Investigation into the death of a young man at the Royal Stoke Hospital in September 2004 whilst a prisoner at HMP Shrewsbury

Report by the Prisons and Probation Ombudsman for England and Wales

January 2007

This is the report of an investigation into the death of a young man at the Royal Stoke Hospital in September 2004, who was found hanging in his cell on A Wing at HMP Shrewsbury earlier in the day.

I wish to offer my sincere condolences to the man's family for their loss.

I would like to extend my thanks to the acting Governor at Shrewsbury Prison throughout the latter half of 2004, and his staff for their help and support throughout this investigation. I particularly wish to thank the Shropshire County Primary Care Trust for the vital contribution they have made to my investigation and I commend their proactive response.

The man's death followed the deaths of one man in mid August and a second at the end of August 2004. They all apparently hanged themselves on A wing within a short time of arriving at Shrewsbury. All three men were drug users but none of them were believed by the prison to be at risk of self harm.

Shrewsbury is a small local prison and such a cluster of apparently self-inflicted deaths occurring within the space of little over a fortnight was profoundly shocking for all concerned.

I was very pleased to learn that a new detoxification regime was introduced at Shrewsbury on 1 February 2005. I am also aware that a new Medical Officer has been appointed and will shortly take up the post.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man was arrested on 27 August 2004 for failing to answer bail on, burglary and going equipped charges. He was held overnight at Longton Police Station before appearing at Newcastle Magistrates Court the following day. He was remanded into custody at HMP Shrewsbury until 2 September 2004.

The man went through the reception process with another prisoner, with whom he was acquainted. The two men were later located in the same cell. The man apparently gave no sign of any thoughts of self harm, although he had been on a self harm watch at Shrewsbury at the start of the year.

The medical officer saw the man and placed him on a detoxification regime due to his heroin addiction. His cell mate later described the man's mood as fluctuating over the next few days, which he said was normal whilst detoxing.

Early in the morning of 1 September 2004, the cell mate left the shared cell to attend a court hearing. About 9:30 am the man spoke with a prisoner who was out of his cell for his prison cleaning job. He explained that he had no tobacco and the other prisoner offered to bring him some about 10 am.

Arriving back at the man's cell about 10:15 am, the prisoner looked through the cell door observation panel and saw the man hanging from the window. He raised the alarm and officers quickly entered the cell and took the man down. They began CPR, assisted by the new prison doctor, and administered various drugs.
An ambulance was called and eventually a faint pulse was detected.

By 11:14 am the doctor and the paramedics decided that the man was stable enough to transfer to the Royal stoke Hospital.

The man was treated in the Intensive Therapy Unit but he died from his injuries at 9:12 pm.

CONDUCT OF THE INVESTIGATION

1. I decided to investigate the deaths of these three men by assigning a team of investigators. Each would be responsible for the investigation of the death of one man, but also work collectively to produce a comprehensive report into the circumstances of all three deaths and highlighting any common factors.

2. The investigation team consisted of three investigators working for the Prisons and Probation Ombudsman. They visited Shrewsbury on a number of occasions in August and September 2004, when they were given access to all the documentation held by the prison on all three prisoners.

3. one of the investigators met with the man's family.

4. Taped interviews were held with prison staff who had important contacts with any of the three men who died. Notices to Staff and Prisoners were issued at Shrewsbury inviting anyone with relevant information to make contact with the investigation team.

5. The investigation team maintained regular contact with West Mercia Police. We are extremely grateful to our police colleagues for their cooperation and helpfulness at all stages of our investigation.

6. My investigators wrote to Shropshire County Primary Care Trust requesting a clinical review of the three deaths. The review was led by the Trust's Commissioner for Substance Abuse. I am greatly obliged to him and his colleagues for the quantity and quality of their professional advice on the clinical factors in these three cases.

HMP SHREWSBURY

7. There has been a prison on the present site since 1793, but the main prisoner accommodation currently in use dates from the 1870s. The site offers little room for expansion or structural change.

8. Shrewsbury is a local prison for adult male prisoners. It houses unconvicted and convicted men, mainly from the Magistrates' and Crown Courts in the Shrewsbury, Mid Wales and Stoke on Trent areas. In the 12 month period prior to this investigation, the population had fluctuated between 290 and 350 prisoners. The certified normal accommodation of the prison is 182 but the operational capacity (maximum permitted number of prisoners) at the time of the three deaths was 350.

9. The cells at Shrewsbury are on A and C wings. A wing has a certified normal accommodation of 160, with an operational capacity of 307. C wing has a certified normal accommodation of 22, with an operational capacity of 43.

