Circumstances surrounding the death of a man in August 2004 at a hospital whilst in the custody of HMP Shrewsbury

Report by the
Prisons and Probation Ombudsman
for England and Wales

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During the afternoon of 16 August 2004 the man was found hanging in cell A1-19 at HMP Shrewsbury. He was the sole occupant of the cell and had arrived at the prison from Shrewsbury Magistrates' Court just three hours previously. He was taken to the Royal Shrewsbury Hospital where he died on 19 August 2004. This is a report into the circumstances leading to his death.

In the following fortnight, two other prisoners were found hanging in their cells at Shrewsbury.

Shrewsbury is a small local prison and a cluster of apparently self-inflicted deaths occurring within such a short space of time was profoundly shocking for prisoners and staff. My investigators have studied the individual cases of each death with great care, but I have also examined the possibility that there are connections between them. I have additionally set these three deaths in the context of other recent fatalities at Shrewsbury.

Factors which appear to be common to the three deaths are:

- the very short time between reception at Shrewsbury and death
- the part of A Wing where all three deaths occurred
- significant drug use in the community by each man, coupled with Shrewsbury's detoxification procedures in the late summer of 2004.

These themes are explored in greater detail later in this report. Necessarily, some of the text, findings and recommendations overlap with those in the reports into the other two tragedies.

I offer my profound condolences to the man's family. I thank the acting Governor at Shrewsbury Prison throughout the latter half of 2004 and his staff for their constant courtesy and practical support to my investigation team. I also thank the Shropshire County Primary Care Trust (PCT) and the Section Head of Prison Health at the Department of Health in London, for the vital contribution they have made to the investigation. Three colleagues from my office conducted this investigation on my behalf.

The conclusions and recommendations in this report – as in the other two – require no extra words from me. I simply record that I was very pleased to learn that a new detoxification regime was introduced at Shrewsbury on 1 February 2005. I am aware that a new Medical Officer has also recently taken up post.

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

STEPHEN SHAW CBE **October 2005**
Prisons and Probation Ombudsman

CONDUCT OF THE INVESTIGATION

1. The investigation team are all investigators working for the Prisons and Probation Ombudsman. They visited Shrewsbury on a number of occasions in August and September 2004. They were given access to all the documentation held by the prison on the man.

2. The man's father requested that contact with him be maintained via his solicitor.

3. Taped interviews were held with prison staff and prisoners 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. All staff were offered the opportunity of being accompanied by a friend or trade union colleague whilst being interviewed.

4. The investigation team maintained regular contact with the West Mercia Constabulary investigation led by an Acting Detective Inspector and a Detective Constable. I am extremely grateful to our police colleagues for their cooperation and helpfulness at all stages of the investigation.

5. My investigators wrote to Shropshire County PCT 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 their professional advice on the clinical factors in these three cases.

6. My investigators also wrote to the Section Head, Substance Misuse, Prison Health at the Department of Health in London. I am very grateful to him for supplying expert written comments on the clinical management of the substance misuse of the three men who died.

7. My investigators made available to the Medical Officer at Shrewsbury from 1992 until 31 August 2004 copies of the documents produced by the PCT and the Section Head of Substance Misuse, Prison Health. In response, the Medical Officer has written an eight page letter putting on record some observations that he feels may be pertinent to the investigation.

HMP SHREWSBURY

8. 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.

9. 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.

10. 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.

11. 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 is both complex and wide-ranging. It accommodates a broad mix of prisoners, both remanded and convicted. The wing holds prisoners subject to every level of the 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

12. The most recent full inspection at Shrewsbury by Her Majesty's Chief Inspector of Prisons took place in November 2001. Remarks in the preface to her report are of considerable relevance to the present investigation. The first paragraph of her 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."

13. However, in the second paragraph of her preface, the Chief Inspector 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."

14. The issue of self-harm also appears on the very first page of her report. She writes:

"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."

15. In the section of her report dealing with Substance Use, she writes:

"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 zimovane. Staff and prisoners verified this. The general opinion among them was that 'the detox is crap.' We agreed that the current detoxification practice was inadequate."

16. The Chief Inspector further records:

"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."

17. She 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."*

18. The Inspectorate made an unannounced inspection of Shrewsbury between 9-11 August 2004, the week before the man's death. 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.

19. In the introduction to the unannounced inspection report, the Chief Inspector observed with pleasure that Shrewsbury had retained the very good staff/prisoner relationships and the commitment to continuous improvement that 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".*

20. However, in the same introduction, she indicated that some weaknesses needed attention and she highlighted the issue of detoxification:

"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)."

21. Section 2 of her unannounced inspection report is headed Progress Since the Last Report. This sets out the earlier recommendations and notes progress made in implementing them. In relation to substance use, the first recommendation 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 unannounced inspection report observes that this recommendation was not achieved and that the GP in post at the time of the unannounced inspection was due to leave at the end of that month. The Chief Inspector 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."

