and to return to A wing as a normal prisoner. This surprised the C wing officers who had thought him settled. Mr D, who was a prisoner on A wing and a friend of the man’s both in and out of prison, told my investigator that the move was because drugs were more readily available on A wing. He said:

> “He went VP because he didn’t want to be … back on the heroin and on C wing, you know, the kind of people that are on C wing, there’s hardly anything like that on C wing.”

Mr D also explained that a prisoner (whom he was unwilling to name) persuaded the man to move.

91. The man returned to A wing and told Officer G that he was pleased to be back. He took part in association and said he was looking forward to getting a job on the wing. The following day, he moved to cell A1-07, a single cell. The investigator asked who made the decision to give the man, who was still subject to ACCT monitoring, a single cell and why, but did not discover the answer. Despite changing wing, an ACCT review was not called. These issues are discussed later in my report.

92. The man appeared to settle well into the A wing routine. He told a member of the chaplaincy that he was “on an up” and appreciated having a single cell. He began working as a cleaner and took part in association.

93. On the evening of 18 or 19 August, Nurse A was on A wing and passed the man’s cell. He was talking to an officer at the door and, as she passed, asked her for “his subbies” (Subutex pills). He was smiling as he said this and Nurse A laughed as she pointed out that he was not prescribed that medication. She told the investigator that he had, “laughed quite a hearty laugh and seemed in very good spirits and in a very good mood”.

94. The final ACCT case review took place on the morning of 19 August. Senior Officer B was on annual leave, and so Senior Officer D chaired the meeting. He went through the Care Plan and checked that all the actions were complete, noting in the ACCT plan:

> “[Nenad] stated that he was happier and more settled now off VP and on A wing. Employed as a landing cleaner which is keeping him occupied. Medication is now stable with no issues. Pleased about the support he has had and now wants to come off the book. No thoughts or indications of self-harm.”

95. Two members of the MHIT spoke to the man on 20 August. The man told them that he had just had a legal visit that went well and was waiting for a decision about his licence recall and length of sentence. He said that he was happy with his new job as a cleaner but had applied to return to C wing. They discussed his drug taking and detoxification and the man said he had no thoughts of harming himself. A follow-up appointment was arranged for the following week.

22 August

96. At 8.30pm, the officers on night shift came on duty and at 10.00pm the prison went into night patrol state. Senior Officer E was the night orderly officer (radio call sign Oscar1), the most senior officer on duty in the prison. (At night, all prisoners are locked in their cells and the number of staff in the establishment is much lower than during the day. The night orderly officer is in overall charge of the prison.) Senior Officer E had an assistant night orderly officer (Oscar 2). The wings were patrolled by officers and officer support grade (OSG) staff, as usual.

97. During night patrol state, only the senior officer in charge of the prison carries a full set of keys to unlock all gates and cells. His assistant has keys that allow movement through the prison. Wing staff and nurses do not have keys allowing them free access around the prison and they have to be escorted. The officers and OSGs are each issued with a cell key in a sealed pouch for use in emergencies. The staff instructions are that during the night patrol state, a cell may only be unlocked by a single member of staff where there is, or appears to be, immediate danger to life.

98. There were three officers on duty on A wing that night, Officer H, Officer J and Officer K. Officer H carried out the evening roll count, checking that all the prisoners were locked in their cells. Several prisoners were on open ACCT plans and the officers checked on them throughout the night. As the man was no longer on an ACCT plan, staff did not look into his cell. It is normal for prisoners who are not on ACCT or any other monitoring not to be checked by staff between the evening and morning roll counts.

99. Officer H began the morning roll count at 5.30am. He started on the level four landing and worked down to level one. He reached the man's cell just before 6.00am, opened the observation hatch and looked inside. He saw the man at the back of the cell, under the window, and realised that he was hanging from the window bars. Officer H called for assistance on his radio, telling staff it was a "code blue" emergency (indicating breathing difficulties). Then he broke the seal on his emergency key pouch so that he could unlock the cell door.

