

**Investigation into the circumstances surrounding the  
death of a man at HMP Shrewsbury  
in August 2006**

**Report by the Prisons and Probation Ombudsman for  
England and Wales**

**June 2007**

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Shrewsbury in August 2006. At just after 4.00pm in the afternoon, the man who is the subject of this report was found hanging in his cell. At the time of his death, the man was aged 31. He was a local man, serving a sentence of four years imprisonment.

I offer my most sincere condolences to his family and friends for their loss.

The investigation was carried out by two of my colleagues, who met with the man's family, and I very much appreciate their willingness to discuss his death so soon after their bereavement. I do not underestimate how difficult this must have been.

I also commissioned an independent clinical review of the management of the man's health needs while he was in custody. This was conducted by a clinical reviewer from the Shropshire Primary Care Trust.

I would also like to thank the Governor, Deputy Governor, and staff at Shrewsbury for their ready help and co-operation during the investigation. My colleagues were particularly indebted to the Principal Officer. I would also like to extend my appreciation to the healthcare staff interviewed during the course of the investigation.

Although the man had a number of risk factors, including the ending of a relationship with his girlfriend, nothing that has emerged in this investigation leads me to believe that his death could reasonably have been predicted or prevented. My investigation report includes a number of recommendations and identifies one example of good practice.

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**June 2007**

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## SUMMARY

The man who died was arrested on 18 May 2006 for breaching a community order that had been imposed for burglary offences. At the time of his arrest, he was with his girlfriend and they had run away together. The man appeared before Shrewsbury Magistrates' Court the following day.

At court, the man was charged and remanded to HMP Shrewsbury. He was listed to return to court at a later date for sentencing. He was received into the prison that afternoon and underwent the reception screening which included the induction programme and healthcare screening. The man received the first night care and induction booklet which was explained to him. A Cell Sharing Risk Assessment (CSRA) was also completed. He was currently dependent on drugs, but was a low risk of harm to others. The opening of an Assessment, Care in Custody and Teamwork (ACCT) document was also considered but deemed not appropriate.

The healthcare screening was conducted by the registered mental health nurse. It noted that the man had used heroin, methadone, barbiturates, and was suffering from withdrawal symptoms, although he was in control. He had also used heroin and benzodiazepines daily at the time of entering prison. The man disclosed that he had been in hospital for paranoia ten years previously and had taken medication called clopixel. A standard referral was made for a mental health assessment to be carried out by the in-reach team, as well as a referral to the prison doctor and the Counselling, Assessment, Referral, Advice, and Throughcare Service (CARATS).

The man was familiar with HMP Shrewsbury and applied for protection and to be located in the prison's vulnerable persons (VP) wing. He was subsequently located to A wing, cell A1-41.

Given the man's drug problem, the doctor referred him for substance detoxification and noted his records accordingly. The man agreed to participate on the programme, which he later completed successfully.

Although the man that died had asked to be treated as a VP, he continually asked staff to be let out of his cell at times which was in conflict with his VP status. Staff said he was demanding at times, and sought attention. It was known that he smoked a lot and had incurred debts amongst other prisoners. The man was also upset that his girlfriend did not visit him whilst in custody.

The man was anxious about how long a sentence would be imposed upon him. On 14 July 2006, he was sentenced to four years imprisonment - the longest custodial sentence he had ever received. He told staff that he just wanted to get on with serving his sentence.

Around 20 July, he apparently received a letter from his girlfriend which ended their relationship. His mother visited him a week later and noticed his demeanour had changed.

On the morning of 11 August, the man was asked by staff if he wished to take exercise but he declined. A short while later he requested a cell move, saying he did not get on with his cell mate. Staff said they would look into this.

Later that morning, the he collected his lunch. Staff did not notice anything of concern. His lunch tray was collected from his cell at approximately 1.10pm, and his cell locked as normal. At around 4.00pm, the afternoon roll check commenced. On arriving at the man's cell and looking through the observation panel, the officer saw his head slumped facing slightly down, with a noose around his neck. Immediate assistance was requested. Staff, including the prison doctor, carried out cardio pulmonary resuscitation (CPR) until the paramedics arrived. Sadly, the man showed no signs of life and the doctor declared him clinically dead at 4.27pm.

My report makes eight recommendations and highlights one area of good practice.

## INVESTIGATION PROCESS

1. The investigation began on Monday 21 August 2006 when my investigators visited HMP Shrewsbury. They met the Governing Governor, Deputy Governor, Healthcare Manager and Chaplain, and with representatives of the local branch of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). My investigator explained the nature and scope of the investigation and the report handling process.
2. On the same day, notices were issued to staff and to prisoners announcing the investigation and inviting anyone with concerns or information relating to the man that died to make themselves known. Three prisoners came forward to speak with my investigators, although one later declined to be interviewed. In total, my investigators interviewed 16 members of staff, and one prisoner, who had contact with the man during his time in prison. The clinical reviewer assisted my investigator in interviews where appropriate. The man's first landing officer's interview was conducted by written correspondence as she had transferred to another prison at the time of the investigation.
3. My investigators also contacted the office of HM Coroner of Mid and North Division County of Shropshire, and the investigating police representative. I am grateful to them both for providing me with timely and useful information.
4. On 2 October 2006, my investigator and one of my Family Liaison Officers, visited members of the man's family at their home in Shrewsbury to find out what matters they would like the investigation to address. The family raised the following matters which are considered in the report:
  - Why the man moved wings (A to C to A), and whether he was subjected to any bullying?
  - What care he received in respect of his drug addiction and his mental health and whether this was appropriate?
  - The family wondered if the breakdown of the relationship he had with his girlfriend, along with the fact that he was given a four year sentence (which was a considerably longer than past sentences), might have been difficult for him.
  - When they last saw him, his demeanour had changed – he was repeating himself, his head was down, and he did not accept a hot drink and chocolate bar as he usually would. He would not tell them why he had moved back to A wing, but said he would put his reason in a letter. They felt that, as he was well known in the prison, any change could have been recognised.
  - They enquired about his only pair of trainers which were missing as they had not been returned with his possessions. The investigator agreed to ask the prison about this.

