

**Prisons &  
Probation**

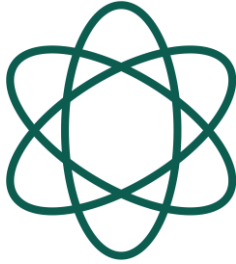
**Ombudsman**  
Independent Investigations

**Independent investigation into  
the death of Mr Andrew Shirley,  
a prisoner at HMP Hewell,  
on 23 March 2021**



## Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



## Our values

**We are:**

**Impartial:** we do not take sides

**Respectful:** we are considerate and courteous

**Inclusive:** we value diversity

**Dedicated:** we are determined and focused

**Fair:** we are honest and act with integrity

**OGI**

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Andrew Shirley died on 23 March 2021 at HMP Hewell from hanging. He was 25 years old. I offer my condolences to Mr Shirley's family and friends.

This is a worrying case.

Mr Shirley had only been at Hewell for three weeks before he took his life in the segregation unit. He suffered from paranoid schizophrenia for which he received medication. After arriving at Hewell, he repeatedly complained that his medication was no longer working for him. Despite his repeated requests for review of his medication, this did not happen before he died.

I am very concerned about the standard of mental health care Mr Shirley received. Not for the first time, a clinical reviewer has concluded that the standard of mental health care at Hewell fell below that expected, including a failure by health staff to assess Mr Shirley's needs based on all available information about him.

In addition, information about Mr Shirley's possible risk of suicide was either ignored or not taken into account, so staff did not start suicide and self-harm procedures.

I am also concerned that Mr Shirley was segregated despite telling a nurse that he was hearing voices that told him to kill himself, and that he then spent long hours in his cell with nothing to distract him. I am especially concerned that a segregation board decided that Mr Shirley should remain segregated precisely because his mental health was poor. Segregation units are not suitable environments for prisoners with serious mental health issues.

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

**Kimberley Bingham**  
**Acting Prisons and Probation Ombudsman**

**December 2022**

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# Summary

## Events

1. On 1 March 2021, Mr Andrew Shirley was remanded to HMP Hewell charged with assaulting two police officers. He had a history of paranoid schizophrenia and substance misuse and had spent previous periods in prison and in psychiatric units.
2. A mental health nurse completed an initial health assessment when Mr Shirley arrived at Hewell. She noted that Mr Shirley was pleasant and appropriate in mood and behaviour and denied having any present thoughts of suicide or self-harm. She made a standard referral to the mental health team because Mr Shirley had paranoid schizophrenia for which he was receiving medication.
3. A prison GP saw Mr Shirley immediately after the nurse. Mr Shirley said that he did not think his antipsychotic medication was working as it was not controlling his symptoms. He denied thoughts of suicide or self-harm. The GP noted Mr Shirley's speech was pressured and he was unable to sit still. He made an urgent referral to the mental health team for assessment within 48 hours and prescribed a five-day alcohol detoxification programme.
4. Mr Shirley should have been discussed at the weekly complex healthcare case meeting on 10 March, but this did not happen. When he was discussed at the next meeting on 17 March, he was given only a routine appointment for review by a psychiatrist although there were indications that he should have had a more urgent review.
5. On 20 March, Mr Shirley was moved to the segregation unit for spitting at officers and obstructing them in their duties. At a segregation review board on 22 March, it was noted that segregation was thought to be the safest place for Mr Shirley due to his poor mental health.
6. At about 7.00pm on 23 March, an officer went to check Mr Shirley after the prisoner in the next cell raised concerns about him. She saw Mr Shirley lying below his wash basin with something tied to the basin tap. She went to the office to ask for help from colleagues before going into the cell. Staff removed the ligature from Mr Shirley's neck and started efforts to resuscitate him. Ambulance paramedics arrived at 7.17pm but at 7.44pm they confirmed that Mr Shirley had died.

## Findings

7. The clinical reviewer concluded that Mr Shirley's healthcare at Hewell was not of the required standard and was not equivalent to that which he could have expected to receive in the community.
8. She found many separate instances of sub-optimal care, including a failure to deal adequately with his repeated concerns that his medication was no longer proving effective, and a failure to read, consider and share important information received from community providers.
9. Mr Shirley had a number of factors to suggest he might be at risk of suicide or self-harm. This included his mental health issues, his repeated comments that his antipsychotic medicine was no longer working, and saying that he was hearing

voices telling him to kill himself. Despite this, staff did not consider starting ACCT procedures.

10. We are very concerned that Mr Shirley was segregated despite saying he was hearing voices telling him to kill himself. In addition, he was not managed in line with national requirements for prisoners held in segregation. He did not have a designated officer and there is no evidence that staff had meaningful contact with him. He also appears to have received little or nothing by way of distraction material.
11. There was a brief delay in entering Mr Shirley's cell when he was seen apparently hanging. We cannot say whether the delay affected the outcome for Mr Shirley, but it is important that staff respond to medical emergencies correctly and without delay, subject to an appropriate risk assessment.
12. Some staff reported that they received insufficient support after Mr Shirley's death.