10. A wing cells are located on four Victorian galleried landings. The wing has one anti-ligature cell and two constant observation cells. C wing is used for vulnerable prisoners with special needs and it has one anti-ligature cell. A wing's role was both complex and wide-ranging. It accommodates a broad mix of prisoners, both remanded and convicted. The wing holds prisoners subject to every level Incentives and Earned Privileges Scheme, those detoxifying from various substances, and prisoners requiring support with issues such as mental health and learning difficulties. Newly admitted prisoners are generally housed on the ground floor of A wing, which is known as A1.

HER MAJESTY'S CHIEF INSPECTOR OF PRISONS REPORT

11. The most recent announced full inspection at Shrewsbury by Her Majesty's Chief Inspector of Prisons, Anne Owers, took place in November 2001 and the remarks in the Preface to her report are of considerable relevance to the present investigation. The first paragraph of HMCIP's Preface observes strikingly:
"Shrewsbury Prison has no inbuilt advantages. It is one of the oldest, most overcrowded and cramped local prisons in the country. It has to manage the great majority of its 330 prisoners on one wing, with no inpatient healthcare, limited training space and no outdoor recreation facilities."

12. However, in the second paragraph of her Preface, HMCIP remarks:
"Yet it has among the best staff/prisoner relationships of any prison we have inspected. From the Governor down, staff were visible and approachable."

13. The issue of self-harm also appears on the very first page of HMCIP's March 2002 report. She stated:
"One area that urgently needs addressing is the risk of self-harm in the early days of imprisonment. This is very strongly linked to the absence of proper detoxification facilities, which itself reflects inadequate medical cover. 60% of those identified as at risk of self-harm were in the process of detoxification. The prison's only recent suicide was a recently admitted drug user, and the majority of self-harm incidents had taken place in reception and induction cells within the first few weeks in the prison. Listeners (Samaritan/Trained Prisoners) and staff were in effect having to support those with substance related needs. It is to the credit of the Governor and management that they had identified this dangerous gap, and were seeking advice from other local prisons in order to identify the risks and deal with them more appropriately."

14. In the section of her report dealing with Substance Use HMCIP wrote at Chapter 3.8.4:
"Apart from a recently written alcohol detoxification protocol, there were no current detoxification protocols for substance users. We were told that the normal practice was to prescribe up to three days of dihydrocodeine, diazepam and zimophain. Staff and prisoners verified this. The general opinion among them that "the detox is crap". We agreed that the current detoxification practice was inadequate."

15. At Chapter 3.2.4 of her report, HMCIP recorded:
"The most recent death in custody had been in August 2000. There had been an inquest in April 2001. The Governor of another prison had carried out an internal investigation and had reported that the prisoner belonged to that group of drug users who appear to be at risk in the first week or so after reception. He commented that these were prisoners who were voluntarily coming off drugs or unable to renew medication

and also said that they should merit special attention from the policy makers on suicide awareness and self-harm." HMCIP then recommends: "The Prison Service should ensure that the observations and recommendations of an investigation into a death in custody at HMP Shrewsbury (2001) are addressed and reflected in policy throughout the service."

16. HMCIP made an unannounced inspection at Shrewsbury between 9-11 August 2004. The inspection report was published in December 2004. One of the central purposes of this unannounced inspection was to check on progress made at Shrewsbury in response to recommendations made by the Chief Inspector after her previous visit in November 2001.

17. In the introduction to her newly published document Anne Owers observed with pleasure that Shrewsbury had retained the very good staff/prisoner relationships and the commitment to continuous improvement which had impressed her on the previous inspection. She remarked that the great majority of her recommendations had been achieved and important areas of the prison had significantly improved "even though Shrewsbury has the dubious accolade of being the most overcrowded prison in an overcrowded prison system".

18. However, in the same introduction, HMCIP indicated that some weaknesses needed attention and she highlighted the issue of detoxification as follows:
"In our last report, we expressed great concern about detoxification procedures, and these remained defective, in spite of the fact that nearly two-thirds of prisoners admitted to having injected heroin in the period immediately before imprisonment. More analysis of patterns of suicide and self-harm was needed, in a prison that had experienced three self-inflicted deaths that year (and has since had three more)." The three additional deaths to which HMCIP refers are those of the two men in August and the man who is the subject of this report.

