Investigation into the circumstances surrounding the death of a man on 3 April 2011, whilst in the custody of HMP Shepton Mallet

Report by the Prisons and Probation Ombudsman for England and Wales

April 2012

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

This is the report of an investigation into the death of a prisoner at HMP Shepton Mallet who died on 3 April 2011. The man was discovered hanging from the bars of the window in his cell. The post mortem examination concluded the cause of death was asphyxia (a lack of supply of oxygen to the body). He was 40 years old.

Whilst he was in custody the man received treatment for his mental health. In December 2009, he transferred from Shepton Mallet for treatment at a psychiatric clinic. He returned to Shepton Mallet in November 2010 after he was discharged from the clinic. The man was a United States citizen who was subject to a deportation order. However, due to his mental health needs, and problems associated with his sentence progression, he was unable to return to his home country.

I offer my sincere condolences to the man's family and to all those affected by his death.

The investigation was undertaken by one of my senior investigators. I would like to thank the Governor of Shepton Mallet and his staff for their assistance during the investigation. I am sorry that this report has been slightly delayed.

A clinical review into the man's medical care at Shepton Mallet was commissioned from Somerset Primary Care Trust. They appointed a doctor to conduct the review. The review concludes that the man's clinical care was equitable, and sometimes exceeded, what he would have received in the community.

The man had significant mental health issues and was also clearly frustrated by his inability to progress to release. However, both my investigator and the clinical reviewer conclude that he gave no cause for concern with regards to self-harm or suicide. All those who knew the man, prisoners and staff alike, were shocked that he apparently took his own life. As his tragic death was not foreseeable, I make no recommendations.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2012**

SUMMARY

1. The man was born in 1971 in the United States of America (USA). He was 40 years old when he died on 3 April 2011 at HMP Shepton Mallet.

2. On 21 October 1997, the man was remanded into the custody of HMP Bedford having been charged with attempted murder. He was convicted on 16 March 1998 and sentenced at Crown Court to life imprisonment. He was later held at HMP Woodhill, HMP Gartree and HMP The Verne before moving to HMP Shepton Mallet on 25 October 2002. He was briefly transferred to HMP Risley in 2004 to attend an offending behaviour programme. However, he stopped taking his medication and his mental health deteriorated, he lost weight and was returned to Shepton Mallet.

3. The man's mental health was an issue throughout his time in custody. Whilst still on remand, he developed anxieties and complained of hearing voices in his head and having paranoid thoughts. During 1998, the man was diagnosed with psychopathic personality disorder and depression and prescribed anti-psychotic and anti-depressant medication. He often requested to change medication and a number of different combinations were tried by healthcare professionals. The man was also a smoker and he was given smoking cessation advice on a number of occasions.

4. Other issues for the man during his time in prison were the progression of his sentence and his potential deportation (since he was a citizen of the United States). However, due to his mental health issues and the risk of harm he presented, the Parole Board did not recommend his progression to a lower security prison or release, which was affected by his being subject to a deportation order. Psychiatric care in the USA could not be guaranteed beyond 90 days and even then it might have been on a voluntary basis. This seemed to be a source of much frustration for the man in that he felt he was in an irresolvable situation.

5. In September 2007, the man told staff he had thoughts of self-harming and in July 2009, he claimed to have swallowed five bleach tablets. Accordingly, self-harm observation and support plans were started on both occasions. This involved regular observations being carried out and recorded. Both plans were closed within a month of them being started when the risk of self-harm or suicide was assessed to have lessened.

6. As a result of the behaviour which led to the opening of the second self-harm observation and support plan, the man was transferred to HMP Dorchester for 12 days in August 2009 for a mental health assessment. The self-harm observation plan was closed on 17 August 2009. The man was moved to a psychiatric clinic on 17 December 2009 under the provisions of the Mental Health Act[1]. Just under a year later, he was discharged and returned to

[1] The Ministry of Justice has the power to make a transfer direction to hospital. That is, if two registered medical practitioners agree a prisoner is suffering from mental disorder, of a nature or degree that makes it appropriate for them to be admitted to hospital for medical treatment (section 47 of the Act) and that such treatment will alleviate, or prevent, a worsening of that disorder.

Shepton Mallet, having undergone both psychiatric and psychological treatment whilst at the clinic. Staff noted that he seemed to be in a much better state on his return to Shepton Mallet. However, over the following months his mental health again deteriorated. Despite this staff had no concerns that the man presented a risk of self-harm or suicide. Prisoners also concurred with this view, saying that he had seemed his "normal self" the day before he died.

7. Just after 7.10am on 3 April 2011, staff discovered the man hanging from the window bars in his cell. Staff entered the cell and cut the ligature but it was apparent that the man had been dead for some time and therefore they did not attempt to resuscitate him. An ambulance was called and paramedics pronounced death at 7.25am.

8. The clinical review carried out on behalf of Somerset Primary Care Trust considered both the care provided for the man throughout his time in prison and the emergency response when he was found hanging. In the clinical reviewer's view, the quality of care given to the man was equitable with, and sometimes exceeded, what he would have received in the community. We have also concluded that staff used the self-harm observation and support plan appropriately and that the man's death was not foreseeable.