## Recommendations

- The Head of Healthcare should ensure that a robust process is put in place for the review of prisoners' community records.
- The Head of Healthcare should ensure that staff upload clinical assessments to SystmOne on the day they complete their assessment.
- The Head of Healthcare should ensure that MPCCC meetings receive a full presentation of each prisoners' clinical needs.
- The Head of Healthcare should ensure that prisoners with relevant long-term medical and mental health conditions are placed on the appropriate care pathways.
- The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all information about risk, and start ACCT procedures where appropriate.
- The Head of Healthcare should share a copy of this report with Nurse A and arrange for her clinical supervisor to discuss the Ombudsman's findings with her.
- The Governor and Head of Healthcare should ensure that all staff who have prisoner contact receive ACCT training in accordance with national instructions.
- The Governor and Head of Healthcare should ensure that staff manage prisoners held in the segregation unit in line with national guidelines, including that:
  - managers who authorise prisoners' segregation do so only after they have seen the health screen assessment algorithm and have spoken to relevant staff;
  - nurses who complete health screen assessment algorithms have received mental health awareness training;
  - the designated officer has purposeful conversations each day with his or her allocated prisoners; and

- a minimum of three quality entries are recorded each day for each prisoner.
- The Governor should ensure that segregated prisoners are provided with radios and other appropriate distraction material as a matter of urgency.
- The Governor should ensure that all prison staff are made aware of, and understand their responsibilities during medical emergencies, including that staff:
  - understand and use the appropriate emergency code when they discover a medical emergency;
  - enter cells as quickly as possible in life-threatening situations where it is safe to do so.
- The Governor and Head of Healthcare should ensure that staff receive appropriate support following a death in custody.

## The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Shirley's prison and medical records. She also obtained CCTV of the segregation unit between 20 and 23 March; body-worn camera footage from 20 March; recordings of Mr Shirley's last 10 prison telephone calls (made between 16 and 19 March); and recordings of prison radio transmissions from 23 March. The investigator interviewed 17 members of staff between June and August 2021. Due to the COVID-19 pandemic the interviews were conducted by video-link and telephone.
15. NHS England commissioned an independent clinical reviewer to review Mr Shirley's clinical care at the prison. The investigator and clinical reviewer jointly interviewed clinical staff.
16. We informed HM Coroner for Worcestershire of the investigation. The Coroner gave us Mr Shirley's post-mortem report. We have sent the Coroner a copy of this report.
17. The PPO's family liaison officer contacted Mr Shirley's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Shirley's mother asked:
  - When Mr Shirley arrived at Hewell, did healthcare staff review his community GP record, his medication and his history of suicide attempts?
  - Was he told what length of sentence to expect?
  - How long was he locked up for under COVID-19 restrictions?
  - Was he being seen by the mental health in-reach team?
  - Was he taking medication for his mental health problems?
  - Why was he in the segregation unit, given his mental health problems?
  - Did he have a key worker?
  - Was he subject to use of force?
  - Did he self-harm in prison?
  - Is there any evidence that he was being bullied?
  - Did he receive the letter she sent him after 6 March?
  - Who did he speak to on the telephone on 16 March?
18. We have answered these questions in the body of this report and in separate correspondence. We have sent Mr Shirley's mother a copy of this report.
19. We shared our initial report with the interested parties. HM Prison and Probation Service (HMPPS) asked that our report should reflect that we did not establish whether the officer who discovered Mr Shirley hanging, made a dynamic risk assessment on whether she should have gone into the cell immediately nor did we establish why she did not radio a code blue emergency. We have amended our report to reflect this and have amended our linked recommendation. We have annexed the HMPPS action plan to this report.

## Background Information

### HMP Hewell

20. HMP Hewell in Worcestershire consists of a Category B local prison holding around 870 adult male prisoners on remand or serving short sentences, and a separate open prison holding around 200 prisoners. Physical healthcare is provided by Practice Plus Group (formerly Care UK). The Midlands Partnership Mental Health Trust delivers mental health and substance misuse services via the integrated Inclusion team.
21. In February 2020, Hewell was identified as one of six prisons in need of special support to bring stability and reduce violence and self-harm under the Prison Performance Support Programme (PPSP – formerly known as ‘special measures’). As part of the initiative the prison will receive additional staff, enhanced standards training from a Standards Coaching Team and airport-style security.

### HM Inspectorate of Prisons (HMIP)

22. The most recent full inspection of Hewell was in June 2019. Inspectors found that the number of prisoners segregated on the closed site was much lower than at the previous inspection, but that the quality and cleanliness of cells and communal areas in the segregation unit remained extremely poor and the regime was too limited. Segregation unit staff were often overwhelmed by balancing the needs of the prisoners and the large number of adjudications they dealt with.
23. Since the last inspection there had been four drug-related deaths, two self-inflicted deaths and one manslaughter on the closed site and self-harm had almost doubled. PPO recommendations following deaths in custody had not been fully implemented and oversight of their progress was inadequate.
24. Health services had improved overall but further improvements were needed. A well-led and skilled primary care team delivered good care within a challenging environment. Staffing in the integrated mental health and psychosocial substance use teams had increased recently, and the introduction of a duty professional role had reduced waiting times for patients. Some prisoners awaiting transfer to a secure mental health hospital were held in the segregation unit due to behavioural problems, and inspectors said this was not an appropriate environment for prisoners with severe mental health problems.
25. HMIP also carried out a Scrutiny Visit (a shortened inspection during the COVID-19 pandemic) in August 2020. Inspectors found that Hewell had taken prompt action to manage the effects of the COVID-19 virus but, five months on, there had been little progress in ensuring that prisoners had sufficient time out of cell or purposeful activity. This contributed to a feeling of frustration among prisoners who were found to have a high level of complex needs, with more than two thirds of prisoners identified as having mental health concerns. Inspectors reported that the segregation unit was clean and bright with friendly and approachable staff and prisoners were generally positive about their treatment there.