19. Section 2 of HMCIP's December 2004 report is headed Progress Since the Last Report. This section sets out recommendations made by HMCIP in March 2004 and notes progress made in implementing these recommendations. In relation to substance use, the first recommendation made by HMCIP in March 2002 was that the medical officer should undertake training in working with substance users, so that he might provide the services set out in Prison Service Order 3550. The December 2004 report observes that this recommendation was not achieved and that the GP in post at the time of the unannounced inspection (August 2004) was due to leave at the end of that month. HMCIP accordingly made a further recommendation as follows:
"The replacement medical officer should receive adequate training in working with substance users to support and complement the work of

the substance misuse nurses and the specialist medical officer from the Newhouse Shelton Psychiatric Hospital."

20. The concluding paragraph in the Substance Use subsection of HMCIP's new report sets out the recommendation made in March 2002 that a work plan for developing a comprehensive detoxification programme for prisoners should be developed in consultation with the area drugs strategy coordinator and the clinical adviser to the Prison Service Drugs Strategy Unit.

21. The December 2004 report from HMCIP recorded the fact that:
"Two specialist substance misuse nurses had been recruited to work with prisoners who needed detoxification drugs. However, the large percentage of prisoners whose main drug use was heroin were not prescribed any medication on the first night. Wing staff said that such prisoners, especially those experiencing their first time in prison, were therefore under additional stress through not knowing how to cope with the initial withdrawal of drugs."

THE DECEASED MAN

22. The man was born in 1973 and he had two younger sisters.

23. He attended Trentham High School, leaving without qualifications at 16. He began an apprenticeship to become an auto electrical engineer. He was progressing well until he turned 19, when he left home and moved in with a friend. That friend was a heroin addict and the man's parents believe that his addiction stems from then. After a very short time the man stopped attending work and began to get into trouble with the Police. The friend died from an overdose of heroin last year.

24. The man had been in a steady relationship with his fiancée since 1999. In September 2003 they had a son and for a while they both came off heroin. By January 2004 however, they realised that they could not cope and his fiancée's parents looked after the baby. The man and his fiancée had visiting rights and saw their baby son fortnightly. According to his fiancée they had a £60 per day heroin habit.

25. On 25 August, they were told that their son was to be adopted, they had last seen him the previous Thursday. They both knew, and according to the man's fiancée, had accepted, that the Social Services were intending to collect their son for adoption on 27 August. That was the day that the man was arrested on a warrant for bail offences, going equipped and burglary.

THE MAN'S FAMILY

26. My investigator spoke to the man's parents and his fiancée, at their home. His mother said that they were contacted by the prison and were able to attend the hospital before he died. His mother and the man's fiancée expressed concern that he was not on suicide watch at the prison, as they knew that he had been whilst at the Police station. They also felt that the man's hanging was a cry for help and that he expected the prisoner doing the cleaning to find him in time. Neither his mother nor the man's fiancée could suggest what help the man would have hoped to get from the incident. The family were happy with the level of contact and the information given by the Prison.

EVENTS PRIOR TO THE MAN'S DEATH

27. On 27 August 2004, the man was taken to Longton Police station upon arrest on a warrant for bail offences, going equipped and burglary, and was held there overnight. The man's family and his cell mate, assert that the man was on a constant self harm watch whilst in Police custody. If correct, details of that concern were not communicated either to the Court or to the prison. What happened whilst the man was in Police custody is currently the subject of an investigation by the Independent Police Complaints Commission (IPCC) and will not be commented upon further in this report.

28. On 28 August he was brought before the Newcastle Magistrates, who adjourned the case until 2 September and remanded the man into custody.

29. The man arrived at HMP Shrewsbury from Newcastle Magistrates Court on 28 August with his cell mate from the police station. They were the only two prisoners arriving on that Saturday afternoon and the officers in Reception knew both of them from previous periods at Shrewsbury. As the staff completed the reception process both engaged in light hearted banter with them. The man had injured his right hand two days previously and it had been x-rayed and strapped at hospital.

30. He was seen by Nurse Jones as part of the reception process and she completed the First Reception Health Screen form. The information to complete the form is supplied by the prisoner as answers to questions posed by the nurse.

31. The man admitted to using heroin and benzodiazepines the previous day. When asked if he had ever tried to harm himself, he answered no. He also answered no when asked if he might consider harming himself. The reception nurse had the PER form (Prisoner Escort Record) and saw that the Police had ticked the self harm risk box, but the man's behaviour did not give her any cause for concern. She was not aware of any previous self harm attempts that he had made whilst at Shrewsbury prison earlier in the year. The nurse ticked the health screen form for the man to see the doctor regarding his injured hand and his substance misuse.

32. Both men were assigned to share cell A1-12, one of a small number of cells with restricted natural light due to building work elsewhere in the prison. A scaffold covered with a tarpaulin had been erected a few feet from the cell windows which blocked a portion of the available natural light entering the cell.