9. We make no recommendations.

THE INVESTIGATION PROCESS

10. The investigator was formally notified of the man's death on 4 April 2011. Notices were subsequently issued to both staff and prisoners at HMP Shepton Mallet to inform them of the investigation process and asking anyone who had information relevant to the investigation to contact the investigator. One prisoner asked to be seen. The investigator also studied all the relevant prison records relating to the man which included his main prison record and his medical records.

11. A clinical review was commissioned from Somerset Primary Care Trust into the medical care provided for the man during his time in custody. The purpose of the review was to establish whether the care which the man received in prison was comparable with that he would have been offered in the community and to identify any points of learning. A doctor was appointed to lead the clinical review. We are grateful for his report which was received on 30 June 2011 and is annexed to this investigation report. We apologise for the delay in issuing the draft report. This was due to work pressures at the Ombudsman's office and the difficulties experienced by the investigator in his dealings with the man's solicitor.

12. Mr Del-Greco contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.

13. One of our Family Liaison Officers contacted the man's family. They were informed about the purpose of the investigation and offered the chance to raise any concerns or questions that they wanted to be addressed. The family had been contacted by staff from the US Embassy in London two days before the man's death. They were informed that he had been in good spirits, was starting a new job and would be having a medication review which could have led to a re-admission to the psychiatric clinic. The family were concerned that his mental health deteriorated so quickly and wanted clarification about the sequence of events and information about the man's care whilst in custody. We have attempted to address these issues within the report and hope that this helps the man's family to understand the events leading up to his death. The family received a copy of our draft report and we would like to thank them for taking the time to read and for providing thorough comments on the report.

14. Mr Del-Greco visited HMP Shepton Mallet on 8 April and spoke to the Governor as well as other staff involved in the care of the man. The investigator interviewed staff from the US Embassy's Special Consular Services Unit and returned to Shepton Mallet on 28 May to conduct joint interviews with the clinical reviewer. The investigator also interviewed two prisoners who were located on the man's wing. Transcripts of these interviews are attached to this report. After completing the interviews, the investigator discussed the emerging issues with the prison, on 28 May, and later confirmed his findings in writing.

HMP SHEPTON MALLET

15. HMP Shepton Mallet is a small prison in the South West, dedicated to holding Category C[2] life and indeterminate sentenced prisoners. It is the oldest operational prison in the country, and became the first Category C Lifer centre in the Prison Service in 2001. The operational capacity is 189 prisoners. The prison is organised into four residential wings, the majority in single cells, with 24 shared cells. The healthcare centre is staffed seven days a week.

16. The investigator reviewed the Ombudsman's reports into earlier deaths at HMP Shepton Mallet. All of the previous eight deaths investigated since April 2004 (when this office began investigating all deaths in prison custody in England and Wales) were due to natural causes. There are no similarities between those deaths and the man's. Like this investigation, recent investigation reports have reflected well on the care provided at Shepton Mallet.

Insiders and Listeners

17. Shepton Mallet recruits experienced prisoners to operate as Insiders and Listeners. Insiders welcome new prisoners, highlight any concerns and explain the processes they will encounter in the early days of custody.

18. Listeners support prisoners who may be at risk of suicide or self-harm. They are selected, trained and supported by the Samaritans to offer confidential emotional support 24 hours a day, to fellow prisoners in distress. The Listeners scheme is confidential and any prisoner can ask to speak to a Listener any time of the day or night.

Assessment, Care in Custody and Teamwork (ACCT)

19. The ACCT system monitors and supports prisoners who are assessed as at risk of suicide or self-harm. It is a flexible, prisoner-centred assessment and care planning system, which aims to identify individual needs and offer personalised care and support before, during and after crisis, in a safe and caring environment. Once placed on ACCT support, the prisoner is observed at intervals determined by their perceived level of risk. The observations continue during the day and the night. Additional support is offered from Listeners, personal officers[3] and other staff. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. The arrangements are reviewed regularly by a multi disciplinary meeting, which should include the prisoner.

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[2] On arrival into prison, all adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. The categories are: Category A: prisoners who would be highly dangerous to the public, police or national security if they were to escape. Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult. Category C: prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt. Category D: open conditions, prisoners who can be trusted not to try and escape.

[3] Each prisoner is allocated a personal officer, who is the first point of contact for them.

Independent Monitoring Board (IMB)

20. A prison's Independent Monitoring Board (IMB) is appointed by the Secretary of State for Justice from unpaid volunteer members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB report directly to the Secretary of State if they have any concerns. They also submit annual reports on how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record.

21. The last annual report published by the Shepton Mallet IMB covers the period 1 April 2010 to 31 March 2011. The Board noted that:

> "Adverse Parole Board decisions can be very upsetting for prisoners and the unit has developed procedures to support prisoners. Parole Board outcomes are reviewed first in the unit, after which the offender supervisor personally takes the Parole Board letter to the prisoner, going through the points raised and ensuring full understanding of any requirements or reasons for refusal. Staff always assess if an ACCT needs to be opened should a prisoner's response cause concerns."