## **HMP SHREWSBURY**

5. Shrewsbury is a category B prison for adult men. It houses unconvicted and convicted prisoners, mainly from the magistrates' courts in the Shrewsbury, mid Wales and Stoke-on-Trent areas. It is a local prison and therefore prisoners serving long term sentences are transferred elsewhere. There has been a prison on the 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.
6. Cells are on A and C wings. A wing has a certified normal accommodation of 160, with an operational capacity (maximum crowded capacity) of 307. C wing has a certified normal accommodation of 22, with an operational capacity of 43.
7. A wing cells are located on four galleried landings. The wing has one anti-ligature cell and two constant observation cells. Also located here is the suicide intervention suite. A wing also has a small segregation unit comprising three punishment cells and one special cell.
8. C wing is used for vulnerable prisoners (VPs) with special needs, and has an anti-ligature cell. It is a self contained wing with its own servery and direct access to the kitchen. It also has its own workshop and education classroom. VPs also overspill to A1 wing because of the high number of prisoners requesting VP status.
9. The local Primary Care Trust (PCT) is responsible for the healthcare provision within the prison. There is no in-patient / hospital bed accommodation.
10. Shrewsbury was last inspected by HM Chief Inspector of Prisons, in June 2006. She described it as the most overcrowded prison in an overcrowded system. Staff-prisoner relationships were mainly cheerful and mutually respectful. Bullying was well managed and levels of self harm had fallen. However, she identified that the inadequacy of accommodation meant that vulnerable prisoners were housed in poor conditions with grossly inadequate exercise facilities. Drugs remained a serious problem, but the detoxification facilities had improved since the last inspection, although wider drug treatment services were hampered by staffing and management deficiencies.

### **Vulnerable Prisoners (VPs)**

11. A prisoner can request VP status (which results in them being segregated from the normal prison regime) in order to protect themselves. It is usually requested because of the prisoner's offence or because of difficulties (often caused by debt) with other prisoners.
12. In HMP Shrewsbury, the overspill of VP prisoners is located by A1 Landing office. Originally it consisted of up to eight prisoners, but of late this number has often fluctuated up to 20. This means that VP prisoners on A Wing are housed with non VP prisoners.

## **CARATS**

13. The Counselling, Assessment, Referral, Advice and Throughcare Service is offered to prisoners who have misused drugs.

## **Addiction Team**

14. Through the local Primary Care Trust, HMP Shrewsbury has a team of addiction nurses. Their role is to work with prisoners who are actively withdrawing from drugs and alcohol, and they offer detoxification programmes, and advice on harm minimisation, harm prevention and blood borne viruses. Referrals to other agencies are made if necessary, as well as communicating with the CARAT workers and drug services in the community or doctors.

## **Assessment, Care in Custody and Teamwork**

15. Shrewsbury has implemented the Assessment, Care in Custody and Teamwork (ACCT) approach to helping and monitoring prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, to identify prisoners' individual needs and to offer individualised care and support before, during and after a crisis.

## **Insiders**

16. Insiders are prisoner-volunteers. The role of an Insider is to welcome newly arrived prisoners, highlight any concerns they may have, and to explain the processes they will encounter in the early days of custody.

## **Personal Officers**

17. A personal officer scheme enables named staff get to know individual prisoners who can turn to them for advice and assistance.

## **Mental Health In-reach Team**

18. The mental health in-reach team provides support and continuous care to those prisoners who have had a previous admission to a psychiatric hospital or are under current psychiatric treatment. At the time of the man's arrival at Shrewsbury, the in-reach team was understaffed.

## **Roll check**

19. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur on a number of occasions during the day. At all times, staff must sign that the roll check is correct.

### **Adjudication hearings**

20. Adjudications are disciplinary hearings against prisoners following an alleged breach of prison rules. They are almost always conducted in the segregation unit.

### **Smoker's packs**

21. New prisoners can be issued with a standard smoker's pack on reception. It contains a packet of tobacco, cigarette papers, a box of matches, a pen and a Mars bar.

## KEY FINDINGS

### 19 May 2006

22. The man was arrested on 18 May 2006 in the London area for breaching his Community Order, imposed for burglary offences. At the time of his arrest, he was with his girlfriend and they had run away together. The man was escorted on 19 May from London to Shrewsbury Magistrates' Court. The Prisoner Escort Record (PER) form indicated the following observations in respect of him -

*Risk categories - Medical condition, violence, conceals weapons, drug/alcohol issues and suicide/self harm.*

*Commentary - "suffers from schizophrenia/paranoia & depression. Recent drug addict-claims to have given up. Has previously slit wrist and OD'd on paracetamol."*