33. The man appeared to settle into prison life and began to receive his drug detoxification medication. According to his cell mate, the man's mood fluctuated during the next few days but he says that is normal whilst detoxing and that he was the same.

34. On Sunday 28 August, the man telephoned his fiancée. He told her that he was 'rattling', a term commonly used by drug abusers to describe the various symptoms of drug withdrawal. He was also talking about going to court the following Thursday and Friday, saying that he was 'gutted' to be in prison.

35. On Monday, both men were moved into cell A2-06. The man rang his fiancée and sounded more 'upbeat', talking about being in for five or six weeks and not being too bad. On Tuesday 30, the man tried to ring again, and spoke to his sister for a short time before his credit ran out. He apparently sounded and said he was ok.

36. On the morning of Wednesday 1 September, his cell mate had a court appearance and was let out of the cell early to collect his medication and then again to go to court at about 7:30 am. About 9:30 am, a prisoner cleaning the wing spoke to the man through the cell hatch. The man had run out of tobacco and the cleaner said that he would bring him some about 10 am, after he had finished handing out the lunch menus on the wing. This did not happen as he was unavoidably delayed.

DISCOVERY OF THE MAN HANGING

37. At 10:15 am the cleaner returned to the man's cell and saw him through the cell door, hanging from the window bars. He immediately raised the alarm and two officers ran to the cell and entered it. They found access was impeded as the bunk bed had been moved and obstructed entry. They supported the man's body to relieve pressure on his neck. Other officers joined them, and the ligature, a piece of torn bedsheet, was undone and his body was lowered to the cell floor. The prison doctor arrived at that time and she and the officers began cardiopulmonary resuscitation (CPR).

38. The Control Room had called an ambulance and the paramedics arrived at the cell at 10:35 am. CPR continued, Adrenaline, Atropine and Naloxone were administered and by 10:52 am a faint pulse was detected. By 11:14 am, the doctor and the paramedics decided that the man was stable enough to move and he was taken by ambulance to the Royal Stoke Hospital. The man was cared for in the hospitals' Intensive Therapy Unit but did not regain consciousness. He died at 9:12 pm that night.

CLINICAL REVIEW

39. The Shropshire County Primary Care Trust appointed a team of people to carry out the clinical review into the death of the man.

40. The clinical review makes eight recommendations, which I endorse. A copy of the clinical review can be found in the attached annex: However the following points are worth repeating here.

    1. The F2169 'First Reception Health Screen' form notes that the man reports that he was prescribed nitrazepam and diazepam. These are medications used to treat anxiety, and their prescription may indicate some underlying mental health problem. There is no record of any attempt to find out why these medications were being prescribed or for how long. People physically dependent upon these drugs may upon their abrupt withdrawal, experience withdrawal symptoms, including increased anxiety, agitation, sleep disturbance and re-emergence of the problems for which they were originally prescribed. There is no apparent agreed policy or protocol for benzodiazepine withdrawal in use at Shrewsbury.

    2. The man appears to have been seen by the former medical officer on either 28 or 29 August. He was prescribed voltarol 75mg, presumably for pain and inflammation resulting from his broken wrist; he was also started on a drug detoxification programme. The doctor had written up a drug chart for Dihydrocodeine 90mg twice a day for three days, Dihydrocodeine 30mg twice a day for three days and Mirtazepine 15mg at night for 9 days. The man was into the fourth day of this programme when he died. There is no entry in the medical notes concerning the detoxification programme.

    3. The Clinical review Panel notes wishes to record that in its opinion the detoxification regime described above is not in line with recognised clinical guidelines for the management of substance misuse problems.

41. As well as the commissioned clinical review, the investigation team asked the Section Head for substance misuse at Prison Health, to report on the clinical management of the man's substance misuse programme.

42. He states that "individuals withdrawing (from opiates) often experience symptoms of depression and can have rapid and unpredictable mood swings". He agrees completely with the recommendations made by the clinical review team and notes that he saw nothing in the clinical record papers to indicate whether the prescribing regime for the management of the man's heroin addiction was effective or not.

43. He quotes from a 1999 Department of Health report which states, 'The product licence for dihydocodeine does not include the treatment of

opiate dependence, and there is concern amongst practitioners about its widespread use.'

44. The Section Head for substance misuse makes one recommendation regarding the establishment of a clinical withdrawal management unit, which I endorse.

OBSERVATIONS AND CONCLUSIONS

Reception

45. As is common throughout the prison service most of the information recorded or known about a prisoner when they first enter a prison is elicited from the prisoners themselves. Certain information about an individual's previous period in custody is held on the service database, LIDS. Much of the detail stored on that system is lost within 12 weeks of first being entered and, in any case to retrieve anything but the basics, requires a level of knowledge of the system greater than possessed by most front line officers.