100. Officer J and Officer K heard the radio call and went to the cell. Senior Officer E was on the A wing landing very close to the door through to the healthcare centre. He unlocked the door to allow Nurse A access to the prison. She had already collected the bag of emergency equipment, oxygen tank and defibrillator. (A defibrillator is a portable electronic device which measures

electrical activity in the body and advises on action to be taken.) Senior Officer E helped her carry the equipment to the cell, arriving just as Officer H opened the cell door. Officer H switched the light on and went into the cell while Senior Officer E used his radio to request an ambulance. They went to the man and supported his weight. Custody Officer J jumped onto the top bunk to reach and cut the strip of bed sheet that was tied to the window bars.

101. The officers lowered the man on to the floor and cut the sheet from his neck. They then stood back to give Nurse A room to examine him. She noted that his body was very cold and rigor mortis had begun to stiffen his arms. She saw blood on his chest, which she thought was because he had bitten his tongue. Nurse A established that the man was not breathing, had no pulse and the pupils of his eyes were fixed and dilated. Nurse A told the investigator that, in her opinion, the man had been dead for some time. She attached the defibrillator to him and the machine confirmed that he had no heartbeat.

102. Two paramedics arrived at 6.10am and used their equipment to examine the man. They agreed that he had died and that no treatment was possible. Five minutes later, a third paramedic arrived and he certified the man's death at 6.17am.

103. After a death, prison managers must hold a "hot debrief". This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on information sharing and how staff can support each other. The duty governor held a debrief immediately afterwards and offered staff the opportunity to briefly discuss what had happened. He then offered practical support and the Care Team were on duty to provide emotional support.

104. The chaplain went round the cells and broke the news to the prisoners. He and the chaplaincy team were available for prisoners who needed to talk to them, as were the Listeners. The prisoners who were on ACCT plans had case reviews later that day to check whether they had been affected by the man's death. Prisoners later collected £154, which the man's family donated to charity.

105. The prison had no contact details for the man's next of kin and therefore asked the police to investigate. The police subsequently broke the news to his mother and then his father. Deputy Governor, Mr G, who is also the prison's family liaison officer, was on leave at the time of the death. However, Reverend A was appointed to deputise in his absence. On his return to work, Mr G visited both parents on several occasions and invited them to the prison. The man's father visited and went to see his son's cell. The funeral was held on 4 February. Mr G and Reverend A attended and the prison met the expenses.

ISSUES

The man’s health

106. For most of his time in prison, the man was prescribed medication for anxiety and depression. In early 2005, he spent several weeks as an in-patient in the healthcare centre at Dovegate after an assessment concluded that he was “low in mood and suicidal”. From around this time onwards, he was prescribed the anti-depressant fluoxetine (Prozac). He harmed himself on several occasions. Mr A, the clinical reviewer, notes,

> “During this period his mood was frequently low, and he frequently refused input from the Mental Health Inreach team, and other health professionals.”

107. In 2009, as the date of his release approached, the man again appeared to suffer from a low mood. Staff referred him to the MHIT but he refused to attend appointments. A consultant psychiatrist assessed the man and concluded that he “had capacity to decline involvement with [the Mental Health In-reach] team”, meaning that he was capable of taking decisions about his treatment.

108. The man’s refusals also extended to his medication. The clinical reviewer, Mr A, discusses his refusal to take fluoxetine from 7 to 22 August. He notes that the refusal:

> “… is recorded in the Prescription chart but is not mentioned in the CCR [Continuous Clinical Record] and was not communicated to Prison In-Reach. There is no evidence that it was discussed by the healthcare team, or was considered in the ACCT reviews.”

109. He concludes,

> “It is not possible to ascertain whether this had any influence on the event, [that is taking his life] but should have been considered when assessing risks following the initial self harm event.”

The Primary Care Trust should ensure that when a prisoner refuses medication it is recorded in the Continuous Clinical Record, as well as the prescription chart and that relevant staff are informed of the refusal.