HM Chief Inspector of Prisons

22. The last inspection of the new HMP Shepton Mallet by the HM Chief Inspector of Prisons was between 14 June and 18 June 2010. The Chief Inspector noted that:

> "This very positive report, of a full announced inspection, is testament to the benefits that can flow from having a small-scale niche prison with a settled population. Despite its ageing physical environment, the prison was a very safe place, with positive staff-prisoner relationships, a reasonable amount of activities, and a strong focus on addressing the serious risks posed by the population"

During our investigator's visits, he observed this calm environment and the positive attitude of those prisoners and staff he had informal contact with.

23. In relation to healthcare facilities the Chief Inspector reported that:

> "Health services were commissioned by Dorset Primary Care Trust (PCT) and provided by Somerset PCT which was about to take over the commissioning … a good range of Department of Health quality and regulatory frameworks and publications was accessible to staff. For most prisoners, access to health services was equivalent to that found in the community… relations between prisoners and health care staff were generally good and there was a high level of mutual respect … Responses to questions about health services in our survey were mostly very positive, including that significantly more prisoners than the comparator said the care provided by the doctors was good or very good."

KEY EVENTS

24. The man was born in 1971 in the United States of America (USA). He was 40 years old when he died on 3 April 2011 at HMP Shepton Mallet.

25. The man left school at 17 years of age. He then worked in a number of jobs including in a tar factory, a restaurant, a shop and as a doorman. In a psychiatric report completed after he committed his offence, it was recorded that the man used illegal drugs from 14 years of age. He more recently regularly used amphetamines, steroids and cocaine and was reported to be under the influence of drugs at the time of the offence. The man moved to Britain eighteen years ago with his wife at the time and has four children in this country.

26. Following an alleged attack on 19 October 1997, the man was arrested and two days later he was remanded into custody at HMP Bedford. He then moved to HMP Woodhill on 22 December. This was his first time in custody. Whilst still on remand, the man developed anxieties and complained of hearing voices in his head and having paranoid thoughts. He was assessed by a psychiatrist who recorded that he had previously been diagnosed with multiple personality disorder (also known as Dissociative Identity Disorder - a psychiatric diagnosis which describes a condition in which a person displays multiple distinct identities). The man admitted he had been given depot injections (this is an injection of a medication which releases consistently over a long period of time and is sometimes used to treat psychosis) when he lived in the USA.

27. The man was convicted at Crown Court of attempted murder and sentenced to life imprisonment on 16 March 1998. During that year, the man was diagnosed with psychopathic personality disorder and depression and prescribed anti-psychotic and anti-depressant medication. The clinical reviewer writes that,

> "As the picture of his mental illness evolved, the diagnosis included psychosis and paranoid schizophrenia. A number of different medications were tried, both anti-depressants and anti-psychotic agents."

28. An overview of these different medications can be found in the clinical review (annexed to this report) and amounts to at least 27 different combinations of medications during his time in prison. These changes were often considered and initiated at the man's request.

29. From 22 June 1998, the man was held at HMP Gartree where he completed two courses in relation to his offending behaviour. He also completed a detoxification and received counselling for issues relating to his childhood. In 2000, the man complained of back pain, which had started after a car accident years previously. He was assessed at outside hospital and given physiotherapy advice. He was also prescribed pain killing medication which he took for much of his time in prison. The man was given advice for both asthma and smoking cessation, issues which remained for the duration of his time in prison.

30. The man transferred to HMP The Verne on 23 January 2001 and onto HMP Shepton Mallet on 24 October 2002.

31. As he was a citizen of the USA convicted of a serious violent offence, for which he received a life sentence, the man was served with deportation papers in April 2003.

32. The man briefly moved to HMP Risley in early 2004 to attend an offending behaviour programme. However, while there, his mental health deteriorated as and it was assumed that he may have stopped taking his medication. He later told the parole board this was because he thought it would help him feel more alert to other course participants who he perceived to be aggressive. However, his mental health subsequently deteriorated and he lost weight. He was transferred back to Shepton Mallet where he was reassessed by the visiting psychiatrist as well as healthcare staff and the prison medical officer. Although the man started to take his medication on his return to Shepton Mallet, it took a few months for his condition to stabilise again.

33. In June 2004, an officer was assigned as the man's personal officer and remained so for the rest of his time at Shepton Mallet. The personal officer told the investigator that he felt the man had a good relationship with healthcare staff. The officer said that aside from his mental health issues, the man's main concern was maintaining contact with his parents in the USA. Due to his distance from his parents, the personal officer said at times the man felt lonely but as long as he had contact with them via the telephone he seemed to be able to cope. The personal officer said they had a good relationship whereby he felt the man could talk to him if he was having any problems.

34. The man had to serve a minimum tariff of six years before he could be considered for parole. Therefore, after this had been served, from 2004 onwards, enquiries were made as to the possibility of deportation with psychiatric care in the USA. However, due to the provisions available in the USA such care could not be guaranteed beyond 90 days and even then it would probably have been on a voluntary basis (the man could not be forced to attend under American law as his offences had been committed abroad). Transferring to the USA as a prisoner was also considered. However, a life sentence in the USA would mean the man would be in prison until he died. Therefore, he would not agree to this since there was a chance of release on licence if he remained in England. He was to be subject to a deportation order after his release with which he was willing to comply.