## **Independent Monitoring Board**

26. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 30 September 2020, the IMB was concerned that the measures put in place to keep prisoners as safe as possible from infection, had seriously damaged prisoners' broader welfare, rehabilitation and mental health. They were also concerned that a small number of vulnerable and mentally ill prisoners were often accommodated in the segregation unit because of the lack of an appropriate alternative.

## **Previous deaths at HMP Hewell**

27. Mr Shirley was the tenth prisoner to die at Hewell since March 2019. Of the previous deaths, four were self-inflicted deaths and five were from natural causes.
28. In one of our previous investigations into the death of a prisoner at Hewell in March 2019, we found that healthcare staff did not review all of the prisoner's reception records. We recommended that the Head of Healthcare should ensure that medical records were always accessed, along with any other evidence that arrives with a prisoner during the reception process. The prison accepted our recommendation and said that all healthcare reception staff would be reminded of their responsibility to access all available information when a prisoner arrives at reception.
29. In an investigation into the death of a prisoner at Hewell in July 2019, we found failings in mental health provision. We recommended that the Head of Healthcare and the Mental Health Team manager should review the system for receiving and actioning referrals to the mental health team to ensure they are processed appropriately. The prison accepted our recommendation and said that since December 2019, all referrals are reviewed, processed and actioned by an appropriate clinician with inclusion for discussion at the daily management meeting.
30. In another investigation into the death of a prisoner at Hewell in February 2021, we found there was a delay in the emergency response. We recommended that the Governor should remind staff of the medical emergency response protocol and ensure they were clear where codes were appropriate and should be used immediately. The prison accepted our recommendation and said that a staff notice reminding staff of the medical emergency protocol was re-issued in August 2021 and would be re-issued every six months, or when the instruction changes. Also, staff were reminded during briefings, of the importance of calling clear and appropriate medical emergency response codes as soon as an incident is discovered.

## **Segregation units**

31. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings.

32. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and have a daily period in the open air. A manager, a member of the chaplaincy team and a member of the healthcare team should visit the segregation unit daily and speak to each segregated prisoner to check their welfare. A doctor should visit at least every three days and a registered nurse on the other days to assess the physical, emotional and mental wellbeing of the prisoners and whether there are any apparent clinical reasons to advise against continuing segregation.
33. Segregation is authorised by an operational manager at the prison who must be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff.
34. The unit at Hewell is known as the Care and Separation Unit (CSU) and comprises 25 cells.

### **Assessment, Care in Custody and Teamwork (ACCT)**

35. ACCT is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

### **Multi-Professional Complex Case Clinic (MPCCC)**

36. The MPCCC meeting is a weekly multidisciplinary meeting where custodial and healthcare staff come together to discuss and plan care for prisoners with complex needs.

### **Targeted Care Pathway (TCP)**

37. The TCP is a pilot run by Midland Partnership Foundation Trust and Practice Plus Group following the closure of the mental health inpatient unit at Hewell in 2020. The pilot delivers an enhanced service to prisoners who require targeted care due to acute episodes of mental ill health and includes daily input by mental health nurses in addition to the Care Coordinator role.

### **Liaison and Diversion (L&D) Services**

38. Liaison and Diversion services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. The service can refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required.

## Key Events

39. Mr Andrew Shirley had a history of substance misuse, serious mental illness and attempted suicide and self-harm. He had paranoid schizophrenia, was under the care of community mental health services and had been admitted to mental health facilities on a number of occasions. Mr Shirley was prescribed paliperidone (an antipsychotic) and received this by monthly depot injection (which slowly releases medication into the body over a number of weeks).
40. Mr Shirley served three sentences in young offender institutions as a teenager. In 2016-2017 he spent around three months in Hewell and was briefly managed under prison service suicide and self-harm monitoring procedures (known as ACCT) because he felt suicidal. In 2017, he reported attempting to hang himself.

### Police and court custody 28 February to 1 March 2021

41. On 28 February 2021, Mr Shirley was arrested for stealing two cans of lager and throwing them at a police car. Police records indicated that Mr Shirley underwent a psychiatric assessment at the Caludon Centre (a mental health facility) under the Mental Health Act 1983. We have not seen a record of this assessment and do not know exactly when it took place. While at the Caludon Centre, Mr Shirley punched a police officer and was charged with assault. The assessment concluded that Mr Shirley did not need to be detained under the Mental Health Act and was fit to be detained in police custody. He was taken back into police custody the same day. Mr Shirley told police that he had suicidal thoughts and would harm himself. He was allocated a cell with a camera and checked every 30 minutes.
42. A nurse from the Liaison and Diversion (L&D) services assessed Mr Shirley the next morning, 1 March. Mr Shirley told the nurse that he felt he was “going mad” and that people were following him everywhere and “coming for him”. He said he felt like harming himself to make the feelings stop. Mr Shirley said the feelings had been getting worse and he did not think his medication was helping. The nurse noted that Mr Shirley’s speech pattern was pressured and he appeared agitated and anxious with delusional beliefs. The nurse also noted that he intended to arrange an assessment under the Mental Health Act but Mr Shirley was taken to court before he could do so.