<u>Mental health</u>

110. The clinical review noted that, although the officer in reception referred the man to the MHIT, staff did not see him before his alleged overdose. However, after his return from hospital:

> “ … Prison In-Reach were contacted and responded quickly seeing him on the day of return to the prison. He was assessed as having complex needs but not presenting any immediate risk. He was seen

again on the 20 August by two members of staff, noted no signs of mental distress and a further visit planned for the 26 August."

111. Mr A notes that it is not clear what stage the referral for the man was at. He concludes that had the referral been actioned, "this would have led to a comprehensive risk assessment, although this would not necessarily have identified any further risk". He recommends that:

> "Where a prisoner is identified as having significant problems these discussions should take place earlier, rather than letting the referral process take its natural course. The need for comprehensive risk assessment should be established involving all appropriate staff."

The Primary Care Trust should ensure that a prisoner who has significant mental health problems should have a comprehensive risk assessment as soon as possible.

The man's use of drugs

112. Many men arrive in prison addicted to drugs but the man was not one of them. Tragically, his use began during his imprisonment. Whilst in prison, the man took opiates (heroin) regularly and became addicted to them. In 2005, he told staff at Dovegate that he had been using opiates for 18 months. He was prescribed detoxification programmes several times but always resumed using drugs.

113. Staff told the investigator that the man would use whatever drugs he could obtain, including other prisoners' medication. He was open about his use and, as his release approached, grew concerned about leaving prison addicted to heroin. Staff arranged for him to be prescribed a detoxification regime. However, because of what the clinical reviewer describes as the man's "chaotic drug use", staff decided to retoxify him by prescribing methadone. It was hoped that this would have made it easier for him to detoxify permanently in the community.

114. The man told a friend in Shrewsbury prison that he took drugs to block out memories of his offence. I know that staff in many prisons try to stop the flow of drugs into the prison, using a variety of methods. In spite of their efforts, drugs do slip through the net and are available to prisoners who want them.

115. The man tried to stop using drugs several times at Dovegate, going through detoxification programmes. However, he always returned to using drugs. In Shrewsbury, he asked to be accommodated on the Vulnerable Prisoners Unit on C wing. His friend, Mr D, told the investigator that vulnerable prisoners generally do not use drugs, and it would have been more difficult to obtain drugs on C wing. Although the man appeared to settle well there, he soon asked to return to A wing.

116. Mr D also told the investigator that he spoke to the man on the night before his death. The man said that he owed two prisoners several hundred pounds

for drugs that he had bought since his return to A wing. The sum involved would suggest heavy use of drugs in the five days before his death. However, the toxicology report provided by HM Coroner found that analysis of a blood sample,

> " … excluded the presence of alcohol and common illicit drugs. A trace of the anti-depressant fluoxetine and a low concentration of Paracetamol were detected".

117. At interview with the investigator, Senior Officer B said that he never saw any signs that the man was using drugs. Similarly, Senior Officer E and Officer G never saw him under the influence of drugs. During an ACCT review a few days before his death, the man openly admitted that he wanted to transfer to Dovegate as he considered that it was easier to obtain drugs there. Whatever the truth about the man's drug use, I am satisfied that the prison took appropriate steps to restrict supplies.

The apparent overdose

118. On 2 August, the man told Nurse A that he had taken an overdose of his fluoxetine medication. She took the appropriate step and contacted the emergency doctor who advised her to send him to hospital. The man spent the night in a local hospital before returning to Shrewsbury the following morning. The prison staff, very correctly, acted on the assumption that the man had taken an overdose. However, the discharge letter from the hospital said that there was no evidence that he had done so.

119. The man maintained that he had taken an overdose but there is no information about why he said this. However, from the letters he handed to Nurse A, he would appear to have been thinking of his past life and contemplating his death.

120. Whilst the man was at Dovegate, staff suspected that he might be attempting to stockpile his medication. Custody Officer A told the investigator that nurses who dispensed the medication alerted wing staff to their suspicion that the man was trying to leave the medication hatch without swallowing his pills. Staff were extra vigilant to ensure he was not able to keep the pills in his mouth until he could hide them in his cell.