46. In this case the man had been at Shrewsbury prison at the start of 2004 and had been on an open F2052SH (the self harm booklet) from 24 January to 2 February 2004. En route from court he had tried to hang himself in the van and had arrived naked and restrained as a result. The following day he pulled a bed on top of himself in an attempt to self harm. Then on constant watch with an officer sitting outside his open cell, the man called to the officer before cutting his neck and arms with a razor blade he claimed to have found in the cell. The injuries were minor and were treated by the healthcare team. A doctor saw him and the man threatened to bang his head against the wall, which resulted in two officers sitting in the cell with him for a number of hours.

47. All of the staff in Reception on Saturday 28 August 2004 knew the man as a previous prisoner at Shrewsbury but only the Senior Officer (SO) knew or recalled the above details. Neither the officers nor the nurse were aware of how to interrogate the database, although it is unlikely that much detail would have been available if they had.

48. After interviewing the staff it is thought unlikely that they would have made different decisions regarding his potential to self-harm if they had the above information on this occasion. In fact the SO stated that because of the way the man appeared in Reception he had no concerns. Also if the man had continued to present as he did, it is likely that any self-harm watch would have been minimal by 1 September. It should be remembered that the man was sharing a cell with someone he felt comfortable with, his manner was positive and forward looking and everyone, including his cell mate, was shocked by the manner of his death.

49. On 27 August 2004, the man was taken to Longton Police station upon arrest on a warrant for bail offences, going equipped and burglary, and was held there overnight. The man's family and his cell mate assert that the man was on a constant self harm watch whilst in Police custody. If correct, details of that concern were not communicated either to the Court or to the prison. What happened whilst the man was in Police custody is currently the subject of an investigation by the Independent

Police Complaints Commission (IPCC) and will not be commented upon further in this report.

50. In conclusion, the best decisions are made based on the best available information and every effort should be made to provide as much knowledge as possible about a prisoner to staff in Reception.

The new Prison Doctor

51. The former doctor had been the part time prison doctor at Shrewsbury for a number of years. He had decided to resign from that post with effect from 31 August 2004. As a result a replacement had to be found. In the short term it was decided to employ the services of an agency doctor for a period of three months. The new doctor was told to report to Shrewsbury at 9:00 am on 1 September 2004. She had not been inside Shrewsbury or any other prison before, and she had not had the opportunity to get any kind of 'handover' from her predecessor and was unfamiliar with exactly what her duties would involve.

52. Upon arrival at 9:00 am she was met by a healthcare nurse and told that she had been expected at 8:00 am and there were a line of prisoners waiting to see her. The doctor was immediately taken to healthcare and proceeded to diagnose and treat her patients.

53. The nurse took her, just after 10:00 am, onto A wing as part of her induction tour of the prison. A few minutes later she found herself involved in the resuscitation of the man who had been found hanging. In my opinion the doctor responded well to the incident and her presence could only have given the man a better chance of survival. However, as she said, she was not aware of what medical equipment the prison had and if the paramedics had not been so quick in responding, her lack of knowledge may have caused a delay in treatment.

54. In conclusion, it was unfortunate that the doctor was not given the opportunity to familiarise herself with the prison environment, facilities and the benefit of a medical handover from her predecessor.

Dark cells

55. The man and the other two men were in cells facing west on A1 and A2 landings. The amount of natural light in these cells was severely restricted by the proximity of metal sheeting erected by contractors engaged in rebuilding work on the site.

56. On 14 September 2004. the acting Governor told his manager that he had consulted widely across the establishment following the recent deaths and that one recurring theme deserved the Area Manager's consideration. He wrote that cells facing west on A1 and A2 landings looked directly towards the fencing that had been erected around the

demolished gymnasium site and new education block extension. "The prisoners believe the lack of light is oppressive and has contributed to the depression that led to all three suicides. The fencing is less than a metre from the cells. Prisoners located in the A1 cells cannot see anything but the fence, irrespective of where they stand."

57. The Governor suggested that cells A1-12 to A1-20 should be taken out of commission and that affected cells on A2 landing should be occupied by prisoners on the Enhanced Level of Incentives and Earned Privileges Scheme as such prisoners are confined to their cells for shorter periods of time. His suggestion was duly accepted by the Area Manager.

Detoxification regime

58. Although there is no evidence that the man died because he was withdrawing from drugs, it is apparent that the management of drug abusers at Shrewsbury at the time of his death was out of line with recognised clinical guidelines for the management of substance misuse.