### HMP Hewell

43. From court Mr Shirley was remanded into prison custody and he arrived at Hewell at about 4.00pm on 1 March. The paper version of his Person Escort Record (PER) that accompanied him from police custody to court and then to the prison, showed that Mr Shirley said he often felt like killing himself. The medical section said he had attention deficit hyperactivity disorder (ADHD), anxiety and paranoia. The electronic version of the PER was printed and stapled to the front of the paper PER. The suicide and self-harm warning section of the electronic version said that Mr Shirley said that he had suicidal thoughts and intended to attempt suicide or to harm himself.
44. Nurse A, a mental health nurse, completed an initial health assessment. She noted that Mr Shirley was pleasant and appropriate in mood and behaviour. She also

noted that he firmly denied having any current thoughts of suicide or self-harm. At interview, Nurse A said she could not remember the suicide and self-harm information in the electronic PER, however her records show she had read and recorded the information. She said she could not have been concerned about Mr Shirley's risk of harming himself, otherwise she would have started ACCT procedures. She made a standard referral to the mental health team because Mr Shirley had paranoid schizophrenia and was receiving a depot injection.

45. A prison GP saw Mr Shirley immediately after Nurse A. Mr Shirley said that he had paranoid schizophrenia and received a monthly depot injection of paliperidone, but he did not think the paliperidone was working. Mr Shirley said he usually drank about eight cans of alcohol a day and felt nauseous and shaky after not having had any in police custody. He denied thoughts of suicide or self-harm. The GP noted Mr Shirley's speech was pressured and he was unable to sit still. He made an urgent referral to the mental health team for assessment within 48 hours and prescribed a five-day alcohol detoxification programme.
46. Mr Shirley spent the first night in an observation cell on the detoxification landing and was checked hourly. The next day he moved to a single cell on Houseblock 3 (where newly arrived prisoners spent their first two weeks in quarantine from the general prison population as part of Prison Service measures during the COVID-19 pandemic).
47. On 2 March, Mr Shirley's community GP summary was received at Hewell and scanned into his clinical record. The summary showed that Mr Shirley had threatened to jump in front of a train in October 2020 and had taken a deliberate overdose of pain medication in November 2020. We have seen no evidence that anyone at Hewell read this summary.
48. A nurse from the substance misuse team completed a substance misuse assessment the same day. Mr Shirley said he had used drugs in the past, but his current issue was alcohol misuse. He said he wanted to work with the substance misuse team in prison and accepted a hepatitis B vaccination. Mr Shirley was prescribed a 28 day course of thiamine (vitamin B1 supplement, used in the treatment of alcoholism).
49. On the afternoon of 3 March, Nurse B met Mr Shirley for an urgent mental health assessment. At 4.00pm, she recorded on his clinical record that although she had completed the assessment on paper, she had not had time to add it to his electronic record. Nurse B explained at interview that she worked part-time, that this was her last day in work that week and she had run out of time to add the notes before leaving the prison.
50. At 4.58pm, the nurse from the L&D service emailed healthcare at Hewell with his record of contact with Mr Shirley. He gave contact details of Mr Shirley's community mental health team with a view to the prison obtaining his treatment plan. A healthcare administrator scanned the information from the L&D nurse onto Mr Shirley's clinical record the next morning, 4 March. She also forwarded the nurse's email to the mental health nurse who had been allocated as Mr Shirley's care co-ordinator. (Prisoners receiving secondary mental health care are allocated a care co-ordinator to cover the role of their community psychiatric nurse.)

51. We have not seen any evidence that anyone at Hewell read the information from the L&D nurse or contacted Mr Shirley's community mental health team for details of his treatment plan. The nurse who was Mr Shirley's care co-ordinator left her job at the prison on 5 March.
52. Nurse B's next day in work was 7 March, when she added the notes from her assessment on 3 March to Mr Shirley's clinical record. Nurse B noted that Mr Shirley had been delusional, agitated and could not sit still. His speech was pressured and loud and he seemed "manic". He told her he was being followed, that people from the future were coming to get him, that people were putting thoughts into his mind, and that he was having trouble sleeping. He said that although he had had thoughts of self-harm, he had not acted on those thoughts.
53. Nurse B told the investigator that Mr Shirley should have been discussed at the next Multi-Professional Complex Case Clinic (MPCCC) meeting, on 10 March 2021, and that he was to be reviewed by the visiting psychiatrist. She said that Mr Shirley's care co-ordinator would be responsible for gathering the information for discussion at the MPCCC.
54. On 8 March, the mental health team manager allocated Nurse A as Mr Shirley's new care co-ordinator.
55. On 9 March, Nurse A and another nurse gave Mr Shirley his depot injection. The nurse said Mr Shirley appeared settled in mood.
56. Mr Shirley was not discussed at the MPCCC on 10 March as planned, but we do not know why.

## **15 to 18 March**

57. On 15 March, Mr Shirley completed his two weeks' quarantine on Houseblock 3 and moved to a single cell on Houseblock 6.
58. On 16 March, Nurse A saw Mr Shirley for the first time since becoming his care-co-ordinator at a well-being appointment. Mr Shirley described his mood as 2 out of 10 that day and 5 out of 10 on average. He said his depot medication was not "holding him" and he could hear his thoughts. He said he was not sleeping or eating well and asked for medication to help him sleep.
59. Nurse A told the investigator she planned to discuss Mr Shirley at the next MPCCC meeting set for 17 March and to ask the psychiatrist to review his depot injection. She said at interview that she did not read Nurse B's assessment or the information sent into the prison by the L&D nurse. She also acknowledged that she did not complete a care plan for Mr Shirley as she should have done.
60. Mr Shirley was discussed at the MPCCC on 17 March. The minutes showed Mr Shirley had reported that his depot injection was not controlling his symptoms and he could hear his own thoughts. It was agreed that Nurse A would monitor Mr Shirley and he should have a routine appointment with the psychiatrist (a routine appointment meant he would see the psychiatrist in approximately four weeks' time.)