23. At court, the man was charged and remanded to HMP Shrewsbury. He was listed to return to court at a later date to be sentenced. He arrived at the prison at around 2.40pm on 19 May. He underwent the prison's reception screening which included the induction programme and a healthcare screening. He received the prison's very comprehensive first night care and induction booklet which was explained and completed by staff. A Cell Sharing Risk Assessment (CSRA) was also carried out. This said that He was currently dependent on drugs, but was a low risk of harm to others. The opening of an ACCT document was also considered but deemed not appropriate.
24. The man was interviewed by an Insider at reception and the use of the prison's telephone PIN system was explained to him. As this was not his first time in prison, he was familiar with the regime. He immediately applied for protection and to be located in the prison's vulnerable prisoners (VP) wing. He said that this was because, when he had previously been at Shrewsbury, he had been on C Wing where he had trouble with drugs and debts.
25. The healthcare screening was conducted by the registered mental health nurse (RMN). She highlighted no concerns but noted the man had used heroin, methadone, barbiturates, and was suffering from withdrawal symptoms although he said he was in control. She also completed the health screening document on which she noted that he told her he was receiving prescribed medication – methadone and diazepam. He had also used heroin and benzodiazepines daily at the time of entering prison. The man told the RMN that he had last self harmed over four years ago, but he had no intention of repeating this. He also informed the RMN that he had been in hospital for paranoia ten years previously and had been taking medication called clopixel although he had not taken this for over two and a half years. The RMN referred the man for a mental health assessment by the in-reach team, as well as a referral to the prison doctor and CARATS. These referrals were

standard practice for a prisoner who had drug and/or mental health needs. The RMN did not indicate whether the referrals were urgent.

26. The doctor on duty on the day of the man's arrival examined him. The doctor noted in his records that he had been previously diagnosed with paranoid schizophrenia, and had self harmed four years previously. Given his drug problem, the doctor referred him for substance detoxification and He agreed to participate on the programme.
27. After seeing the doctor, the man saw the out of hours CARATS worker. He said that he had had issues with heroin, but felt motivated to stop using it. He did not raise any other risks to himself or others, or any other concerns. He told the CARATS worker that he had previously worked with a community drug misuse treatment team. His details were taken and he was referred to the CARATS office and subsequently allocated to a drug worker. The drug worker met the man and completed the initial assessment on 19 June.
28. After the man's reception and initial induction, he was allocated to A wing (cell A1-41).

#### **From 20 May onwards**

29. A nurse saw the man that morning on C wing, where there is a treatment hatch on the second landing. She was the first nurse to see him this day and was a qualified mental health nurse. She told my investigators that she spoke with him about his past drug use and the detox process. She completed a substance misuse assessment, noting that he had been a daily user of heroin and cocaine and was orally taking diazepam. He tested positive for morphine and benzodiazepines, and told her that he had been on a methadone prescription a week prior to entering prison. He said that he had undertaken an in-patient detoxification about seven years ago, but failed to complete the treatment. He had also attended a rehabilitation placement about a year previously. The man said he had once been prescribed the drug naltrexone (an opiate blocker used when abstinent from heroin or methadone). He gave the name and address of a local community drugs team that he used as well as the details of his doctor. He told the first that he had no current mental health problems or thoughts of self harm or suicide.
30. The nurse immediately commenced the man's subutex detoxification programme, explaining to him how it would work. The detoxification period would last 14 days. He was happy with this and signed the consent form accordingly. A withdrawal monitoring chart was completed for 20 – 22 May. He progressed through the withdrawal process without any significant problems, and his clinical notes revealed an appropriate reduction in the observable symptoms of withdrawal. He successfully completed the detox programme two weeks later. He did not approach staff to request any further intervention or treatment in regard to his drug problems during the remainder of his time in custody.

31. On 22 May, nursing staff contacted the man's doctor to ascertain and confirm what drugs he was prescribed. The doctor confirmed that the man was prescribed methadone, but he had not been prescribed diazepam since January 2006.
32. The man was issued with a smoker's pack on 26 May. This would have contained a packet of tobacco and cigarette papers.
33. A week later, on 1 June, he was issued with three more smokers' packs by the first landing officer. She told him that this would be the last time that he would receive packs in advance. The landing officer told my investigators that the man's canteen order had not gone through and he was without tobacco. She therefore arranged for him to have three smoker's packs, which was more than usual, but advised him that he should be familiar with prison regime and more organised with his money and canteen.)
34. On 7 June, the man declined to attend a triage assessment meeting, stating he had no problems. This meeting would have involved staff from the in-reach, CARATS and healthcare teams, as well as himself.
35. An entry on the man's wing history sheet on 12 June by his second landing officer, states:

*"Very manipulative of staff will try anything to get out of his cell despite being a VP on A wing."*
36. At interview, the second landing officer told my investigators that staff generally had no problems with the man. However, despite having applied for VP status, he tried to get out of his cell even when other prisoners were about. He said the man wanted protection when it suited him, but would often ask if he could go out on to the landing to get tea bags or tobacco even when the rest of the wing was unlocked. Staff refused his requests because he was on protection. The second landing officer said that he had to explain on more than one occasion that staff were responsible for ensuring the man's wellbeing. It was also explained that he was on VP status of his own choice, and could give it up by applying to the governor to be located back within the normal prison wing.
37. The first landing officer said she came into regular contact with the man whenever she was on duty. She described him as someone who always wanted something, whether it be some sugar, tea, a smoker's pack, or an application form. His requests were challenging to staff because he was on A1 landing, and had to be kept separate from other prisoners.
38. The man had his first full assessment interview with the CARATS officer on 19 June. The CARATS officer, told my investigators that it was normal practice for someone to be referred to CARATS if they had a current or past drug and/or alcohol problem. The man acknowledged that he had a drug problem, and had recently had a relapse after about six months of being heroin free. He also felt his alcohol intake was becoming a problem. He admitted that he

had suffered from depression and was now more aware of why he used drugs. In respect of his mental health, this was an area the man did not want to talk about in detail, other than to say he felt that he was receiving enough support. They discussed options he could take to help his situation. This included referral to various outside agencies for help, although he was quite content with having “talking” therapy.