22. The concluding paragraph in the Substance Use subsection of her unannounced inspection report records the earlier recommendation 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. The Chief Inspector writes:

"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 MAN

23. He was born in August 1974. He was arrested by West Mercia Police on Saturday 14 August 2004. He spent the weekend of 14 and 15 August 2004 in police cells in Telford and Shrewsbury. On the morning of Monday 16 August 2004 he appeared at Shrewsbury Magistrates' Court where he was sentenced to 94 days imprisonment.

24. The man arrived at HMP Shrewsbury at 1:05 pm on the afternoon of 16 August. He was the first prisoner to be received at Shrewsbury that day and therefore the reception procedures were completed relatively swiftly. He was transferred from the Reception area of the prison to the ground floor level of A Wing shortly after 2 pm. At approximately 2:15 pm, he had a conversation in his cell with an officer with whom he had had previous contact when she worked for the private company which supplies custody staff at Shrewsbury Magistrates' Court. His behaviour at that time caused the officer no concern.

25. The same officer conducted a roll check on A1 landing shortly before 4 pm. When she looked into his cell at approximately 3:55 pm, she saw him lying on his bed. She is absolutely certain that he was alive at that time.

26. At approximately 4:10 pm, staff were alerted to an emergency in his cell when a prisoner came running to the staff office at the other end of A1 landing to inform them that a prisoner was hanging in his cell.

27. Staff ran down the landing and were directed to cell A1-19 by another prisoner. When they opened the cell door they saw him hanging by a bedding sheet from the window bars at the back of his cell. Determined efforts were made to revive him in his cell and he was transferred by ambulance to a nearby hospital at 4:43 pm. He died in the hospital on the afternoon of Thursday 19 August 2004.

28. He was an intravenous heroin user. He told the Addictions Nurse who conducted his Reception Health Screen at the prison that he used heroin and methadone on a daily basis and had last used these drugs on 14 August. He was suffering heroin withdrawal symptoms on the afternoon of his arrival at Shrewsbury. He was due to see the prison doctor on the evening of 16 August but that standard evening appointment was overtaken by the events of the afternoon.

29. He had been held in custody at Shrewsbury on a number of occasions prior to his death. On one of those occasions, in January 2003, a Self-Harm at Risk form was opened because he told staff that he felt suicidal. The form was closed three days later and there is no evidence that a similar form was opened on any of the subsequent occasions when he was received at Shrewsbury. He was not perceived as being a suicide risk when he arrived at Shrewsbury on 16 August. During the afternoon he had dealings with a number of staff and prisoners and none of them observed any indication that he was contemplating self-harm.

THE EVENTS OF 16 AUGUST 2004

30. Before 9:00 am on the morning of Monday 16 August 2004, the man was transferred from Monkmoor Police Station, Shrewsbury to Shrewsbury Magistrates' Court. Responsibility for his care and custody transferred at that point from West Mercia Police to the custody staff who manned the cells area at the Magistrates' Court. The police had already opened a Prisoner Escort Record (PER). This document is used to highlight any information of importance about a prisoner who is being transferred from one agency to another. The outside cover of the PER form states that there were no known medical or security risks in relation to him. In the final column of the Risk Categories Section of the document the police ticked drugs/alcohol issues and in section 5 of the document they made reference to a Cannabis Resin entry on their Police National Computer. There was no reference to his heroin addiction and the police were not aware of any suicide/self-harm risks so they did not tick that particular box on the form.

31. Part B of the PER form indicates that he came back down from court to the cells area at 10:53am after being sentenced to 94 days imprisonment. He received a short legal visit and then the next entry of note comes at 12:15 pm when he refused his lunch. At 12:47 pm, he began the short journey from the court cells to Shrewsbury Prison, with the prison's gate book showing that he arrived there at 1:05 pm. Twenty-three prisoners were received at Shrewsbury that afternoon and evening but he was the first to arrive.

32. The procedure at Shrewsbury, as in all local prisons in England and Wales, is that newly arriving prisoners are processed in the Reception area before being transferred to the residential part of the prison. Shrewsbury is a smaller than average local prison and the vast majority of prisoners there are held on A Wing with a much smaller number on C Wing, which is reserved for vulnerable prisoners.

33. On the afternoon of 16 August, he was coming straight into Shrewsbury Prison from the outside community so he had to be given a new prison number. The list of prisoners received in the Reception area at Shrewsbury that afternoon confirms that he was the first prisoner to be received and was allocated his new prison number of HG8838 at 1:13 pm. The reception process at Shrewsbury Prison would have been very familiar to him as he had been held at the prison on several occasions previously.