35. In August 2007, the Parole Board met to determine the man's eligibility for release or move to open conditions in a category D prison. He was not deemed suitable due to the ongoing risk issues which had yet to be fully addressed and the need to stabilise his mental health issues.

36. On 21 September 2007, a multi-disciplinary case conference involving a psychiatrist who regularly worked at the prison, Probation Officer, Mental Health Nurse and a Senior Officer, was held to discuss the man's sentence and

current mood. The man was frustrated as he felt his sentence was not progressing as he had hoped by either being moved to a lower category prison or being deported to USA. As part of his treatment regime he had also had a recent reduction in medication (throughout his time in custody his medication was reviewed and changed sometimes at the man's request) which had led to an increase in symptoms. As a result of these experiences, he started to express some thoughts of self-harm. Therefore, staff decided to start an Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support plan.

37. Medical staff also decided to increase his medication and contact staff at the US Embassy to see if they could assist the man in progressing his sentence by assisting with his repatriation. Following reviews, the ACCT plan was closed on 11 October, when the medical assessment identified that the risk of self-harm had lessened and the man had come to terms with his situation. The man had been referred to the gym and the medical record reflects that he seemed to feel "more settled in himself".

38. Wing history sheet entries from this period until July 2009, indicate that the man was mainly concerned with obtaining international telephone calls to his parents, his upcoming Parole Board and trying to obtain a visit to town[4] (this did not occur due to his possible deportation). He is described as complying with his sentence plan and maintaining employment. His personal officer noted that the man's behaviour was very good but, although he was self motivated and reliable, his medication sometimes meant he needed to be reminded of work as he became very tired and withdrawn. The Probation Officer also described the man's behaviour in the prison as good and from his knowledge of him over seven years there had never been any signs of aggression

39. On 7 July 2009, the man said he thought he was likely to be released after his Parole Board hearing which was to take place on 20 July 2009. The day after this Board met he said he felt stressed and did not think it had gone well.

40. The Board decided that he was not suitable for release on licence or transfer to open conditions. The Board wrote:

> "The panel therefore reaches the view, from their assessment of all available information and balancing your interests in sentence progression against the interests of public safety, that evidence is not yet present that your risk of violent offending has reduced to a level such that a direction or recommendation could be made to the Secretary of State for your progression from closed conditions."

[4] A prisoner is allowed out on a day release on a town visit to a place near the prison in the company of relatives, or friends. Such visits are only considered when a prisoner has reached a point in his sentence where is preparing for release back into the community.

41. In a letter dated 28 July, the Pre-Release Section of the Public Protection Unit of the National Offender Management Service (NOMS), informed the man that the Secretary of State agreed with the view of the Parole Board and considered the following risk factors were outstanding and required further work in closed conditions:

- Drug and alcohol abuse
- Use of violence
- Childhood experiences
- Minimisation and denial
- Anti-social behaviour and lifestyle
- Self identity

42. The Parole Board were unable to recommend re-categorisation towards his release due to his mental state, as his risk of harm remained at medium and a deportation order had been imposed. If deported, the Parole Board had no guarantees that psychiatric care and support could be given to prevent the man becoming a risk to the public. The situation therefore seemed irresolvable throughout the man's time in custody.

43. On 31 July, the man was upset by the decision of the Parole Board and he told staff that he had swallowed five bleach tablets the previous evening as he had felt "flat" and wanted the voices he was hearing to stop. He said he had not expected to wake up and was disappointed when he did. When asked if he wanted to die he said he wanted the voices in his head to stop and if he was dead they would leave him alone. As staff believed the man had taken the tablets, an ACCT plan was put in place and he was taken to hospital for treatment. The man returned to prison the same day.

44. As a result of concerns of the medical staff regarding his recent behaviour and following a consultation between the psychiatrist and healthcare staff, on 4 August the man was transferred to HMP Dorchester healthcare[5] to assess his mental health, confirmation of a diagnosis of paranoid schizophrenia (the patient has false beliefs (delusions) that somebody or some people are plotting against them or members of their family. They may also hear things that are not real (auditory hallucinations, and a possible referral to inpatient mental health services. Both the Community Mental Health Nurse and prison psychiatrist at Dorchester agreed with the diagnosis of paranoid schizophrenia. As a result, on 7 August, a referral was made to a psychiatric clinic.

45. The ACCT plan was reviewed regularly both at Shepton Mallet and Dorchester and the required level of observations and conversations were gradually reduced. The man returned to Shepton Mallet on 14 August while waiting for an inpatient assessment by the psychiatric clinic. He said he felt better and reported no feelings of self-harm or suicide. Following review the ACCT plan was closed on 17 August.

[5] HMP Shepton Mallet does not have an inpatient facility.

46. An ACCT post closure review took place on 23 August and coping strategies were discussed with the man. He was given extra airmail letters to write to his parents and he said he felt much more focussed now that he knew he would be sectioned (sent for treatment under the Mental Health Act) and was waiting for a place in a secure unit.