39. Due to staff shortages in the mental health in-reach team, the man’s referral for a mental health assessment was not arranged until two months after he arrived in prison. Two female members of staff from the in-reach team eventually interviewed him on 12 July. He was surprised that he was being interviewed after being in custody for two months.
40. The man told the two women about his history of mental illness, saying that he had been diagnosed as a paranoid schizophrenic and had been an inpatient following a diagnosis of drug induced psychosis. In interview, the in-reach worker said she spent some time explaining the role of the in-reach team to him to try and fully engage him in the process. She did not think that he displayed any symptoms of a depressive illness. His mood was said to be appropriate to his circumstances in prison, and he was not pessimistic in his outlook on life. He also said that he had no thoughts of harming himself. The two members of the in-reach team assessed that there were no signs of a treatable mental health problem or psychosis, and that no further intervention was required. The CARATS team were to be informed of the assessment.
41. On 12 June, the man telephoned his girlfriend. He asked her a number of times if she would visit him in prison. She was reluctant to do this, saying that her mother would not let her. He was upset and tried to persuade her but, although she eventually agreed, she did not in fact make a visit.
42. Four days later, on 16 June, space became available on C Wing and the man was allocated to cell C1-03.
43. The man’s second session with the CARAT officer took place on 19 June. He was very motivated but recognised there were a lot of challenges ahead if he was to remain drug free. He told the CARAT officer that he had had a drug relapse approximately six months previously, and they discussed some of the issues which he felt affected his on-going drug use. He was offered the services of the prison counsellor, which he said was something he might consider at a later date. The man also spoke about his mental health history, mainly depression, but said that he felt stable and was receiving sufficient support. The CARAT officer suggested that, in future meetings, it would be useful for the man to engage in sessions focussed on anger management and irrational thought processes. Although he was not opposed to the suggestion, the man said he preferred to wait until he had been sentenced. This was noted on his care plan as a longer term objective and the next meeting was scheduled to take place in a fortnight’s time.

44. At his own request, on 28 June the man was moved back to A wing as he said he did not get along with prisoners on C wing. No issues were recorded by staff on his wing history sheet.
45. The man met his CARAT officer on 7 July for their third session. They worked through his care plan discussing his needs. His CARAT officer said that he still remained motivated, but again was realistic about the temptations of drugs whilst in prison. He said he was determined to remain drug free. As he was still waiting to be sentenced, he was a little unsettled and told his CARAT officer that at present he felt his main need was just to have someone to talk to as and when he wanted to. He identified that he was not very good at talking about his thoughts or feelings, but felt that if he got a long sentence it was an area that he could improve on. The CARAT officer noted that the man was not ready to fully engage with CARATS, but just needed basic contact until his sentence was known. Perhaps then, he would be able to make clearer decisions about his involvement with their services.
46. On 9 July, the man's cellmate accused him of taking his tobacco without permission whilst he was out of their cell. The two got into an argument and had to be separated by staff. The cell mate was later moved to another cell. Three days later on 12 July, the man's new cell mate also complained about him and requested a cell move.
47. At around 7.50am on 14 July, the man appeared at Shrewsbury Crown Court. He was sentenced to four years imprisonment, the longest custodial sentence he had ever received. The post sentence report completed by the court stated that he was an experienced prisoner and there were no immediate concerns. He was taken back to Shrewsbury, arriving around 12.40pm. There are no records to suggest that the man was interviewed at prison reception on his return.
48. Around 3.50pm later that day, his cell mate requested another move because of the man's behaviour. Staff attempted to reallocate the man onto C wing, but he refused to move and was put on disciplinary report. The following day, he attended an adjudication hearing for not obeying a lawful order. The adjudicating governor found the charge proved and the punishment was seven days loss of canteen and 70 per cent loss of earnings. He was to remain on A wing until transferred out of Shrewsbury which was inevitable now that he had been sentenced for a long term. Staff told my investigators that transferring VP prisoners out sometimes involved waiting for months rather than weeks.
49. An assessment was completed on 19 July because of the man's relationship with his girlfriend who was subject to a Social Services care order. This resulted in him being prohibited any form of contact with her whilst he was in custody. Staff explained the reasons behind the order and asked the man to sign the compact but he refused to do so.
50. Following a request to see his CARAT's officer, she spoke with him again on 17 July. This was shortly after he had been sentenced. He declared that he

was not surprised at the length of sentence, but he was doing okay and just wanted to get on with prison life. His CARAT officer said his outlook had changed slightly in that he now intended to channel his positive feelings into dealing with his problems, including thinking about further education and transfers to other prisons. The man said that he would prefer to complete one to one work with the CARATS team nearer the end of his sentence term as he realised he was not due for release until at least 2008. It was agreed that their next meeting would take place in approximately two to three weeks time, when his CARAT officer would continue to develop and work through his care plan. As Shrewsbury was a remand prison, the man expected to be transferred out and saw this as a positive step. He could try new things, get some qualifications and earn some money before release.