34. The three main components of the reception process at Shrewsbury are:
    i. a series of contacts with three or four prison staff who work in the Reception area;
    ii. an interview with a nurse in the Reception area so that the First Reception Health Screen document can be completed;
    iii. the last part of the process is that the prisoner sees the First Night Officer whose task is to settle the new prisoner as effectively as possible, complete the Cell Sharing Risk Assessment document and arrange the new prisoner's transfer from the Reception area to a cell in the residential part of the prison.

35. A helpful explanation of the duties undertaken by the prison officers working in Reception is contained in the interview with an Officer, recorded on 10 September 2004. He explained in interview that the usual complement of staff in the area is a Senior Officer and three prison officers. He outlined their respective duties as follows:

“The Senior Officer will accept the prisoners in and check the warrants and make sure that we can legally hold them, take their money, check the money and those kind of things. The first officer will be doing what is called the page 1 which is all personal details, height, weight, address and that sort of thing. The second officer would list the prisoner’s property and canteen and that kind of thing and the third officer’s job would then be to do fingerprints and strip searching and then handing the prisoner over to the First Night Officer.”

36. The officer was responsible for completing page 1 of the man’s prison record (Personal Summary Sheet). The officer’s name and signature appear at the bottom of the page. The Addictions Nurse had signed the Prisoner Escort Record to indicate that she saw the man for his health screen at 1:15 pm, so it is probable that she completed her brief confidential medical and psychiatric history of him before the Officer recorded the page 1 details.

37. The information recorded on the Summary Sheet by the officer includes the fact that the man was single and had two children. The address where he had been living in Oswestry was recorded, but when he was asked for the name and address of his next of kin he supplied no information. Similarly, when asked for the name and address of any other persons to be notified in an emergency, he supplied no information. Near the bottom of the form are what the officer called the D boxes and in box D4 he wrote "States not suicidal". In interview, the officer explained that his normal procedure is to ask three times in three different ways if a prisoner feels he will self-harm. The officer always looks the person in the eye and, in the man’s case, he remembered that *"he obviously caused me no reason for concern and he reiterated that he felt fine and was adamant that he was not going to hurt himself".* The man also told the officer that he had last been in prison custody in September 2003 when he was discharged from HMP Liverpool, after serving a three months sentence.

38. When the officer was asked whether there were any issues that concerned him in relation to the man, he replied:

"No, definitely not, I remember him being chatty and he seemed to have no problems."

39. When asked if the man was "rattling" (suffering physical consequences) as he withdrew from heroin, the officer replied as follows:

"He looked thinner than he did as I recall last time I saw him but that is pretty standard, he certainly was not shivering or he did not have any sort of major withdrawal symptoms at that point."

40. When asked to sum up his overall impression of the man following approximately ten minutes of contact with him that afternoon, the officer replied:

"I had no concerns, the only reason that it has actually become a feature is the fact of how fine he was, how normal and chatty that he was….. it was just a normal run of the mill processing of the man."

41. The man's health screen in the Reception area was conducted by the Addictions Nurse. On the second page of the screen, she wrote that he had been homeless in the past year and on the next page she recorded that he had seen a doctor in the last few months for heroin abuse. The Addictions Nurse noted that he had been receiving 120 milligrams of methadone a day for the last four months of his life. On page 4 of the form she wrote "Nil of note" in response to a question about his physical appearance.

42. In the Substance Use section of the form, she recorded the man's admission that he had used drugs in the past month. He told the nurse that he used heroin and methadone on a daily basis and had last used both substances two days previously. The urine test conducted by her gave a positive result for both substances. He confirmed his intravenous drug use. At the bottom of page 5, the form requires the nurse to refer a prisoner to a doctor or nurse-led drug service if a prisoner is using drugs more than once a week or supplies a positive urine test. The man fell into both categories and she duly referred him to both the doctor and the drugs service in the Planned Action section of the form at page 8.

43. In the Mental Health section of the health screen form he was asked if he had ever received medication for any mental health problems. He said he had not. I have discovered that, when receiving his First Reception Health Screen at HMP Shrewsbury on 25 January 2003, he had told the Registered Mental Nurse (RMN) that he had received anti-depressants, although he had taken none for two weeks previously.

44. The man told the Addictions Nurse that he had never tried to harm himself but in January 2003 he told the RMN that he had cut his right wrist eight months previously. He told the RMN that he had suffered from depression in the past, that he felt like hurting himself at the moment (in January 2003) and that he often contemplated suicide.

45. In January 2003, the RMN opened a F2052SH (Self-Harm At Risk Form) because the man seemed withdrawn and depressed and admitted contemplating suicide prior to imprisonment. On 16 August 2004 he did not reveal such information to the Addictions Nurse so she did not refer him for a mental health assessment nor did she consider opening a F2052SH. Her recorded impression of his behaviour and mental state was "Nil of note" because she was not aware of information to the contrary.