47. A Consultant Forensic Psychiatrist and Staff Nurse from the psychiatric clinic assessed the man on 22 September. On 21 October, the Healthcare Manager at Shepton Mallet was informed that the doctor recommended that the man be admitted to the clinic for assessment and treatment under the provision of Section 47 of the Mental Health Act. (Under Section 47 of the Mental Health Act, the Secretary of State for Justice can order the transfer, if satisfied by evidence from two doctors that (a) an offender has a mental disorder of a nature or degree that makes detention for medical treatment appropriate; and (b) appropriate medical treatment is available for him or her.)

48. On 9 October, having met with the man, a doctor recorded in the medical notes that he had been experiencing voices which were abusive and telling him to harm himself. However, he denied having suicidal intentions. On 29 October, he told staff that he felt low in mood and tearful at times but still denied any suicidal thoughts.

49. An entry on the wing history sheet on 3 November asks staff to be aware that the man's condition seemed to be deteriorating. On 11 November, an entry requested night patrol staff to observe the man during the night since he had not been sleeping well and to report their observations to healthcare. The medical record indicates that staff said he had a quiet night and was asleep when checked by wing staff.

50. On 17 December, the man was sectioned under Section 47 of the Mental Health Act for assessment and treatment and admitted to the psychiatric clinic. While at the clinic the man had psychiatric and psychological input as well as trying different combinations of medication. A nursing report in September 2010 states that the man had had a "significant period of stability in mental state" although he at times he had seemed overly anxious about his medication and had been prescribed antidepressants in August due to seeming low in mood. He had weekly psychology sessions and a report detailing these also stated that his mental state had significantly improved over time and he had taken his medication to "good effect".

51. Following his discharge from the clinic, he returned to Shepton Mallet on 18 November 2010. On his return, the prison doctor noted that the man "feels he has benefited from time there and has no active symptoms of illness that trouble him other than anxiety and occasional insomnia". The mental health nurse noted that on his return he was the "best I have ever seen him".

52. His personal officer also said that the man seemed "a different person, he really was. He was open, chatty, very bright, willing to interact".

53. However, the clinical reviewer writes that within weeks of his return to Shepton Mallet the voices the man heard had increased and he asked for a change in medication on 9 December. After discussion with the psychiatrist, it was agreed this would be changed to olanzapine (anti-psychotic medication). This occurred gradually and by early March 2011 he was being given the daily maximum amount. However, on 10 March, a nurse noted that,

> "his mood had deteriorated, increased auditory hallucinations [hearing voices] and feeling that people could read his thoughts. Feels he was best on clozapine [another anti-psychotic medication] and would like to restart this, and in meantime restart the depot whilst waiting to discuss with the psychiatrist."

54. The nurse told the clinical reviewer that during February and March there had been no lapse in his mental state but the derogatory voices had continued. She said the voices were not asking him to self-harm or harm others which was how they normally presented. On 11 March, the man's antipsychotic depot injections (depixol) were restarted whilst his prescription of olanzapine continued.

55. During this period in early 2011, the personal officer wrote monthly entries in the man's record indicating that his behaviour was very good, he was always polite and respectful and regularly attended the manufacturing workshop. He wrote in March that he "has been a little quiet of late, this could be down to medication". The personal officer told the investigator that he felt the man slowly got quieter after his return from the clinic and went "backwards" and became "withdrawn". However, he also explained that this was not out of the ordinary and he did not regard it as particularly significant since the man was a quiet individual anyway. The personal officer had no concerns regarding any risk of self-harm or suicide and was shocked by the man's death. The last time he saw the man was 27 March.

56. During the morning of 24 March 2011, the man was assessed by a nurse who made the following entry in the man's medical record:

> "Feels he is experiencing an increase in symptoms, hearing people laugh at him, voices are calling him names and trying to get him 'into trouble' as others can read his thoughts, so the voices call them rude names to make other people angry. He can see no evidence to support this concept, however feels it is real. He would like a move to a quieter wing to get away from the large amount of background noise he hears on B wing."

The nurse suggested that he visit A and C wings to establish whether he would be "happy" on either of these.

57. Since the man was from the USA he had annual meetings with a consul from the United States' embassy. These meetings were to check on his welfare and to ask if there were any issues he wanted addressed with the prison service. To this end, the man was visited by a Consul from the United States Embassy

on 24 March after he was seen by the nurse. Their meeting lasted around thirty minutes and the Consul describes the man as being "hopeful" and "optimistic" but also added that this was the first time she had met the man and therefore did not feel qualified to assess his mental state. The only assistance he required from the Consul was that she call his parents. The Consul said that the man "seemed to have a good relationship with the prison".

58. On the following day, the man submitted an application to move to another wing. He wrote: "I would like to move to A,C, D wing but in a single cell. I'm currently in a single cell on B wing, can I please be added to any list". It does not appear that a response was received before the man's death.

59. The prison General Practitioner (GP) had an appointment with the man on the same day. The doctor asked the man whether he had any thoughts of self-harm or harm to others, both of which he denied.

60. The prison psychiatrist told the clinical reviewer that throughout this time that the man:

> "was able to maintain insight and detachment from the voices, that he was working, and that there were no signs of distraction, poor sleep, answering back, poor concentration, self-neglect or disordered speech, any of which would have tended to indicate a deterioration of his paranoid schizophrenia. Thus his schizophrenia was well controlled and always fully medicated. He had also frequently been asked about suicidal ideation, which he had always denied."