51. The CARAT officer told my investigators that, on 24 July, she briefly chatted with the man whilst on her way through the prison to see another prisoner. He said he was alright but had one issue that was bothering him. He went on to say that his cell mate was not particularly hygienic. He hoped he would not be sharing for too much longer with him because he liked to have a clean and tidy cell. The man said that, if it became a problem, he felt confident of talking to landing staff and asking for a move or for consideration to be given to whom he was sharing a cell with. The CARAT officer said that the man looked physically better, appeared to have put on weight and joked about the prison food.
52. My investigator was told by the police that the man received his last letter from his girlfriend around 20 July. This ended their relationship. Prior to this, he apparently received three letters from her, all between 19 and 30 May.
53. The man's mother last visited him on 27 July. She told my investigators that his demeanour had changed. He was repeating himself, his head was down, and he did not accept items from the canteen as usual. He mentioned that he had moved back to A wing but would not tell her the reason, saying he would put it in a letter. The man was told by his mother that she had planned a holiday in August with other members of the family.
54. On 4 August, a new cell mate joined the man. They shared the cell for a week until the man's death. The cell mate described him as a quiet individual who did not converse much and spent a lot of his time sleeping. The man rarely came out of his cell and took no showers. He was always shaking his cell mate's hand, although he did not have much to say to him despite his cell mate attempting to initiate conversations. He also would sometimes have a towel over his head to block the light out. His cell mate told my investigators that the man was always pressing the cell bell for staff attention. When staff would arrive at their cell, he would request either a razor, toothpaste or toilet roll, but said that most of the items He did not need. On other occasions, being a heavy smoker, he would ask for permission to leave his cell for "dimps" off the landing. (Dimps were cigarette ends that he would collect, roll up and smoke.) His cell mate believed he just wanted to get out of his cell and have some interaction with the staff. The staff response to the man's frequent use of the cell bell was mixed: some would accede to his requests,

and some would not. When the cell mate first shared a cell with the man, the man had asked to borrow some of his tobacco. This he did, but as the man continually asked for more, his cell mate stopped lending to him. The man was in debt to a lot of other prisoners.

55. Because the VPs were over-spilling onto A Wing, it was difficult to house new prisoners on A1 wing where VP prisoners took up a lot of cells. A Principal Officer (PO) was tasked with trying to reduce the number of VPs. He did this by speaking to all those with VP status to ascertain if there were any issues that could be addressed to enable the prisoner to return to the normal regime.
56. The PO told my investigators that he spoke to the man with an Insider present. (It was thought an Insider could possibly assist and clear up any questions or misconceptions the man (or any other VP prisoner) might have had.) The man declined to give up his VP status and was very adamant about this. He said this was because he had had major drug issues and debts prior to coming into custody. He had also burgled houses of some serving prisoners and their relatives, and was aware that he had not built up a very good name for himself in the establishment.
57. The PO said he had no concerns or issues about the man being at risk of suicide or self harm. He recalled the man looking healthy, upbeat, and answering the questions put to him quite openly. He had no issues with being a VP; on previous periods in custody the man had also been a VP. The PO said that the man gave the impression he was quite happy to remain on VP status for the duration of his sentence.
58. Prisoners are normally allocated a personal officer whom they meet to discuss any concerns or issues. Although the man was allocated a personal officer in early July, there are no records on his wing history sheet. The allocated personal officer told my investigators that he introduced himself to the man some time in July, and was aware that he had previously spent time in Shrewsbury. Whenever he was on duty, he would speak with him to see if he needed anything. The last time this occurred was on Wednesday 9 August. The man said he had no problems. His mood was okay and he seemed fine and was eating his meals.

### **Friday 11 August**

59. A third landing officer told my investigators that she began her shift at 7.00am on A1 landing. She quickly made herself familiar with the prisoners on the landing, their names and status. She proceeded to check on those prisoners who were subject to ACCT procedures, as well as the VPs. She was aware that the man was a vulnerable prisoner. In respect of those prisoners on ACCT, She visited every cell to gain a response. She then would press the cell bell to ensure that the control room was aware that she had completed the check and that it was logged. The landing officer then went back to write up the responses from the prisoners individually.

60. At approximately 8.30am, during the third landing officer's routine checks, she opened and entered the man's cell. He was alone because his cell mate was in court for the day and had left earlier that morning. She asked him if he wanted to take exercise that morning, but he declined. It appears that refusing exercise was quite common for him. Sometimes he also did not go out for association, which meant he did not mix as much with other prisoners. Before leaving the man's cell, the landing officer asked if he was okay and he responded positively. She was familiar with the man and knew he was used to prison regime. She said the man was very helpful and would often be paired with new prisoners to look after them and help them settle into prison life.
61. Within the next hour, the landing officer responded to a cell call request from the man. He was standing up when she got to the cell and she asked him what the problem was. He responded abruptly that he wanted a cell move. She sensed that he was unhappy, and she enquired what the reason was. He told her that he was not getting on with his cell mate as neither of them liked each other and there was a personality clash. He was reluctant to provide any further details, but said they did not get on together. She told my investigators that she got on well with him. If he had a problem, he would say so straightaway to get the matter off his chest.
62. The landing officer told the man that the cell move could not be arranged straightaway, but it might be possible by the end of the day. She said she would tell staff of his request and let him know the outcome. As his cell mate would be away until at least 5.30pm, he appeared to accept that there was no immediate problem. She felt that the man seemed content that his request would be dealt with in a positive way and continued with her duties on the wing. Before leaving A1 landing at 12.45pm to go to A3 landing, she briefed staff on duty of the man's request for a cell move.
63. The man collected his lunch between 11.30am and 11.45am. On returning to his cell, he approached another prisoner from whom he had borrowed some tobacco earlier in the week. They spoke briefly and the man returned what he had borrowed. The prisoner said there was nothing unusual in their conversation and they both returned to their cells which were locked soon afterwards.
64. At approximately 1.10pm, an officer began to collect the empty lunch trays from the cells. On arriving at the man's cell, he looked through the observation panel in the door and went in. The man was sitting on his bed and the Officer said he seemed fine. He asked for the lunch tray which was empty and the man handed it over without saying anything. The Officer collecting the trays then left the cell, locking it behind him.
65. A fourth landing officer came on duty at 12.30pm when all prisoners were locked in their cells. At around 12.51pm, the man's cell bell, number 41, was activated and he responded. He spoke to the man through the observation panel to ask why he had pressed his cell bell. The man asked for a roll of toilet paper. He was polite and courteous and the landing said that he