46. The last officer to see him before he was transferred to his cell on A Wing was the First Night Officer. Another experienced First Night Officer explained the purpose of the First Night task thus:

"I may need to make sure the new prisoner is reasonably calm and if he is not, he is nervous, try and calm him down a bit, especially new prisoners and also give him information which will help him settle into the prison and then I will locate him onto the

landing, onto the Wing. Most days when I am doing it I will actually go to the cell with him and check his cell as well, make sure the cell is reasonably clean and show him, especially if he is brand new, where the light switches are, the kettle, the television and allow him a phone call."

47. Another job conducted by the First Night Officer is to complete sections 1 and 2 of the Cell Sharing Risk Assessment and the First Night Officer also signed section 4 of that document. In interview, she explained that her colleague the Addictions Nurse completed section 3 of the risk assessment in which she indicated there were no concerns that the man might harm himself. In section 1 of the form, the First Night Officer put a tick to say there was no current F2052SH. At question 6 of section 2, she wrote that the man was currently dependent on drugs. She said that, although he was "rattling", he did not seem as bad to her as other prisoners she had seen coming through reception. At the seventh question, she ticked the box indicating that he did not have an open F2052SH and the No box was again ticked at question number 8 which asks: "Is there evidence of the prisoner having a previous F2052SH?" The man, as indicated at paragraph 62, had indeed been on F2052SH for a few days in January 2003 but the First Night Officer was not aware of that information at this time. He told the officer that he would prefer to share a cell with another prisoner who was “rattling”.

48. The First Night Officer described him as buoyant when she interviewed him. She said that he was chatting to her and to the Reception orderlies as well:

"He was laughing and joking with them at the same time as he was doing a discussion with myself. He seemed buoyant and quite uplifted in his mood, he showed no concerns to myself of being upset or down in any way."

49. Shortly after her discussion with the man, the First Night Officer accompanied him to A Wing and located him in cell A1-19. She could not be precise about the time when she moved him to A1 landing, but she thought it was approximately 2:30 pm. Another officer is fairly confident that her discussion with him in cell A1-19 occurred at around 2:15 pm so it is quite possible that he was located on A Wing more promptly than the First Night Officer remembered subsequently.

50. The man cannot have spent much more than two hours on A Wing during the afternoon of 16 August, but during that two hour period he had contact with at least one member of staff and at least two prisoners. The first known contact was with an officer at approximately 2:15 pm. In interview, she explained that she became a Prison Officer at Shrewsbury in September 2003 and prior to that was a Custody Officer at Shrewsbury Magistrates’ Court. In that job she met the man on a number of occasions because, according to her, *"He always seemed to be in and out".* She knew that he was a heroin user and remembered that sometimes when she saw him in court he was quiet and subdued due to his withdrawal from the drug. At page 9 of her interview, she recalled that *"Under no circumstances did I think there was anything wrong with him… we were having a laugh and a joke".*

51. The last prisoner to occupy cell A1-19 before the deceased was interviewed. He recalled that when he was returning from a gym induction session at about 2:30 pm or

2:40 pm he was told by an officer to go into his cell (A1-19), gather up his belongings and move to a new cell on A2 landing. When he went into the cell he had occupied for the previous four days, he found the man already there and the two men had a conversation for 10 or 15 minutes. The man was lying on the bottom bunk bed in the cell and he seemed very relaxed to the other prisoner.

52. When asked to describe the man's behaviour and attitude at this time, the prisoner said:

"He was very relaxed, lying on the bed and me taking my belongings and he said that it was not the first time he has been in prison so you know in my head I felt he was here before, he knows the system. In my opinion he was very relaxed about it."

53. After what he described as a normal conversation, the prisoner left cell A1-19 and all the available evidence strongly suggests that the man remained alone in the cell until the time when he was discovered hanging later in the afternoon.

54. A conversation took place between the man and his friend at approximately 3:45 pm. His friend asked to see the investigation team and explained that they were friends outside prison. He had last seen the man about two months previously in Oswestry, and he said they had also lived together in Shrewsbury. The man told his friend that he had been in police custody since Saturday (two days earlier). He said that the medication he had been receiving at the police station had been stopped on his arrival at HMP Shrewsbury.

55. He asked his friend about others from Shrewsbury who were in the prison at that time. The friend knew that on the last occasion when the man was in Shrewsbury he had asked to be segregated from other prisoners for his own protection.

56. The friend explained that the man had been worried about another person who was in the prison at the same time. The friend did not know the identity of that prisoner, but he knew there was some problem between the two men in the outside community and that the man did not wish the problem to carry on in prison. On the previous occasion, he had felt "a bit intimidated" so he had thought it better to put himself on protection.