61. On 18 March, a prison GP prescribed three days of promethazine hydrochloride (an antihistamine that causes drowsiness) to help Mr Shirley sleep.

## 19 March

62. The investigator listened to Mr Shirley's last ten telephone calls which he made between the afternoon of 16 March and the late morning of 19 March (when he ran out of telephone credit). The calls were made to two male friends and one female friend. During the calls Mr Shirley spoke about his medication. He said he could not sleep properly, was having nightmares, and he needed sleeping tablets. He subsequently confirmed that he had been given tablets. He said he had been on the same depot medication for four years and he thought it had stopped working as his mental health was deteriorating and he was feeling paranoid. He wanted antipsychotic medication and antidepressants.
63. Mr Shirley said that when he got depressed he felt like killing himself when he was on his own, but then the thoughts would go. He also said that he was happy when he was on the telephone, but when he was on his own he started to dwell on his situation. Mr Shirley also said that he was worried that the mother of his unborn child would turn the child against him. Mr Shirley said he thought he was likely to be sentenced to 18 months in prison and spoke about doing English and Maths and getting a wing job.
64. The investigator noted variations in Mr Shirley's speech. Sometimes he sounded subdued, but at other times his speech was loud and fast with a lot of laughter.
65. An officer told the investigator that Friday was the day prisoners received their prison shop orders (known as canteen). She said that Mr Shirley pressed his cell bell many times during the afternoon of Friday 19 March to ask if his canteen had arrived. Mr Shirley was anxious because his canteen would be sent to Houseblock 3 as that was where he had been living when he submitted his order. The officer said she explained to Mr Shirley that she would try to get his canteen for him, but he might have to wait until the weekend when staff had more time. The officer said Mr Shirley appeared to understand what she was saying to him, but then they would have the same conversation the next time she answered his cell bell.
66. A Supervising Officer (SO) made an entry in Mr Shirley's electronic prison record (known as NOMIS) to say that he had repeatedly pressed his cell bell that afternoon and had been warned that the cell bell should only be used for emergencies. The SO issued Mr Shirley with a negative behaviour warning for repeatedly misusing his cell bell.
67. The SO made another entry to say that he went to speak to Mr Shirley when an officer reported that Mr Shirley had threatened to harm an officer when unlocked. The SO told the investigator that he recognised Mr Shirley from his previous time in Hewell. He said that Mr Shirley's presentation was very different this time. He said Mr Shirley was standing too close to him which he thought was due to poor mental health. In his NOMIS entry the SO added that Mr Shirley asked to move to Houseblock 1 as he believed other prisoners had tampered with his food. The SO told the investigator that if he was concerned about a prisoner's mental health, he usually asked an officer to make a referral to the mental health team, but he could not recall doing this for Mr Shirley. (We have seen no evidence of such a referral.)

## Saturday 20 March 2021

68. At about 10.00am on 20 March, an officer answered Mr Shirley's cell bell. Mr Shirley asked her again whether his canteen order had arrived. The officer said she told Mr Shirley she would try to find out where it was and he then prevented her from closing the cell door by putting his hand in the way. The officer asked him to move back into the cell, but Mr Shirley stayed where he was and again prevented her from closing the door. The officer said she pushed Mr Shirley back using minimum force and closed the door. She put Mr Shirley on report on a charge of breaking prison rules by disobeying a direct order. This meant he would remain in his cell until being taken to the segregation unit for a prison disciplinary hearing (known as an adjudication).
69. At about 11.40am, two officers took Mr Shirley his lunch. One officer wrote in a report that Mr Shirley spat in her face. The officer wrote that she pushed Mr Shirley towards his bed but he spat at the other officer so she pushed him again towards the back of the cell. She wrote that she struck Mr Shirley in the face for personal protection and pressed the personal alarm on her radio. A SO and another officer responded. They restrained Mr Shirley and placed him in handcuffs before returning him into his cell where the handcuffs were removed.
70. The investigator viewed an officer's body-worn camera footage of the incident. The recording started after Mr Shirley had spat at the officer. Mr Shirley told her she was a "corrupt little bitch" and she told him to "fuck off". Other staff used control and restraint techniques to place Mr Shirley face down on the floor and apply handcuffs. The officer then walked to the servery and turned her camera off. The rest of the control and restraint is not on camera.
71. Soon afterwards, a Custodial Manager (CM) and an officer escorted Mr Shirley to the segregation unit where he arrived at 12.33pm. Mr Shirley was compliant and allowed staff to handcuff him during the move.
72. Nurse C was called to the segregation unit to complete Mr Shirley's segregation safety algorithm (a snapshot assessment of a prisoner's physical, emotional and mental well-being to decide whether it is safe to segregate them). Nurse C told the investigator that before she went to see Mr Shirley she read his clinical record and rang Nurse A to ask if there was anything she should be aware of. Nurse A told her that Mr Shirley heard voices but that she had no particular concerns about him.
73. Nurse C noted that Mr Shirley had a one centimetre long red mark on the right side of his face but he said he had no other injuries and he refused to let her examine him. Mr Shirley said that he was hearing voices telling him to kill himself and he wanted a radio to drown out the voices. He also said his medication was not working.
74. Nurse C said she asked Mr Shirley two or three times if he was going to harm himself in any way and he said he would not. In answer to questions on the safety algorithm on whether Mr Shirley would be able to cope with a period in segregation, Nurse C noted that he would be able to cope and was fit to be segregated. In answer to a question on whether Mr Shirley was within four weeks of the start of detoxification/stabilisation, Nurse C (incorrectly) answered this was not the case. Nurse C told the investigator that she was a general nurse and started working at