59. The possibility that the man might be dependent on benzodiazepines and the possible consequences of a sudden withdrawal do not seem to have been considered either by the nurse who undertook the First Reception health Screen, or by the former medical officer.

COMMON ISSUES EMERGING FROM THE THREE DEATHS IN AUGUST/SEPTEMBER 2004

60. There are some significant linkages between the three deaths in August/September 2004. A striking feature is that each hanging incident occurred so soon after reception at the prison. All three men were dead within less than a week after their arrival at Shrewsbury. Two of the deaths occurred within 24 hours of reception and Lee did so before he had received his first meal at the prison.

61. All three deaths occurred in cells facing west on A1 and A2 landings. The amount of natural light in these cells was severely restricted by the proximity of metal sheeting erected by contractors engaged in rebuilding work on the site. I commend the Governor, for his prompt identification of this issue and I noted that Area Manager agreed to take the cells out of the commission in response to the suggestion. It would not be surprising if prisoners held for prolonged periods of time in such dark cells suffered adverse psychological consequences. However, as indicated in the previous paragraph, the three men who died spent only brief periods of time in their respective cells. All of them had been held at Shrewsbury before.

(i) Detoxification

62. The most important connection between the three men was that they all used heroin in the community and all three were withdrawing as they entered Shrewsbury. I have paid particularly close attention to the detoxification arrangements that were in place at Shrewsbury in August/September of last year. The advice I have received on this matter is contained in the reviews conducted by Shropshire County PCT and the Section Head, for Substance Misuse, in the Prison Health team at the Department of Health in London.

63. The Clinical Review Panel (CRP) appointed by Shropshire County PCT commented as follows in its reviews of the deaths of all three men:

“The CRP believes that any individual withdrawing from opiates is at an increased risk of self-harm or suicide, noting that individuals withdrawing from opiates often experience symptoms of depression and can have rapid and unpredictable mood swings.”

64. The CRP was told by the Healthcare Manager at HMP Shrewsbury, that at the time of the three deaths:

“the prescribing of medication to relieve the symptoms of opiate withdrawal between admission and the commencement of detoxification was not available.”

65. The healthcare manager also explained that prisoners did not start a detoxification programme until the day after their arrival at the prison. In response, the CRP recommended that:

66. **The prescribing of medications for the symptomatic relief of the effects of opiate withdrawal be made routinely available especially in the period between reception and the commencement of detoxification the next day.**

67. The CRP also noted that the detoxification regime in place at HMP Shrewsbury at the time of the three deaths in August/September 2004 did not follow recognised clinical guidelines for the management of substance misuse problems. The standardised Shrewsbury prison detoxification programme consisted of the prescription of dihydrocodeine 90 mg twice a day for three days, dihydrocodeine 60 mg twice a day for three days, dihydrocodeine 30 mg twice a day for three days and Mirtazepine 15 mg at night for nine days. The CRP accordingly recommended that:

    A detoxification programme, which is in line with national guidelines, should be introduced at HMP Shrewsbury as soon as possible.

68. The Substance Misuse Section Head reports that "dihydrocodeine detoxification is not recommended by the Department of Health". He refers to guidelines issued by the Department of Health in 1999 in the document *Drug Misuse and Dependence – Guidelines on Clinical Management*. The guidelines state at Page 38 that codeine-based drugs, such as dihydrocodeine, are not licensed for use for the treatment of drug dependence and the same page of the document adds:

    "The product licence for dihydrocodeine does not include the treatment of opiate dependence and there is concern amongst practitioners about its widespread use."

69. He also observes that contrary to Prison Service Order 3550, the dihydrocodeine protocol at HMP Shrewsbury shows no evidence of the involvement of the local NHS Substance Misuse Specialist.

70. He concurs with the Panel's conclusion that prisoners withdrawing from opiates without the assistance of medication are at a heightened risk of suicide. He therefore recommends:

    As part of a first-night reception, prisoners reporting a current problem with opioid drugs should be given a brief assessment using the Short Opioid Withdrawal Scale, or a similar measure. A moderate score on this scale would occasion symptomatic prescribing and a more acute problem should indicate medical examination on the first night.

71. He further recommends:

That the PCT and the prison consider the establishment of a clinical withdrawal management unit where drug-dependent prisoners would stay for the first few days of custody, until their symptoms stabilise.

72. Prison Service guidance on detoxification and related issues is set out in the Prison Service order entitled *Clinical Services for Substance Misusers* issued in December 2000. The introduction to the order states that it requires all Governing Governors "to ensure that effective treatment of substance misusers is delivered by evidence-based services which identify, assess and treat substance misusers in line with Department of Health guidelines (1999)."