57. My investigators have studied the records relating to the two separate periods of imprisonment that the man served in 2003. The more recent prison sentence was imposed at Shrewsbury Magistrates' Court on 16 October 2003 and there is no record that he asked for protection on that occasion. However, on 3 June 2003, he was sentenced to three months imprisonment by Shrewsbury Magistrates' Court. He was received at HMP Shrewsbury the same day. On 5 June 2003, he wrote a statement to the prison Governor as follows:

"I wish to apply for VP (Vulnerable Prisoner) status due to the fact that 3-4 lads have made threats and I fear for my safety."

58. An entry on his prison record on 5 June 2003 states that he was granted C Wing status and a further entry on the same date confirms that he was received onto C

Wing, being located in cell C2-8. C Wing is a small unit at Shrewsbury which holds those who have asked to be kept separate from the main body of prisoners on A Wing. A further entry on his prison record indicates that he spent less then two weeks on C Wing because, on 17 June 2003, he was transferred from Shrewsbury to HMP Stafford.

59. The friend stood at the flap outside the man's cell door and reassured him that he would have no problems on this occasion. He explained that there were no prisoners who would cause him any trouble. There were only a few Shrewsbury men in the prison at the time and his friend described them as "good lads".

60. The man's friend asked him how long he was serving. He replied that it was 92 days so he would not need to spend long in prison. The man's friend promised that he would try to get some sugar and tobacco for him. His friend then left and went to his job of cleaning the Visits area.

61. The investigator asked the man's friend if he had any concerns at that time about him. He replied:

"No, I would not have said you are going to commit suicide myself, it was the furthest thing from my mind because he did not seem depressed…. to my reckoning he did not look like committing suicide, even if I were an officer I would not have been able to say you know put you on a watch because you are depressed or whatever, I would not have been able to tell that, and I am his friend."

62. An officer was the last person to see the man alive. She did a roll check on A1 landing and she is confident this check began at around 3:55 pm because she distinctly remembered looking at her watch as she started the task. When the officer looked inside cell A1-19 to ensure that the man was there, she saw him lying on the bottom bunk bed. He was awake, his eyes were open and he was facing towards the cell door. They did not speak to each other at this time but in interview the officer was absolutely certain that he was alive.

DISCOVERY OF THE MAN

63. At approximately 4:10 pm on the afternoon of 16 August 2004, most of the prisoners on A Wing were locked in their cells They were not due to be unlocked until the evening meal was served at approximately 4:45 pm. Two prisoners were outside their cells at the time and they shouted to another prisoner, whose job was to do general cleaning duties on A1 landing, that a prisoner was hanging in his cell. At the time, the cleaner was on A1 landing four or five cells away from the emergency. He shouted for an officer straightaway. A number of officers were gathered in or outside the wing office at the opposite end of the landing from the man's cell.

64. An officer's account states that he was A1 Landing Patrol at the time and at approximately 4:10 pm he was in A1 landing office when a prisoner came running to the window of the office to raise the alarm.

65. He ran down the landing and another prisoner directed him to Cell A1-19. The officer opened the cell door and saw the man hanging by a bedding sheet from the window bars at the back of the cell. He was almost directly facing staff as they ran into his cell.

66. The officer grabbed him around the top of his legs in order to lift him up while a prisoner tried to remove the noose from around his neck. The prisoner had jumped on to the top bunk bed in the cell and in interview he explained that he used his hands to remove the noose. The officer said the noose was tied with "like a slip knot" but he eventually managed to slip the noose up over the top of the man's head. Once the noose had been removed, the officer and a colleague placed the man on his back on the cell floor and the prisoner left the cell.

67. At the time that the man was found hanging the Staff Nurse was also on A1 landing. Her job at the time was to administer medication to the queue of prisoners who came to the window of her office on the landing. She became aware of a number of people running towards the office. Two prisoners shouted that another prisoner was hanging in Cell 19. She immediately closed her medication bag and went to the incident.

68. When she got there, she found the man on the floor in the recovery position. An officer felt for a pulse in the man's wrist and the Staff Nurse felt for a pulse in his neck. She noticed that the pupils of his eyes were fixed and dilated. She touched his eyes to try and get a response but there was none so she and the officer commenced resuscitation. He placed a facemask over the man's mouth and gave him mouth-to-mouth resuscitation. The Staff Nurse administered chest compressions. The officer was rapidly relieved by another officer who maintained mouth-to-mouth and the Staff Nurse continued with chest compressions until she was relieved by the Addictions Nurse. When the Staff Nurse was relieved she rang the Healthcare Centre and asked for a defibrillator to be brought to the cell. (The defibrillator is attached to a patient's chest and administers an electric shock to the heart in an effort to restart it.) Prior to the arrival of the defibrillator, the Senior Officer had taken over from the officer at the man's head. The Senior Officer and the Addictions Nurse jointly administered cardiopulmonary resuscitation (CPR).

69. The Addictions Nurse had recently been trained in the use of a defibrillator. The machine indicated that a shock should be administered to the man and she duly did so. Then the machine told staff to commence CPR so they resumed chest compressions and mouth-to-mouth.