The man had a review booked with the psychiatrist for 6 April 2011.

61. The clinical reviewer comments that:

> "He was assessed and supported by psychologists at intervals, and seen regularly in health care. Sometimes this seeing in health care was once or twice a week, and sometimes daily – for instance in June and July 2009, and also from November 2010 until April 2011 he was seen daily at medications and for other appointments, so a considerable amount of supporting and informal as well as formal monitoring and care was in place."

62. On 31 March, the man's solicitor visited him. The investigator contacted the solicitor on a number of occasions to request that she forward a statement detailing what was discussed at their meeting. The solicitor forwarded her statement to the Coroner after the draft report was issued for consultation. In her statement to the Coroner, the solicitor wrote that during her meeting with the man they discussed his forthcoming parole review. She said the man was content to proceed on the basis that they were asking for consideration of a move to open conditions whilst investigating further options in America. Towards the end of their meeting the man said that he was feeling unwell as he had a headache and the meeting was brought to a close. In her statement the solicitor wrote:

> "I do not believe there was anything unusual about the way the interview went or the way it ended. I had no particular concerns for the man's health or wellbeing and simply thought that he had a headache. I felt optimistic about his forthcoming parole review and felt that our meeting had been productive and positive. The man gave no indication during our meeting or at any other time that he intended to harm himself or take his own life. Had he done so I would have taken appropriate action. I was shocked and upset when I heard that the man had committed suicide. During our meeting he had said or done nothing that caused me to worry about his mental state and he was rational, co-operative and polite throughout."

63. The nurse who dispensed the man's medication to him on 1 April said he seemed quieter than usual. The nurse asked him how he was and the man said that he was "fine". She knew that the mental health nurse would be coming in the following day so she entered a "task" on the medical record to indicate that he was quieter than usual and that the mental health nurse should speak to him. However, the nurse had no concerns regarding self-harm or suicide and said that "it was fairly insignificant in the big picture of things with him. We have been through a heck of a lot worse with him".

64. When interviewed by my investigator, the mental health nurse confirmed that she saw the man on 2 April when he collected his daily medication. She asked how he was to which the man gave his usual response of "yeah, a bit alright". His presentation was unchanged. He gave her no cause for concern and she reminded him that he had an appointment with the psychiatrist on 6 April as he wanted to discuss his medication. The mental health nurse finished her shift at 12.30pm and did not see the man again.

65. When interviewed as part of this investigation, the US Consol that she had contacted the man's family on 1 April to update them about her visit the previous week. She had tried unsuccessfully to make contact on a number of occasions with his family earlier that week. The Consol said that the man had asked her to send his love to his parents and inform them that he "missed them very much". The Consol thought she also mentioned to them that the man seemed "quite positive" and he was hoping to see the psychiatrist and have a review of his medication.

66. The man called his mother that at 9.45am on 2 April. He did not make any comments which would have caused concern. He discussed his medication and asked if his mother could send him some money, clearly giving the impression he was making plans for the future.

67. Since 2 April was a Saturday, the man was locked in his cell at 5.30pm. A prisoner told the investigator he spoke to the man before he was locked in his cell and thought he "seemed alright". He said that he never thought he would take his own life and that the prisoner could not fault the prison officers who he believed were "outstanding".

68. Another prisoner told the investigator he had also spoken to the man that afternoon and had a cup of coffee in the man's cell. He said that the man said his day had been "fine" when asked. He was also looking to the future in discussing what he was going to do at work the following Monday. The prisoner says he left the man's cell at around 5.08pm. The prisoner said that he was concerned about the man in the week leading up to his death and whether the medication he was taking was having the desired effect. However, he was not sufficiently concerned to tell any member of staff which he said he would have done if he was worried for the man's safety.

69. At around 8.30pm on 2 April, two officers commenced their duty on the night shift at the prison. They received a verbal briefing from the Night Orderly Officer[6] on their arrival at the prison. According to the statement made to the police it was confirmed that the roll check was completed at 8.00pm (a check that all the prisoners were secure in their cells and there was nothing to report).

70. The officer who checked on the man told the police that when he looked through the flap of the man's cell door he could not recall what position he was in only that the man was awake and he shouted a greeting to him but did not wait to hear any reply.

71. At around 7.05am on 3 April, an officer started the morning roll count. At 7.10am when he arrived at the man's cell (B3-7) he pulled down the flap in the door and looked inside. The officer could see that the bed was empty and the covers were folded back. He thought that the man was using the toilet at the rear of the cell but soon realised that he had used a ligature attached to the bars on his window to hang himself. The officer immediately used his radio to call for assistance. The Night Orderly Officer heard this request and immediately made his way to B wing, requesting another officer to follow him as he passed him in the corridor. They then entered the cell[7].