The man's refusal to cooperate with his resettlement plans

121. Staff who spoke to the investigator described the man as an intelligent man who was very clear about what he would and would not do. This can be seen very clearly in his refusal to participate in offending behaviour courses. Partly, this was due to his social phobia. Many of the courses use group work, which the man would have found difficult. However, the phobia did not prevent him taking part in education and completing a number of classes.

122. Staff tried to persuade the man to undertake offending behaviour work and arranged for him start courses. However, he found reasons not to do them.

Similarly, when managers at Dovegate changed the man's classification from category B to category C, he refused to request a transfer to a category C prison. So, his objection to the suggestion that, prior to his release, he should move to Shrewsbury, was completely in keeping with his previous refusals.

123. Given that the man's refusals were very clear, staff decided not to force him to comply. It would have been possible for them to arrange courses and transfers to other prisons. However, I am satisfied that such actions may very well have been counter-productive as the man's sentence progression depended on his co-operation.

124. Staff at Dovegate spent several months making arrangements for the man's release. Custody Officer C and Custody Officer B worked closely with the man to ensure that he had support in the community. Ms B liaised with the MAPPA panel and the approved premises in Worcester to arrange accommodation for him. The clinical reviewer sums up the support that staff prepared for his release:

> "Because of his chaotic drug use it was decided to retoxify him prior to release. A multi agency approach was taken to his release with Prison In-Reach, the Probation Service, Forensic Service and local mental health services. It was recognised that he was anxious about his release and was vulnerable to self harm."

125. The man spoke to staff of his hopes and anxieties about renewing relationships after his release. However, as an adult, it was for the man to decide to tell his family about his release plans, if he wished. Custody Officer B and Ms A both encouraged him to re-establish contact with his family before his release.

Monitoring under the suicide and self-harm prevention measures

126. Throughout the man's imprisonment, staff opened a number of ACCT plans to monitor and support him through difficult times. For the three months before his release, staff at Dovegate used the ACCT plan as well as the resettlement process to try to address his worries about re-integrating into the community and re-establishing links with his family.

127. I judge that the Care Map and case reviews were well focussed on trying to meet his needs. Many of the entries are detailed and show a good knowledge of the man. The ACCT plan remained open until the man was about to leave Dovegate. An equivalent support plan was waiting for him at the approved premises. Both the ACCT plan and the planned continuity of care are commendable. (I will share my report with the Director at Dovegate and West Mercia Probation Trust.)

128. At Shrewsbury, the reception officer opened an ACCT plan for the man after he said that he was feeling "low" because of his recall. The following day, at the case review meeting after the assessment, the staff and the man agreed to close the plan. They made the decision because they believed that his

issues were being addressed. While I do not disagree with the decision, I point out that in my experience prisoners who have been recalled to custody can be at increased risk of self-harm. The shock of being back in prison and the uncertainty about their future are additional to any other problems they may have. The Governor may wish to remind his staff of this fact.

129. After the man returned from hospital on 3 August, Senior Officer B opened another ACCT plan and completed the Immediate Action Plan. The following day, he completed the assessment and Care Map, setting out ways to address the man's problems. Having the same senior officer carry out both parts of the ACCT process provided good continuity of care. The Care Map actions were focussed and designed to meet the man's need. In a report on a previous death at Shrewsbury, I criticised a Care Map for being sub-standard. I am pleased to note that the plan for the man was both precise and practical.

130. It would have been preferable for a further ACCT review to have taken place when the man moved from C to A wing. However, before Senior Officer D closed the ACCT plan, he checked that actions to resolve the issues were complete. The man said that he was happy to be back on A wing and with his job as a cleaner. He also said that he had no thoughts of self-harm. Again, everyone agreed and the ACCT plan was closed.

131. However, as already noted, the staff were unaware that the man had been refusing his anti-depressant medication. Senior Officer D noted in the summary, "Medication is now stable with no issues." The nurses who gave out the medication knew of his refusal but, as the fact was not recorded anywhere, the information was not available to the rest of healthcare staff, let alone wing staff. I have commented earlier that ACCT reviews should be multi-disciplinary and, unfortunately, on this occasion no healthcare staff were present.