70. At 4:13 pm, the prison's control room had been notified of a Code Brown Emergency. This is a code used at Shrewsbury to indicate a hanging. An ambulance was called at 4:14 pm and arrived at the prison at 4:22.pm. When paramedics arrived at the man's cell they checked his airway. The paramedics put a mask back over his mouth and gave him oxygen.

71. The Addictions Nurse later made an entry in the man's medical record, in which she noted the arrival of the Sister and the paramedics at approximately 4:25 pm. She wrote that, after a period, the paramedics managed to feel a carotid pulse in his neck

but his larynx was in spasm and they were unable to intubate him. The paramedics continued to ‘bag’ him. (The Addictions Nurse explained that was a reference to an ambu bag which is attached to oxygen and squeezed to supply artificial breaths to a patient.)

72. The prison's control room log states that the ambulance left the prison at 4:43 pm bound for the Accident and Emergency Department of a nearby hospital. The man remained in hospital until his death.

73. His medical record indicates that medical staff at the prison maintained regular contact with the hospital in order to check on his condition. The Sister’s entry in the medical record at 8:45 am on 17 August states that she contacted the High Dependency Unit and was told that he remained on a ventilator, heavily sedated but showing signs of spontaneous breathing.

74. A further entry in the record at 10 am by the Sister refers to a lengthy phone call she had with the man’s father who was enquiring as to what had happened.

75. An entry in the record at 8:40 am on 18 August states that the Sister had visited him in hospital the previous evening. The report on the morning of 18 August was that his pupils had been reactive but they had since become fixed and dilated. He was unresponsive to painful stimuli. He died in hospital on 19 August 2004.

CONTACT WITH THE MAN'S FAMILY

76. He gave no next of kin information when he was received at Shrewsbury in the early afternoon of 16 August. The authorities subsequently found it difficult to establish contact with his father.

77. As there was no information about next of kin or any other persons to be notified in an emergency, the prison authorities asked West Mercia Police to make the necessary contact. My investigators were told by the Detective Inspector in charge of the police investigation into the man's death that the police found this a very difficult task.

78. His Inmate Medical Record indicates that the Sister in the prison's Healthcare Centre contacted the High Dependency Unit at the hospital where he was being cared for at 8:45 am on 17 August. The HDU stated that they had been in contact with his father and that the family had been advised to contact Healthcare staff at the prison for updates. The Sister then had a lengthy telephone call with the man's father at 10 am the same morning.

79. A letter of condolence was sent to his parents by the prison's acting Governor and appropriate information notices were published to both staff and prisoners following his death.

80. On 7 September 2004, his father formally requested that all parties involved in regard to the investigation into the death of his son liaise directly with his solicitors. His wishes in this matter have of course been respected.

81. On 4 October 2004, the solicitors wrote to my investigator raising two questions from the man's father. The questions were:
    i. Should his son's cell not have been opened around 4 pm for him to receive medication?
    ii. "the acting Detective Inspector has advised the family that the man was checked at 4 pm and at 4:07 pm was found hanging."

    One of my investigators commissioned a note from the Head of Healthcare at Shrewsbury, who explained the procedure for the issue of medication in a memorandum of 3 November 2004. At the time of his death, the man had not been prescribed medication in the prison so his cell was not due to be opened at 4 pm on 16 August.

82. In a letter to the solicitors on 25 November 2004, my investigator explained that he had no information at all that the man was found hanging at 4:07 pm. Since then no further information has come to light which could place the discovery that he was hanging at any time before 4:10 pm at the very earliest.

CONCLUSIONS

83. All the available evidence clearly suggests that his death was self-inflicted. There is no evidence whatsoever that any other person was involved. He left no note behind and therefore the reason for his action is not known. He gave no indication to either staff or prisoners that he was contemplating self-harm. He was withdrawing from heroin at the time of his death

84. He had previously been on an F2052SH at Shrewsbury for three days between 25 and 28 January 2003. He had returned to the prison in February, June and September 2003 but was not placed on F2052SH on those occasions. There is no robust system for identifying prisoners who have previously been on Self-Harm at Risk Forms as they arrive in Reception for a new period of custody.

85. A number of training needs have been identified in the course of this investigation. These include first aid training, especially for Healthcare staff; substance misuse training, especially for addiction nurses; defibrillator training; and systems for calling support to a clinical emergency. There is no evidence that these training needs contributed to his death.

86. He was held at Shrewsbury for such a short time that he was not seen by the doctor on the evening of his reception. In view of his many periods of incarceration at Shrewsbury, he would have been well aware that symptomatic relief was not routinely available to prisoners withdrawing from heroin during their first night in custody.

87. At his own request he had been segregated from other prisoners in June 2003 prior to his transfer to HMP Stafford. There is no evidence that he was similarly segregated when he returned to Shrewsbury in September 2003. When he arrived on 16 August 2004 he was reassured by his friend that there were no men in the prison at that time who would give him any trouble.