Hewell in January 2021. At the time of her interview she had not received ACCT or mental health awareness training.

75. An operational manager signed the segregation unit paperwork to authorise Mr Shirley's segregation pending an adjudication on Monday 22 March. He noted that he completed his authorisation without having read Nurse C's segregation health screen, and the papers also indicate that his authorisation preceded the nurse's assessment.

## 22 March 2021

76. At a routine segregation visit on the morning of 22 March, Mr Shirley was seen by a prison GP. Mr Shirley again asked for a change in medication and the GP told him that the mental health team would follow this up.
77. Shortly afterwards, Mr Shirley spoke to a nurse who was seeing the prisoner in the next cell. He asked her to tell Nurse A that his medication was not working and that he wanted sleeping tablets. She sent Nurse A a task on SystemOne (a message on the electronic medical record).
78. Mr Shirley also asked the nurse for a book to read and she told an officer. The officer and other officers spoke to Mr Shirley at different times that day but we could not identify from CCTV whether Mr Shirley received a book or a distraction pack in response to his request. The officer said there was usually a plentiful supply of distraction packs provided by the mental health team and the chaplaincy. Segregation staff told the investigator that there had not been any radios in the segregation unit for some time. They said that the segregation unit cells did not have power sockets and, although there had once been a supply of wind-up radios, these had been damaged and then not replaced.
79. Later that morning, Mr Shirley attended separate adjudication hearings to consider the charges that he had refused to obey an officer's order to stand back so she could close his cell door and had later spat at another officer. In a houseblock conduct report, an officer wrote that Mr Shirley had displayed a poor attitude and had made a lot of demands using his mental health as a reason for this. In both cases, the adjudicating governors adjourned the hearings for seven days to allow Mr Shirley to obtain legal advice.
80. At 11.15am, an operational manager chaired a review board to consider Mr Shirley's ongoing segregation. A SO told the investigator that she attended the board and that Mr Shirley spoke about hearing voices and that he seemed genuine in what he was saying. The records of the review showed that Mr Shirley appeared confused, that he believed people were conspiring against him, and that he said he did not think his medication was working. They also record that although Mr Shirley was paranoid about his future and a bit depressed, he said he was not going to kill himself. The manager authorised Mr Shirley's continued segregation, writing that he was *"currently demonstrating poor mental health and mental health team deem this to be the safest place at this time"*.
81. A nurse also attended the segregation review. He said that Mr Shirley spoke rapidly and had racing thoughts. He asked for his medication to be reviewed and the nurse agreed they would do so. The nurse told the investigator that he thought

Mr Shirley should be discussed at the MPCCC meeting (the next meeting was set for 24 March).

82. A prison paramedic completed another segregation safety algorithm in which she made two errors: she recorded that Mr Shirley was not taking anti-psychotic medication and that he was not within a four week period of starting a detoxification/stabilisation programme. The prison paramedic told the investigator that she started working at Hewell in December 2020 and at the time of the interview she had not received ACCT training, mental health awareness or any other training in identifying risk. She said that as a paramedic, she was used to accepting what patients said at face value.
83. The mental health team manager told the clinical reviewer that at that time the mental health team contract did not include completing segregation safety algorithms so general nurses were completing them.
84. The segregation monitoring form completed by a member of the Independent Monitoring Board (IMB) showed that four other prisoners were also reviewed that day. Of these, three had mental health issues: one was waiting for a transfer to a secure mental hospital, one was being kept on the segregation unit because his mental health was deemed too poor for location on a standard wing, and a third was subject to ACCT monitoring and said his mental health was deteriorating daily due to the lack of telephone calls and the lack of a radio or television to distract him.

## **23 March 2021**

85. A SO spoke to Mr Shirley on the morning of 23 March as part of her round of all the prisoners on the unit. She recorded that Mr Shirley was polite and compliant, but very paranoid and in need of a medical review.
86. At about 8.30am, Mr Shirley went to the medication hatch for his medication and at about 9.50am he came out of his cell for a shower.
87. In the late morning, Nurse A went to the segregation unit to see another prisoner and noticed from the wipe-board that Mr Shirley was on the unit so she went to see him. Nurse A noted that Mr Shirley initially blamed his mental health for spitting in the officer's face, before acknowledging that his actions were inappropriate. She also noted that officers on the unit told her that Mr Shirley had said that he had not had his depot injection and she noted her view that Mr Shirley was deliberately trying to play staff off against one another. Nurse A noted that Mr Shirley said he was not sleeping and he asked for a radio. Nurse A told Mr Shirley that he would have a psychiatric review and she wrote in her plan the need to chase up the review. At interview, Nurse A said she did not think that Mr Shirley seemed too unwell and he did not display fast speech or racing thoughts.
88. During the afternoon, Mr Shirley came out of his cell to receive his medication and at around 4.28pm, Officer A answered his cell bell and then gave him a toilet roll.
89. Officer A told the investigator that during the late afternoon Mr Shirley had been talking to the prisoner in the neighbouring cell. At about 7.00pm, the prisoner asked her to check on Mr Shirley who he said had been "saying some mad shit". (The investigator contacted the prisoner but he did not want to be interviewed.)