seemed his normal self. If he was experiencing any problems, he would have fully expected the man to say something as they got on well. The landing officer went to collect a toilet roll, returned and handed it to him. He asked the man if he was alright. The man confirmed that he was and the landing officer locked the door to resume his duties. He told my investigators that he would not have hesitated to talk to the man for longer if he felt he was in need of support.

66. The fourth landing officer left the wing at 1.45pm for other duties. On his return at approximately 4.00pm, he assisted other staff with the roll count. At this time, prisoners were returning from workshops, education and visits. Whilst carrying out the count, the landing officer came to cell A34, approximately three metres on the opposite side to the man's, and found that the prisoner had barricaded himself inside. He tried the door, which was locked. He opened the spy hole but could not see the prisoner. He spent about a minute at the door trying to persuade the prisoner inside to acknowledge him or uncover the observation glass so he could see inside. As far as the landing officer was aware, the cell was occupied by a single prisoner. He asked the prisoner several times to move the obstruction, reaffirming that this was a serious matter. He failed to get a response and attempted to barge the door several times, before wedging it with his foot inch by inch. His foot could not hold the door open so he went to the office to inform other staff. They had apparently discovered the barricaded cell earlier and action was being taken to deal with it. The landing officer continued the roll check for the remainder of the landing, starting from cell 43, moving onto cell 42, and then to cell A41, the man's cell.
67. The fourth landing officer told my investigators that as normal he opened the observation panel and looked through. He initially saw the upper part of a pair of legs, from the knees up, against the back wall under the window. He said that he did not see that the man's feet were off the floor. As he looked up to the rest of the body he saw his head slumped facing slightly down, his mouth and eyes open. His colour was pale. The landing officer then saw a noose around his neck. He immediately called for assistance and activated his personal alarm, recorded as going off at 4.07pm. He unlocked the cell, entered and saw that the man was hanging from the window bars. He was followed into the cell by one officer and the Acting Senior Officer (A/SO) who had heard his shout for assistance in the centre office about six feet away from the man's cell.
68. A third officer, who was also in the office and heard the shout for assistance as well as a shout to "get the hospital". He heard the emergency broadcast across the radio, but decided to telephone the healthcare office for immediate assistance.
69. Once in the cell, the landing officer grabbed the man by his waist and lifted him up to support his body. He noticed the noose was very tight around his neck which was red in colour. The first officer from the office told my investigators that, on seeing the man hanging, he quickly called for assistance using his radio, then assisted the landing officer. The A/SO told my

investigators that he used his fish knife to cut the noose, which was made from bed sheets, from around the man's neck. (The decision to carry fish knives, as far as he was aware, was a voluntary one.) The officers then placed the man on his back on the cell floor. The A/SO quickly went to get the resuscitation bag from the centre office. The landing officer said that he had not had any first aid training for a long time, but remembered the basic resuscitation procedures. He checked the man's vital signs and found no response. He shouted to commence cardio pulmonary resuscitation (CPR). The first officer from the office began chest compressions for approximately three minutes whilst the A/SO administered breaths into the man's body.

70. A second principal officer (PO) told my investigators that she arrived at the man's cell approximately 20 seconds after hearing the emergency call. Seeing staff already in the cell carrying out CPR, she remained outside to keep the entrance clear, leaving momentarily to retrieve the medical bag for the first nurse, who arrived at the man's cell seconds after her.
71. The first nurse was in the healthcare office in A wing on the second floor when she responded to the telephone call that there had been a code blue. (A code blue is an emergency request indicating that a person has been found with breathing difficulties.) She shouted to two other nurses in the office that a code blue had come through for cell A1-41. The second nurse in the office said she would collect the medical equipment and make her way to the cell. The first nurse then went to the man's cell, arriving after approximately 30 seconds. On entering, she saw two officers carrying out CPR.
72. The officer who was second to enter the man's cell now left the cell. The first nurse checked the man's pupils which were fixed. He was not responding and did not appear to be breathing. The first nurse and the officer continued CPR, and the second PO called for an ambulance via her radio. The second nurse that was in the office had arrived at the cell by this time with the medical equipment. The officer left to call the prison doctor who was on duty in the prison reception area. The A/SO also left the cell to clear the landing and arrange for staff to meet and direct the paramedics to the cell.
73. The first nurse continued to check the man for any vital signs but there was no response. The second nurse told my investigators that she placed the defibrillator pads on his chest to analyse his condition. She removed his false teeth and inserted an airway to assist with giving breaths. The defibrillator gave instructions to continue with CPR. The first nurse continued CPR with the second nurse relieving her shortly afterwards. The prison doctor arrived at the cell and the first nurse left to get the emergency drugs box for the doctor. She returned and handed it to the doctor, remaining outside the cell. The doctor administered adrenaline to the man's body and CPR continued. A fourth nurse, who had also arrived, replaced the second nurse in carrying out the chest compressions.
74. The paramedics arrived at the prison at approximately 4.15pm and were escorted through the prison to the man's cell. They assisted the doctor and staff in the resuscitation efforts. Sadly, the man who is the subject of this

report continued to show no signs of life and the doctor declared him clinically dead at 4.27pm.