88. He was found hanging in his cell at some time between 4:10 pm and 4:13 pm. The prison's control room called for an ambulance at 4:14 pm and an ambulance arrived promptly at 4:22 pm.

89. When the alarm was raised, the Staff Nurse arrived almost immediately as she was already on the wing dispensing medication to other prisoners. There was a slight delay in bringing the defibrillator to his cell, but the Addictions Nurse had recently been trained in the operation of that equipment and used it effectively.

90. The noose around his neck was removed by a prisoner who performed cleaning duties on A1 landing. It is clear that the ligature was removed very rapidly and he should be commended for his important contribution.

91. Reports after previous apparently self-inflicted deaths at Shrewsbury have recommended the introduction of anti-ligature knives.

92. Both Healthcare and prison officer staff made determined but unavailing efforts to revive the man. He died in hospital at 1:55 pm on 19 August 2004.

93. The authorities experienced considerable difficulty in establishing contact with his father, as there was no current next of kin information on his son's prison record.

94. My investigator discovered that page 6 of open F2052SHs was not being completed when he conducted a survey of all such documents. This page should be completed by the doctor when a prisoner is returned to residential accommodation after medical examination. This observation is not a criticism of the locum doctor, whose contribution to the work of the prison in the last four months of 2004 has been praised by the Governor. Rather, it helps identify a training requirement to ensure there is effective cooperation between medical and non-medical staff in the drive to prevent both suicidal and self-harming behaviour.

95. Examination of the minutes of the Suicide Prevention Meeting indicates that work of good quality is taking place. If the Suicide Prevention Coordinator worked full-time or had more hours dedicated to his work, he would be able to present more helpful information to this meeting and to the Senior Management Group about underlying trends in relation to suicide and self-harm at Shrewsbury. There was also evidence of a need to improve the quality of entries in open F2052SHs so that there is dialogue and interaction rather than mere observation.

96. At the end of the First Reception Health Screen, the Addictions Nurse appropriately referred him to both the doctor and the drugs service because of his substance use. He told her that he was using heroin and methadone daily, but declared he had never tried to harm himself. She was not to know that he gave a different answer to the same question in January 2003 when he told the nurse conducting his First Reception Health Screen that he had cut his wrist eight months previously, and that he contemplated suicide often.

97. Two separate Prisoner Escort Records (PER) were raised by West Mercia Constabulary on 14 August 2004. The PER that was not sent to Shrewsbury Prison identified drugs issues, and stated at section 5 that he was a heroin user who was prescribed methadone. The PER form that was received at the prison and signed by the Addictions Nurse referred only to cannabis resin, which significantly understates the nature and severity of his drug dependency. It is true that the first entry on part B of the same form describes him as a drug addict, but that entry does not have the same prominence as section 5 of part A of the form.

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

98. There are some significant linkages between the three deaths in August/September 2004. A striking feature is that each hanging occurred so soon after reception at the prison. All three men were dead less than a week after their arrival at Shrewsbury. The man was found hanging before he had received his first meal at the prison.

99. 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 note that the Area Manager agreed to take the cells out of commission in response to the Governor's 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, the three men who died spent only brief periods of time in their respective cells. All of them had been held at Shrewsbury before. The man and one of the others had been there on several occasions.

(i) Detoxification

100. The most important connection between the three men was that they all used heroin in the community and all three were withdrawing from their drug use 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, Substance Misuse, in the Prison Health team at the Department of Health in London.

101. 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."

102. 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".

103. She 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:

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.

104. 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 is possible.

105. The Section Head of Substance Misuse, Prison Health, 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."

106. 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.

107. In relation to the man, he observes there is no evidence that his clinical substance misuse management was a factor as he died so soon after arriving at Shrewsbury. *"That said, in my opinion the standard prescribing regime at Shrewsbury would not have been adequate to manage satisfactorily the severe opiate dependence experienced by the man."*

108. 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 that,

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.

109. He further recommends:

The PCT and the prison should 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.

110. 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 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")"*

111. 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)".

112. 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."

113. 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

114. I contacted the Prison Service's Safer Custody Group (SCG) seeking information about clusters of apparently self-inflicted prison deaths in recent years. I am grateful to a member of staff of SCG for his detailed response to my investigator.

115. He has supplied 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 he 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

116. None of the three men who died between 19 August and 1 September 2004 was 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 at Shrewsbury. On the day of our discussion, six prisoners were on an open F2052SH. He told my investigators that they were mainly, but not exclusively, located on A1 landing near the staff office. He 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 F2052SHs 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.

117. The Suicide Prevention Coordinator said he was eager for anti-ligature knives to be issued to staff at Shrewsbury. The senior governor who investigated the circumstances of a death at Shrewsbury on 4 March 2004 made a recommendation that anti-ligature knives should be issued to members of staff with appropriate training. I recommend that this recommendation should now be implemented without delay.