72. One of the officers (an ex paramedic) noted that the man's skin was pale He said that he believed the man had been in the same position for some time and it was clear from his appearance he had died and so did not commence cardio pulmonary resuscitation (CPR)[8]. The Nigh Orderly Officer (who was first aid trained) agreed with this assessment. They requested an ambulance immediately via the control room. The two officers cut the ligature and lowered the man down slightly but he remained in a seated position. The clinical reviewer agrees that, "from this observation … I conclude that death had occurred some hours earlier".

73. An ambulance was called at 7.12am and the paramedics arrived on the wing at around 7.20am. After they examined the man they pronounced death at 7.25am. The IMB, police and chaplain were all informed. A prison doctor

[6] The Night Orderly Officer is the person in charge of the prison at night time.
[7] When entering a cell staff need to be aware of the possibility that the prisoner may be play acting and the risk of a possible hostage situation. It is therefore unusual for a member of staff to enter a cell by themselves.
[8] Cardio-pulmonary resuscitation (often described as mouth-to-mouth resuscitation) is a combination of rescue breaths and chest compressions to keep blood and oxygen circulating in the body.

confirmed death at 9.03am. The prison also telephoned the US Embassy at 10.20am to inform them of the man's death.

74. After the man died, the prison activated its death in custody contingency plan. As is common practice whenever there is a death in custody, the police visited Shepton Mallet and interviewed staff. They found no suspicious circumstances.

75. The prisoners were informed of the man's death during the morning of 3 April. They were also asked whether they required any support or wanted to speak to a Listener. All the prisoners who were subject to self-harm and suicide monitoring were reviewed. Both staff and prisoners were shocked that the man had apparently hanged himself. A nurse said that staff never considered it was something he would do and that prisoners who had spoken to him over the weekend said he seemed his usual self and were shocked by his death.

76. After a death, prison managers must hold a hot debrief. This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other. A hot debrief was held on 3 April at 5.00pm. There were no areas of concern raised at that time and the staff who had been on duty were offered support from the prison's care team.

77. A critical incident debrief took place on 13 April with the aim of understanding the incident further and to discuss the feelings of those involved.

78. Since the man's next of kin (his parents) lived in the USA, at the request of the US Embassy, they were initially telephoned by them, who broke the news of their son's death to them. As they wished to speak with someone from the prison, the Duty Governor called them that evening. A Senior Officer was then appointed as the prison's family liaison officer. She maintained contact with the family and helped with funeral arrangements. Shepton Mallet also offered financial assistance with the costs of the man's funeral. A memorial service took place at Shepton Mallet on 15 April which was well attended by staff and prisoners. The man's funeral took place on 27 April 2011 and the service was conducted by one of the prison chaplains. The man's ashes were later repatriated to his parents in the USA.

ISSUES

79. As mentioned earlier in the report, the man's family were contacted by the Ombudsman's family liaison officer. The family said they were contacted by staff from the US Embassy in London two days before the man died. They were told that when he had last been visited by staff from the Embassy he was "cheerful", was starting a new job and would be having a medication review which could have led to a re-admission to the psychiatric clinic. The family were concerned that his mental health deteriorated so quickly and wanted clarification about the events leading up to the death and the man's care whilst in custody. When interviewed as part of this investigation, the Consol from the US Embassy confirmed that she had last seen the man on 24 March and had no concerns about his mental health following her meeting. The Consol tried to contact the man's family following her visit but was unable to talk to someone until 1 April. It is not clear whether the family understood that the Consol had not seen the man for over a week. We hope that the sequence of events has been addressed within the main body of the report.

80. The man's family received a copy of the draft report and commented upon it. They felt strongly that improvements are needed at Shepton Mallet in the way mentally ill prisoners are cared for and that there was a need for staff to be trained to work with these prisoners. In addition, they felt there has been a breakdown in communication between prison officers and healthcare staff which may have impacted on the man's care and need for help. The family also expressed their thanks to the staff at Shepton Mallet for arranging the man's funeral, and the friends he made at Shepton Mallet.

Sentence progression

81. The man's sentence progression whilst he was in custody was a difficult issue to resolve. Due to being subject to a deportation order, mental health issues and the risk of harm he possibly presented, he was not able to progress to a lower category of prison or to be released into the community.

82. In order for the man to be deported, the Parole Board would in the first instance have to release him and this would be subject to his level of risk being assessed as low. There is no agreement with the USA where they would provide statutory supervision to prisoners sentenced to life imprisonment in the United Kingdom. The US authorities informed the Prison Service that they would offer the man 90 days voluntary support although there was no indication what provision would be made regarding medication. However, this arrangement was not acceptable to the Parole Board who considered that, without the guarantee of medication, they could not assess his risk as being sufficiently low to warrant his release.

83. With regard to the possibility of the man transferring to the USA prison system, it was also confirmed that if he did transfer, life would mean life. Understandably, the man was unwilling to agree to this option. There was also no possibility of him transferring to the USA through their mental health services. Although the man wanted to return to the USA, his mental health

issues, and the increased risk that he posed without medication, meant there was no appropriate mechanism for him to return. He was fully aware of the impasse that existed and we are sure this was a source of considerable frustration for him.

Medical care

84. The family also wanted to know more about the man's medical care. As noted, a review of the man's medical care was undertaken by a doctor on behalf of Somerset Primary Care Trust. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. In his review the clinical reviewer finds that the man's physical conditions "appear to have been cared for in a timely and professional manner".