### **After the man's death**

75. The prison has laid down procedures for deaths in custody which were followed by staff. The cell area was isolated and the police were informed.
76. The prison's Independent Monitoring Board was also informed and a member of the Board attended the prison immediately.
77. Staff were taken to the office suite to make statements and, later that evening, attended a hot debrief held by the Governor where they discussed the afternoon's events. A critical debrief was arranged for a later date to review the events surrounding the man's death and any lessons learnt.
78. The prison's Care Team were called immediately to the prison to be available to support all staff. Staff interviewed by my investigators felt the support offered to them was both welcome and sufficient.
79. All prisoners who were on open ACCTs within the wing were interviewed.
80. Whilst the attempts to save the man were continuing, the prison was still dealing with the prisoner in cell A-34 who had barricade himself inside. He was eventually removed at around 7.00pm by staff using control and restraint procedures.
81. The following day, the safer custody officer briefed the Samaritans and Listeners (prisoners trained by the Samaritans to offer support to other prisoners) about what had happened. A notice about the man's death was issued by the Governor to all staff and prisoners.
82. Attempts to contact the man's family in the immediate period following his death failed. It was discovered that they were on holiday abroad in Cyprus. The decision was then made to ask the police to contact the family. The news of his death was eventually passed to the family on Saturday 12 August. They in turn tried to arrange a flight home as soon as possible. The prison's Family Liaison Officer, subsequently visited the family on Thursday 17 August, providing as much information as possible.
83. The man's mother later visited the prison and met the Governor and some of the staff. She also spoke with one of her son's cell mates. The cell mate told my investigators that, in the short time he shared a cell with the man, he was besotted with his girlfriend. However, to his knowledge, she had not written or come to visit him. The man's mother told the cell mate that his girlfriend was involved in another relationship which she had told her son about just before the family went on holiday. The holiday was something which the man's cell mate said he would have wished to have taken part in.

84. Following the man's death, three prisoners made separate reports that the man was being bullied. The first prisoner approached a member of staff on 15 August and said that He had been bullied by a prisoner whose house he had burgled. On the same day, a second prisoner said that the man had been bullied by a prisoner on A wing but did not give any details. The third prisoner approached a member of staff on 21 August, and said the man had been pressurised by another prisoner to hand over prescribed medication.
85. Security information reports were completed by staff for all three incidents which were investigated by the prison as well as passed to the police. The police were unable to find any evidence to support the allegations. My investigators also spoke to staff about the man and the possibility of him being bullied. Staff said that they never witnessed him being bullied nor had he ever brought it to their attention. In respect of the claim by the third prisoner, the man's medical records show that in the month prior to his death he had only been prescribed paracetamol and Gaviscon (for indigestion).
86. It was alleged by prisoners that during the lunchtime period, the man had given away a number of his personal luxuries, including tobacco, to other prisoners. As he was well known for being in debt with tobacco, it was a strange thing for him to do, and one prisoner later said that he believed it demonstrated that the man planned to take his life.
87. The post mortem report confirmed that the man's death was caused by hanging. The toxicology results confirmed that there were no drugs or drug metabolites in his blood.

## ISSUES CONSIDERED

### Clinical care

88. The clinical reviewer concludes that there were no identifiable contributory factors or root causes relating to the man's death. There was no indication from staff or prison records that he had any mental health problems or mood disorder.
89. In respect of his mental health, the clinical reviewer said that he was screened on reception by a registered mental health nurse and referred for a mental health assessment as someone who, although not suffering from an acute mental illness at the time, had a past history of mental illness. There were no indicators that the referral should be dealt with urgently and, as noted earlier, the assessment did not take place for two months. When it was completed, there were no more concerns about his mental health.
90. The man was assessed three times by the CARATS worker before 12 July, and subsequently twice more. Again, there were no concerns about his mental health.
91. The clinical reviewer says that there were clearly delays in the man's referral, however this had no impact upon him. Staff assured my investigators that if he had displayed some form of abnormal behaviour or acute signs of a mental illness, his referral would have been prioritised and an urgent assessment carried out.
92. The clinical review also confirms that the healthcare provided when the man was discovered was appropriate.
93. The clinical review makes a number of findings and recommendations in respect of the healthcare service provided to the prison which will be separately addressed to the Primary Care Trust. Those which are relevant to this investigation are included below:

**The process for the management of referrals from Primary Mental Health Care into prison In-reach should be reviewed and there needs to a clear referral protocol regarding the management of urgent and non urgent referrals. There is a need to include standards that can be regularly audited.**

**The Primary Care Trust should develop a contingency plan for periods of long-term leave, given the difficulties in securing replacement staff due to the level of security. The locality manager is currently working on increasing the staff that are security checked in order to provide cover should the need arise in the future.**

### **Change of wings from A to C, and back to A**

94. Having immediately requested VP status on entry to Shrewsbury, the man was placed in the VP overspill on A wing because C Wing was full. When a space became available on C wing, he was appropriately relocated. By his own choice, he then asked to move back to A Wing, saying that he was not getting along with other prisoners. He made no mention of bullying, and his request was granted. He kept his VP status and there is no evidence beyond the three statements from prisoners following his death to suggest he was subjected to bullying.

### **The man's drug addiction**

95. His drug addiction was immediately recognised by reception staff when he came to Shrewsbury. He was placed on a detoxification programme the morning after his arrival and later completed the programme successfully. He made no further contact with healthcare for reasons related to his drug use, nor did his behaviour warrant random drug testing.