73. The order contains a checklist on the clinical management of opiate misusers which requires the following mandatory action:

"Each prison will have a detoxification service for opiate misusers, developed in conjunction with (a) local NHS consultant using evidence-based guidelines in line with those of Department of Health (1999)."

75. The prison's Drug Strategy document was most recently reviewed on 1 March 2004. Detoxification does not figure prominently in the document. A number of treatment options are listed at Pages 26 and 27 of the document, with the commentary on detoxification stating:

"Detoxification is carried out in line with the agreed protocol and complies with HCS8 [Prison Healthcare Standard 8]/NHS Guidelines in place."

76. New, improved detoxification procedures began on 1 February 2005. I accordingly recommend that the prison's Drug Strategy document be urgently revised if this has not already happened, and that detoxification arrangements are given greater space and prominence in the new document.

(ii) Clusters of three deaths

77. I contacted the Prison Service's Safer Custody Group (SCG) seeking information about clusters of apparently self-inflicted prison deaths in recent years.

78. I was supplied with a table showing all cases since 1978 where three self-inflicted deaths have occurred in less than 30 days. This table shows the Shrewsbury cluster as being the third worst in Prison Service records. At HMP Manchester three deaths occurred within two days in 1982 and at HMP Leicester three deaths occurred within 11 days in March/April 2000. At HMP Gloucester, another relatively small local

prison like Shrewsbury, three deaths occurred within 18 days in February 2004. In his e-mail Mr Keane observes that:

"only local prisons seem to experience significant clusters" and that "the risk of having additional suicides does increase after an initial death".

(iii) F2052SH Procedures at Shrewsbury

79. None of the three men who died between 19 August and 1 September 2004 were on an open F2052SH at the time of death, but the investigation team examined suicide prevention procedures at Shrewsbury. My investigators discussed these matters with the Suicide Prevention Coordinator (SPC) at Shrewsbury. On the day of our discussion six prisoners were on open F2052SH. The SPC told my investigators that they were mainly, but not exclusively, located on A1 landing near the staff office. The SPC indicated that these documents were mainly opened by Healthcare staff, but the prison was not easily able to provide detailed information about reasons for opening F2052SH's or significant statistical trends. I understand that such information is starting to be collected for Suicide Prevention Committee Meetings and **I recommend the support of such an initiative.** The SPC task at Shrewsbury is not presently full-time and **I strongly recommend to the Governor and West Midlands Area Manager that consideration be given urgently to the appointment of a full-time coordinator.** Although Shrewsbury is a small local prison, the case for a full-time post seems a strong one in view of the number of recent apparently self-inflicted deaths, the need for more refined information to be collected and presented to management at the prison and the need to improve the quality and amount of staff training on this crucial subject.

80. The SPC said he was eager for anti-ligature knives to be issued to staff at Shrewsbury. **The Senior Governor who investigated the circumstances of the death at Shrewsbury in March 2004, made a recommendation that anti-ligature knives should be issued to members of staff with appropriate training. I recommend that this should now be implemented without delay.**

81. The lead investigator audited F2052SH procedures on 23 September 2004 when five booklets were open. Two prisoners were on intermittent watch and three were on hourly watch. With one exception, all the men on F2052SH were in single cells. The explanation given was that it was not considered appropriate for them to share a cell with another prisoner. Regular reviews had taken place but no entries had been made on page 6 of the document by the Medical Officer. This was perhaps not completely surprising because the new doctor had taken over at short notice as locum Medical Officer on 1 September 2004. **I recommend, however, that any new or locum Medical Officer at Shrewsbury receives training in F2052SH procedures within a week of taking up post in view of the importance of exchanging sufficient information between healthcare staff and prisoner**

officers, especially when prisoners at risk are being held on normal location.

82. One the day of the audit it was noticeable that an officer had been detailed to F2052SH duties but the entries over several days in all the booklets examined suggested observation of the men at risk, rather than much interaction with them. My investigators were informed by staff that it was rare for booklets to be opened on men located on the second and third levels of A Wing and rarer still on the fourth (topmost level) of the wing. I am well aware that the staff at Shrewsbury have already been exhorted to write inter-active entries in at-risk documents, but it may well be that further training is required, backed up by regular and vigorous management checks on this matter.