90. CCTV shows that Officer A went straight from the prisoner's cell to Mr Shirley's cell. Officer A said that she could not initially see Mr Shirley but, after she turned on the cell light, she could see his legs under the wash basin and noticed something wrapped around the basin tap. She called his name but got no response. She said she then went to the wing office to call colleagues for help as the segregation rules required three officers to be present to open Mr Shirley's cell. Within a minute, Officer A returned to the cell with a number of colleagues.
91. A SO looked through the observation panel and then turned on his body-worn camera and entered the cell. The SO said Mr Shirley was slumped unconscious next to the basin with a prison issue jumper tied around his neck and to the basin taps. The SO said that Mr Shirley's arm and lips were blue, but rigor mortis had not set in. He and an officer untied the ligature and laid Mr Shirley on the floor. The SO started cardiopulmonary resuscitation (CPR) at 7.02pm. Meanwhile, a CM radioed a code blue emergency (indicating a prisoner is unconscious or is having breathing difficulties), followed by an update that CPR was in progress. Prison control room staff called for an emergency ambulance.
92. A nurse arrived in Mr Shirley's cell at 7.05pm and took over chest compressions. Another nurse and a prison paramedic also arrived with the emergency equipment. At 7.06pm, a defibrillator was attached to Mr Shirley. It checked Mr Shirley every two minutes but advised no shock and to continue CPR. At 7.07pm, Mr Shirley was given oxygen via bag and mask. CPR continued.
93. Ambulance paramedics arrived at 7.17pm and took over efforts to resuscitate Mr Shirley. A second ambulance crew arrived at 7.20pm. At 7.44pm, the paramedics confirmed that Mr Shirley had died and stopped CPR.
94. These timings were established from CCTV, body-worn camera footage and West Midlands Ambulance Service logs. We have taken into account that the prison CCTV appears to be 12 minutes ahead of GMT.

### **Contact with Mr Shirley's family**

95. The prison appointed an officer as family liaison officer (FLO). The FLO and a CM drove to Mr Shirley's family home and broke the news of his death at about 11.30pm that night.
96. The prison contributed to the cost of Mr Shirley's funeral in line with national guidance.

### **Support for prisoners and staff**

97. After Mr Shirley's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.
98. Two members of healthcare staff said at interview that they had not felt well-supported after Mr Shirley died and had not been included in the prison debrief on 23 March. One of them said she had asked for counselling and had waited several weeks before being given a number for a telephone support service. Another said that she was not able to access trauma-focussed peer support as a referral was not

been made in time. Some of the officers interviewed also said that they felt unsupported by senior prison management after Mr Shirley's death.

99. A SO and CM spoke to all the prisoners in the segregation unit individually to offer extra support.
100. The prison posted notices informing other prisoners of Mr Shirley's death, and to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Shirley's death.

### **Post-mortem report**

101. The pathologist gave Mr Shirley's cause of death as external neck compression caused by hanging. Toxicology tests showed that Mr Shirley had no drugs of abuse or alcohol in his system.

# Findings

## Identifying risk of suicide and self-harm

102. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), provides a non-exhaustive list of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. The PSI requires all staff who have contact with prisoners to be aware of the triggers and risk factors and to take appropriate action, including starting ACCT procedures if necessary. The PSI also makes clear that staff should base their judgement on the prisoner's risk factors and having checked relevant documents, including the clinical record.
103. Mr Shirley presented with a number of risk factors for suicide and self-harm during his time at Hewell, including:
  - a history of alcohol abuse;
  - a history of serious mental illness;
  - recent contact with psychiatric services;
  - previous suicide attempts; and
  - he was under the care of the prison's mental health in-reach team.
104. Information about these risk factors was available to healthcare staff: for example, the summary from Mr Shirley's community GP which included information about his previous suicide attempts; the report from the L&D nurse that said Mr Shirley was having suicidal thoughts; and the assessment from Nurse B recording that Mr Shirley said he was having suicidal thoughts. In addition, Mr Shirley repeatedly told staff that his depot medication was no longer working for him and he spoke about hearing voices telling him to kill himself.
105. Despite this, no one considered placing Mr Shirley on an ACCT. There appear to be several reasons for this. We are very concerned that that no one appears to have read the important information provided by the GP and the L&D nurse. We are also concerned that Nurse B did not consider opening ACCT procedures and that she did not share the information that Mr Shirley was having suicidal thoughts with her colleagues for four days.
106. We are also very concerned that Nurse C relied on Mr Shirley's assertions that he did not intend to self-harm, even though he told her the voices were telling him to kill himself. We have found repeatedly in our investigations over many years that staff too often base their assessments of risk on the prisoner's current presentation and statements that they have no thoughts of suicide or self-harm, while known risk factors, are often overlooked.
107. Mr Shirley's risk to himself would have further increased when he was moved to the segregation unit where he had very little access to support and distraction material. We are concerned that Nurse C and the prison paramedic who assessed Mr Shirley's fitness to cope with segregation had both started working at Hewell during the COVID-19 pandemic and had not received ACCT training before Mr Shirley's death in March 2021, and that they had still not received it when we interviewed them in July 2021.