118. 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 a 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.

119. On 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.

120. 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 a F2052SH. The opening of a 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.

121. In the man's case, he said on 25 January 2003 that he felt suicidal when he arrived at Shrewsbury and accordingly a F2052SH was opened by a nurse on that date. Three days later, the form was closed because there were no immediate concerns over self-harm and the assessment was that the man was "coping well at the moment".

122. He was released from prison but by 7 February 2003 he was again received at HMP Shrewsbury. On this occasion, page 1 of his prison record includes a statement by him that he was not suicidal and a Self-Harm at Risk Form was not opened. There is, however, no reference that my investigators have discovered to the closure of the previous at risk form just ten days before. The absence of "organisational memory" in respect of prisoners who have previously been on a F2052SH is disturbing and I draw this issue to the attention of the NOMS 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 at Shrewsbury attempts to devise a more reliable and robust system for retaining information about previous Forms 2052SH. I do not know how soon the Prison Service at national level will possess computer systems of sufficient sophistication to capture such information.

(iv) Action taken at Shrewsbury following the three deaths

123. The Prison Service's Director of Operations requested an urgent review following the deaths of the man and the other two prisoners. This review was undertaken on 2 September 2004 by the West Midlands Area Principal Psychologist and the Outreach Support Cooordinator 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.

124. A report entitled *Common Themes and Learning Points from Recent Deaths in Custody at HMP Shrewsbury* was completed by them on 2 September 2004. They 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. They noted

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

125. Their review made eight recommendations. On 14 September 2004, the Acting Deputy Governor at Shrewsbury wrote to them to provide an update on some of the recommendations they had highlighted.

126. In the First Night Centre section of their report, they refer to the impression that A Wing is poorly lit with little natural light. The Governor at Shrewsbury had written to the West Midlands Area Manager on 14 September 2004 to say 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."*

127. The Governor suggested to the West Midlands 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 the Incentives and Earned Privileges Scheme as such prisoners are confined to their cells for shorter periods of time. The Governor's suggestion was duly accepted by the Area Manager.

128. The Governor's initiative in writing to his Area Manager mirrored concern expressed to my investigators by a 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". He 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 *"the gym was supposed to be falling down, there's been structural damage or something, so they have had to knock the building down".*

129. He also expressed a view that the number of deaths 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

CLINICAL REVIEW

I endorse the six recommendations made by the Clinical Review Panel established by Shropshire County PCT. I attach particular weight to the recommendations calling for the prescribing of medication for the symptomatic relief of the effects of opiate withdrawal on the first night of custody, and for the introduction of a detoxification programme at HMP Shrewsbury in line with national guidelines.

The recommendations made by the Clinical Review Panel were:

1. The Clinical Review Panel believes that any individual withdrawing from opiates is at an increased risk of self-harm or suicide noting that individuals withdrawing often experience symptoms of depression and can have rapid and unpredictable mood swings, we therefore recommend that all prisoners received at Shrewsbury are considered at risk until they are more fully assessed and commenced upon an appropriate detoxification or maintenance programme.
2. The Clinical Review Panel recommends that the feasibility of using an IT system to flag prisoners with a previous risk history be considered.
3. That all prison healthcare staff and discipline staff should receive first aid and life saving skills training and regular update and refresher training.
4. That the protocol for calling support to a clinical emergency be reviewed and that any communication makes the nature of the emergency clear and that appropriate life saving equipment is taken by nurses responding to the call.
5. That 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.
6. The Clinical Review Panel recommend that a detoxification programme that is in line with national guidelines should be introduced at Shrewsbury as soon as is possible.

SUBSTANCE MISUSE REVIEW.

I endorse the two recommendations made by the Substance Misuse specialist from the Department of Health. If they are accepted by the Area Manager and PCT then I recommend that an expanded Action Plan be drawn up as soon as possible. The recommendations made by the Substance Misuse specialist were:

1. 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 of withdrawal symptoms. The results from this scale would highlight the need for medical management on the first night: a moderate scoring from the scale would occasion symptomatic prescribing; a more acute problem should indicate medical examination on the first night.
2. The Primary Care Trust and the prison should 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.

OPERATIONAL

1. A training needs analysis should be undertaken to include the training needs identified in the course of this investigation and the clinical review.
2. Anti-ligature knives should be introduced to individual members of staff.
3. The Governor should meet with senior police and escort contract colleagues with the aim of improving the quality of information recorded on Prisoner Escort Record forms.
4. Consideration should be given to the appointment of a full-time Suicide Prevention Coordinator.
5. Any new or locum Medical Officers at Shrewsbury should receive training in F2052SH procedures within a week of taking up post.
6. A more reliable and robust system for retaining and retrieving information about prisoners previously on F2052SH should be introduced.