85. From virtually the time the man was received into custody until he died, he was prescribed medication for his mental health and had a number of psychiatric assessments during this time. The clinical reviewer comments,

> "… as his illness developed, he was assessed and treated with the most appropriate agent at each point … The health care given to him by the nurses, doctors and other staff of the Health Care Team during his time in HMP Shepton Mallet was exemplary, according with the best standards of General Practice. Indeed, the care he received from the Nurse led and GP service, and access to continued Mental Health Nurse and Psychiatric Consultant care in HMP Shepton Mallet Health Care probably exceeds that possible in the community, not least because of the easy access to Health Care, the intensive follow up, and the fact that daily medication collection gives many opportunities for new illnesses to be assessed and monitored at an early stage."

The emergency response

86. The man was discovered hanging by an officer during their morning roll count. Within a few minutes of this discovery the officer had radioed for and received assistance, an ambulance had been called, a preliminary conclusion regarding the man's state had been made by officers and he had been partially cut down from his hanging position. The paramedics arrived ten minutes after the initial call for help and pronounced death five minutes later.

87. From both the paperwork and the investigator's interviews with staff it appears that all those involved acted quickly but in a professional and considerate manner. We agree with the clinical reviewer's comment that: "The attention given to him by prison staff on April 3rd 2011 was professional and timely. Tragically, he had already been dead for some considerable time when discovered".

88. Furthermore the clinical reviewer concludes: "In particular, I wish to comment that I can find no areas of concern in any aspect of his care, and particularly would commend the high level of nursing and medical attention and expertise

that was given in HMP Shepton Mallet during his stay and last illness." We concur with the clinical reviewer and commend both the healthcare and discipline staff involved in the care of the man.

Assessment, Care in Custody and Teamwork

89. The ACCT suicide and self-harm monitoring arrangements were put in place on two occasions during the man's time in custody. Firstly, in September 2007, he expressed thoughts of self-harm following frustration that his sentence did not seem to be progressing and a decrease in his medication. Secondly, following a Parole Board in July 2009, which again had not decided he was not ready for release or a move to a category D prison, he said he had swallowed five bleach tablets and he was disappointed to have survived.

90. Within less than a month of being opened, both ACCT plans were closed and the appropriate post-closure reviews took place. It is our opinion that the ACCT procedure was used effectively, within a multi-disciplinary setting, with sensible levels of observations and conversations and reasoned assessments regarding reviews and closure. The last ACCT plan was closed nearly two years before the man died.

91. After this the man's mental health deteriorated, leading to him being transferred to the psychiatric clinic under the provisions of the Mental Health Act. However, having undergone psychological and psychiatric treatment for nearly a year there, he was discharged and returned to Shepton Mallet in November 2010.

92. Whilst he continued to work, be polite and was no management problem, he experienced an increase in the voices he heard. However, at this time, he received daily input from the medical team and his medication was reviewed appropriately. He gave no cause for concern with regards to self-harm or suicide. All those who knew him, prisoners and staff included were shocked and surprised that he apparently took his own life.

93. The clinical reviewer concludes:

> "My interviews with health professionals and prison officers have all confirmed that the man's death came as a complete surprise to all, and that there had been no alerting signs that has raised any concerns at all out of the ordinary. Death by suicide is not an uncommon ending of a long-term schizophrenic illness, sometimes in an unpredictable and therefore unpreventable way. It appears that a combination of this illness, despite help and treatment from many health professionals, and some adverse circumstances with no way forward to release, may have induced in the man a fleeting feeling of futility. In this state, just as he self-harmed unpredictably in July 2009, he again self-harmed only using another method in the early hours of April 3rd 2011, this time with tragic outcome … I am satisfied that appropriate risk assessments regarding self-harm and suicidal intent have been carried out and documented on appropriate and relevant occasions."

CONCLUSION

94. In December 2009, the man was sectioned under the Mental Health Act and admitted to the psychiatric clinic. After his discharge from the clinic in November 2010 he returned to HMP Shepton Mallet. On his return to Shepton Mallet it appeared that his mental health initially had improved. However, within weeks of his return his mental health deteriorated but not to the extent where he needed to be readmitted to the psychiatric clinic. It was discovered, during the morning of 3 April 2011, that the man had used a ligature to take his own life. Attempts to resuscitate were not carried out as it appeared that he had been dead for some time.

95. Due to the nature of his offence, his mental health needs and his foreign national status the man's sentence progression was very problematic. He was unable to be released in the United Kingdom as he was subject to deportation due to the seriousness of his offence. However, as it was not clear that the necessary mental health support would be available after he was deported the Parole Board were unable to recommend his release or re-categorisation. This was a very unfortunate position to which there did not seem to be a response unless the man's mental health problems ceased to exist or any legal dispensation could have been granted. It is not clear if this was an avenue being pursued by his legal representative.

96. In his review, the clinical reviewer concludes: "I do not believe that his death was either foreseeable or preventable, and in my opinion he had a high level of health care throughout his stay in the Prison System". We concur with the clinical reviewer's view that the man received a high level of case whilst he was in custody.

97. We make no recommendations.