### **Changes to the man's mood, as recognised by his mother on her last visit**

96. Although the man's mother said that she had recognised a change in her son's mood, she did not report any worries to the prison. Staff who came into contact with him did not identify any concerns about him. He was described as a very polite individual, who kept himself fairly quiet. They also said that at times he was sought attention and always wanted something. It was well known that he was a heavy smoker and borrowed tobacco from other prisoners resulting in him getting into debt. He also often asked to come out of his cell despite being on VP status. Nonetheless, he had raised no concerns to staff which would have been deemed out of character or highlighted any intention to self harm.

### **Possible triggers for the man's death**

97. The man certainly had reservations when he came into prison on this occasion, because he was expecting a longer sentence than previously. However, having been sentenced, he told the CARATS worker shortly afterwards that he accepted his sentence and intended to make the most of his time in custody.
98. His last cell mate believed that the breakdown of his relationship with his girlfriend had a detrimental impact on his feelings. The man knew that he was forbidden to contact his girlfriend, and showed his unhappiness by refusing to sign the order.
99. His cell mate was also aware that, a short time before he took his life, he gave away items of his canteen such as tobacco. This was an unusual gesture for someone who was known to be in debt because of tobacco. Unfortunately, this particular issue was not brought to the attention of staff and was only talked about amongst fellow prisoners.

## **Checking of prisoners on ACCT**

100. Although the man was not on ACCT, and the procedures were not relevant to him, the prison should be commended for routinely pressing the cell bell after checking prisoners on an open ACCT document. This ensures that the prison has a central record of checks on prisoners and is an example of good practice.

**It is good practice that the cell bell is routinely pressed after prisoners on ACCT are checked.**

## **Fish knives**

101. The carrying of fish knives by frontline staff became mandatory on 20 November 2006, following the issue of Prison Service Instruction (PSI) 32/2006. The officer who found the man was not carrying a knife, as this was not mandatory at the time.

**The Governor should confirm that fish knives are now issued in accordance with PSI 32/2006.**

## **First aid training**

102. Although the first officer to arrive at the cell were confident about carrying out first aid, he had not had any first aid training for a long time. Advice as to the proportion of breaths to compressions when conducting CPR has changed in recent years and I suggest that first aid training should be reviewed for frontline staff to ensure that they are fully up to date.

**The Governor should review first aid response training for staff on frontline duties.**

## **Personal officer scheme**

103. Although a personal officer scheme is in place at Shrewsbury, there appears to be some doubt as to how well it operates in practice. (This is not unusual in local prisons where there is a substantial turnover of prisoners.) Despite the man's personal officer saying that they had frequent contact, there are no records to substantiate this. The man's cell mate cast doubt on the scheme by saying that, although he was aware that he had a personal officer, he did not have regular meetings to discuss issues or problems. There is no indication that the man was denied opportunities to speak with staff to raise any anxieties, and several staff believed that he was confident to talk to them.

**The Governor should remind all personal officers of their responsibilities in regard to keeping up-to-date records of contact with prisoners.**

## **The Samaritans**

104. My investigators spoke with a member of the Samaritans. They were told that the prison was supposed to inform the Samaritans when there was a death in custody so that the Samaritans could make sure that prisoners and Listeners were properly supported. The Samaritans were not informed of the man's death until the day afterwards, and so immediate support was not offered to other prisoners.

**The Governor should include the Samaritans on the list of contacts of those who should be informed immediately when there is a death in custody.**

## **The man's property**

105. My investigators enquired about missing trainers. The prison confirmed that all the clothing in his possession (other than what he was wearing when he died) at the time of his death had already been returned to the family.

## CONCLUSION

106. The man was an experienced prisoner, having served a number of custodial sentences. He was also acquainted with HMP Shrewsbury and was a local man. He was therefore familiar with its regime, surroundings, staff and some of the prisoners. However, his familiarity with other prisoners was double-edged as the man requested VP status when he was received into custody.
107. As he was segregated from the main prison population, his association time was predominately spent with other VP prisoners. Although this form of segregation was his choice, it appears the man became frustrated at times.
108. In spite of his frustrations, he was able to successfully complete a drugs detoxification programme and appeared to remain drug free throughout his time at Shrewsbury. He also showed no signs of any acute mental health, something which he had experienced before in his life.
109. Shortly before the man apparently took his own life, he gave away some of his personal effects. Given that he was a heavy smoker, it is notable that this included his tobacco. However, this was not known to prison staff.
110. It is also apparent that he was experiencing problems with his girlfriend and had been told there could be no further contact with her.
111. Nothing I have discovered suggests that the man's actions could reasonably have been predicted.

## **RECOMMENDATIONS**

### **Healthcare**

1. The process for the management of referrals from Primary Mental Health Care into prison In-reach should be reviewed and there needs to a clear referral protocol regarding the management of urgent and non urgent referrals. There is a need to include standards that can be regularly audited.
2. The Primary Care Trust should develop a contingency plan for periods of long-term leave, given the difficulties in securing replacement staff due to the level of security. The locality manager is currently working on increasing the staff that are security checked in order to provide cover should the need arise in the future.
3. The Governor should confirm that fish knives are now issued in accordance with PSI 32/2006.
4. The Governor should review first aid response training for staff on frontline duties.
5. The Governor should remind all personal officers of their responsibilities in regard to keeping up-to-date records of contact with prisoners.
6. The Governor should include the Samaritans on the list of contacts of those who should be informed immediately when there is a death in custody.

### **Good practice**

8. It is good practice that the cell bell is routinely pressed after prisoners on ACCT are checked.