Placement in single cell

132. After returning to A wing, the man obtained a job as a wing cleaner. Officer G told my investigator that it meant that he was occupied for some of the time. The man also moved to a single cell, even though his ACCT plan was still in place. For many people on an ACCT plan, the company of a cellmate is beneficial. The man had got on well with his original cellmate and they moved together to C wing. However, when the man returned to A wing, his cellmate did not.

133. The investigator asked why the man moved to a single cell and who had made the decision. Staff told her that such decisions were made by wing managers. Sometimes a prison doctor will ask for a prisoner to be given a single cell for medical reasons but there is no evidence of this in the man's records. The Deputy Governor, Mr G, told the investigator that there is a computer record of why staff move a prisoner to a single cell. However, in August 2009, the record was only kept for a month and was then deleted. By the time the investigator spoke to Mr G, the record of the man's move was no

longer available. I am pleased that Mr G has now ensured that the monthly records are archived in a computer file, rather than being deleted.

134. Given the absence of information about the reason for the move, I cannot comment on the decision. However, a change of cell can be a significant event for a prisoner on an ACCT plan. As such, it would be helpful for the decision and the reasons for it, to be recorded in the plan.

The Governor should ensure that if a prisoner subject to ACCT monitoring is moved to a single cell, the move and the reasons for it are reviewed and recorded in the ACCT document.

CONCLUSION

135. The man had been in prison for almost seven years when he took his life. He had been diagnosed with a personality disorder and social phobia which prevented him from taking part in offender behaviour courses. In addition, he struggled with coming to terms with the crime had committed and, during his imprisonment, turned to drugs, as a way of coping with his guilt. He was anxious about the prospect of facing his mother. The man tried many times to overcome his addiction, but invariably returned to drug-taking.

136. Throughout the man's initial sentence at Dovegate and then at Shrewsbury, where he was held after his recall to prison, I have found that staff put in place appropriate support to manage his various needs. He was subject to support and monitoring under the suicide and self-harm procedures at both prisons, having admitted to thoughts of harming himself. On one occasion, he claimed to have taken an overdose of drugs. He also sought and received support from the CARATs drug service and mental health team. (Unfortunately, a referral for a more detailed mental health risk assessment had not been acted on by the time of the man's death.)

137. The clinical reviewer concludes that prison staff responded to the man's needs. I too am satisfied that his care and management during his imprisonment was relevant to his needs and that, when he was found hanging in his cell, staff acted quickly and appropriately, albeit too late to save his life.

RECOMMENDATIONS

All the recommendations were accepted.

1. The Primary Care Trust should ensure that when a prisoner refuses medication it is recorded in the Continuous Clinical Record, as well as the prescription chart and that relevant staff are informed of the refusal.

   The response was:

   "To put in place a procedure for clinical staff to follow when prisoners 'do not attend' for treatment continuously for 3 days or refuse to take medication and document in prisoners clinical record.

   Regular monthly audits of prescription sheets and clinical records will take place.

   "Discussions with staff have taken place to inform them that prisoners that have not attended for medication for three days or longer must be seen by a nurse to ascertain why. This must be documented in the prisoner's clinical record. Guidelines as to the appropriate action to take will be written and shared with staff and the next staff meeting."

2. The Primary Care Trust should ensure that a prisoner who has significant mental health problems should have a comprehensive risk assessment as soon as possible.

   The response was:

   "There is now in place a new system of referral TAG. All referrals are now time lined to the urgency of referral to Primary and secondary mental health services. This will be audited quarterly."

3. The Governor should ensure that if a prisoner subject to ACCT monitoring is moved to a single cell, the move and the reasons for it are reviewed and recorded in the ACCT document.

   The response was:

   "The Governor will ensure that if a prisoner subject to ACCT monitoring is moved to a single cell, the move and the reasons for it are reviewed and recorded in the ACCT document.

   The single cell data base should also be updated by the Orderly Officer giving the reasons why the person has been placed in a single cell."