83. My investigators also observed that the prison did not have readily accessible information about prisoners who had previously been subject to Self-Harm at Risk Procedures. I was informed that such information generally disappeared from the LIDS computer system 12 weeks after a man left the prison. Reference to previous F2052SHs seemed a matter of chance or the good memory of a particular officer or nurse in Reception who happened to remember that such and such a prisoner had previously been on F2052SH. The opening of F2052SH does not of itself ensure that a potentially suicidal prisoner will remain alive, but it is most desirable that staff be aware of recent periods when prisoners were thought to be at risk as they make decisions about men who have returned to custody.

84. The absence "organisational memory" in respect of prisoners who have previously been on F2052SH is disturbing and I draw this issue to the attention of the Prison Service's Safer Custody Group. It is not desirable that the only source of information about a prisoner's recent history should be the prisoner himself, so **I recommend that the Governor of Shrewsbury attempts to devise a more reliable and robust system for retaining information about previous Forms 2052SH**. The introduction of NOMIS will capture this information in the future.

(iv) Action taken at Shrewsbury following the three deaths

85. The Prison Service's Director of Operations, requested an urgent review following the three deaths. This review was undertaken on 2 September 2004 by the West Midlands Area Principal Psychologist, and the Outreach Support Coordinator for Safer Custody Group. Their brief was to review urgently the recent incidents in order to identify any common issues that could be acted upon immediately.

86. A report entitled *Common Themes and Learning Points from Recent Deaths in Custody at HMP Shrewsbury* was written by Anne Williams and Spike Falloon on 2 September 2004. . Ms Williams and Mr Falloon examined Reception, First Night Centre and induction procedures at the

prison. They also included a section on drug strategy and detoxification, pointing out that the establishment did not have a dedicated drug detoxification unit. They quoted a staff member who felt there was not a proper system for drug detoxification and that it was not fully set up.

87. They noted that other staff members “stated how the system at HMP Shrewsbury is improving, but they constantly struggle due to lack of resources.”

88. The Williams/Falloon review made eight recommendations. On 14 September 2004 the Acting Deputy Governor at Shrewsbury, wrote to Ms Williams and Mr Falloon to update them on some of the recommendations they had highlighted.

89. In the First Night Centre section of their report Ms Williams and Mr Falloon refer to the impression that A Wing is poorly lit and dark with little natural light. They also wrote that the cells used for first night prisoners were bright and well decorated but a more accurate version of events appears in the memorandum sent by the Governor at Shrewsbury, to the West Midlands Area Manager, on 14 September 2004. the Governor told his manager that he had consulted widely across the establishment following the recent deaths and that one recurring theme deserved the Area Manager’s consideration. He wrote that cells facing west on A1 and A2 landings looked directly towards the fencing that had been erected around the demolished gymnasium site and new education block extension. “The prisoners believe the lack of light is oppressive and has contributed to the depression that led to all three suicides. The fencing is less than a metre from the cells. Prisoners located in the A1 cells cannot see anything but the fence, irrespective of where they stand.”

90. the Governor suggested to the Area manager that cells A1-12 to A1-20 should be taken out of commission and that affected cells on A2 landing should be occupied by prisoners on the Enhanced Level of Incentives and Earned Privileges Scheme as such prisoners are confined to their cells for shorter periods of time. The suggestion was duly accepted by the Area Manager.

91. The Governor’s initiative in writing to his Area Manager mirrored concern expressed to my investigators by a serving prisoner at Shrewsbury. He asked to see my investigation team and said he had identified a possible cause as to “why they are committing suicide”. The prisoner said he had noticed that the people who were committing suicide (his expression) were on the side of A Wing where all the windows had been covered up by sheeting outside. He understood that all the windows on one side of the wing were covered with corrugated sheeting because “gym was supposed to be falling down, there’s been structural damage or something, so they have had to knock the building down”.

92. The prisoner also expressed a view that the number of suicides at Shrewsbury could be diminished if prisoners on induction spent more time out of their cell. He agreed there was an induction programme for new receptions but said that prisoners spent the remainder of their time in their cells apart from association periods on a Wednesday evening and a weekend morning or afternoon.

RECOMMENDATIONS

The clinical review makes eight recommendations and the review of drug services makes one recommendation. I agree with and endorse these recommendations.

The Governor should ensure that any person taking over a role within the prison in which there is direct contact with prisoners is given the opportunity to familiarise themselves with the environment, equipment and responsibilities of that role before being expected to carry out their duties.

A More reliable and robust system for retaining and retrieving information with the aim of improving the quality of information recorded on Prisoner Escort Record Forms.

An appropriate benzodiazepine detoxification programme with agreed principals and policies should be established at Shrewsbury and that ll nursing staff receive training in screening for possible benzodiazepine dependence.

An opiate detoxification programme in line with National guidelines should be introduced as soon as possible.