108. We make the following recommendations:

**The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all information about risk, and start ACCT procedures where appropriate.**

**The Governor and Head of Healthcare should ensure that all staff who have prisoner contact receive ACCT training in accordance with national instructions.**

## Clinical care

109. The clinical reviewer concluded that the care Mr Shirley received at Hewell was not of the required standard and not equivalent to that which he could have expected to receive in the community.
110. She found that no-one at Hewell read Mr Shirley's community GP records or the records from the liaison and diversion team. She found that after Nurse B saw Mr Shirley for an urgent mental health assessment on 3 March, she did not upload her assessment on his SystemOne record until her next day in work on 7 March. She noted that Mr Shirley was not discussed, as he should have been, at the weekly MPCCC meeting on 10 March and he was not placed, as he should have been, on the Targeted Care Pathway (TCP). Nor did he have a formal mental health care plan as should have been the case under National Institute for Health and Care Excellence (NICE) guidelines.
111. The clinical reviewer found that Mr Shirley's first formal assessment by his care coordinator, Nurse A, was on 16 March, when she saw him without having read the liaison and diversion records, or his community GP's summary recording his previous suicide attempts. Although Nurse A recorded that Mr Shirley reported his mood as 2 out of 10 and said his depot medication was "not holding him", she did not arrange a medication review. The clinical reviewer noted that Nurse A believed that Mr Shirley had behavioural issues, rather than having acute mental health problems, and did not seem to have gathered a full picture and understanding of Mr Shirley and of all of the possible risks with which he was presenting.
112. The clinical reviewer also noted that when Mr Shirley was discussed at the MPCCC meeting on 17 March he was found to only need a routine psychiatric assessment in around four weeks. It is not clear whose responsibility it was to collate the information on Mr Shirley for discussion at the MPCCC - we were told it was the care coordinator's role - but the clinical reviewer considered that if a full picture of Mr Shirley's risk profile been presented at the meeting, a more urgent appointment would have been considered and he would also have received more intensive support via the TCP.
113. The clinical reviewer considered that from a mental health perspective, Mr Shirley had a high risk of suicide and self-harm based upon his complex mental health history, his reported attempt at suicide in November 2020, his worrying presentation of psychosis and hearing command hallucinations telling him to kill himself, and his frequent reports that his depot medication was not working. The clinical reviewer concluded that Mr Shirley's mental health treatment lacked a holistic approach.

She said that assessments of his mental health and risk profile were generally made in isolation as single ‘snap shots’ of time, were taken at face value and failed to identify his high risks.

114. We recommend that:

**The Head of Healthcare should ensure that a robust process is put in place for the review of prisoners’ community records.**

**The Head of Healthcare should ensure that staff upload clinical assessments to SystemOne on the day they complete their assessment.**

**The Head of Healthcare should ensure that MPCCC meetings receive a full presentation of each prisoner’s clinical needs.**

**The Head of Healthcare should ensure that prisoners with relevant long-term medical and mental health conditions are placed on the appropriate care pathways.**

**The Head of Healthcare should share a copy of this report with Nurse A and arrange for her clinical supervisor to discuss the Ombudsman’s findings with her.**

## Segregation

115. Segregation is an extreme and isolating form of custody used for prisoners who have misbehaved or who cannot be kept safely in normal prison accommodation. It inherently reduces protective factors against suicide and self-harm, such as activity and interaction with others, and should only be used in exceptional circumstances for those known to be at risk of taking their own life.

116. We have a number of significant concerns about the way Mr Shirley’s segregation was managed.

117. Prison Service Order 1700, Segregation, sets out the purpose and reasons for segregation, together with the process that should be followed when a prisoner is segregated. It says:

*“Those prisoners who are the most ‘difficult’ are often the most vulnerable ... Staff are undoubtedly faced with difficult decisions as to where to hold some prisoners and frequently care for prisoners in segregation units when all other options have been exhausted. However, there have been cases where prisoners have been held in segregation units and the justifications for doing so have not been convincing. There have been cases where alternative options to segregation have not been adequately explored.”*

118. The PSO specifies that an Initial Segregation Health Screen must be conducted within the first two hours of a prisoner being placed in segregation. The primary purpose of this screen is to assess a prisoner’s ability to cope with the effects of being segregated. A prisoner’s segregation must then be authorised by a duty governor or operational manager based on the outcome of the health screen (as well as discussion with staff and the prisoner).

119. We are very concerned that Nurse C assessed that Mr Shirley was fit to be segregated despite the fact that he told her he was hearing voices telling him to kill himself. We share the clinical reviewer's concern that Nurse C had not received mental health awareness or suicide and self-harm training before she completed the segregation health screen algorithm and that she made the decision that Mr Shirley was fit to be segregated without a knowledge of his mental health issues or his history of suicide attempts. She said that she was advised by prison officers who knew Mr Shirley that it was normal for him to say he was hearing voices to kill himself.
120. We consider that Nurse C should have opened ACCT procedures when Mr Shirley told her about the voices telling him to kill himself. If she had done, prison managers would have been required to consider alternative locations for him before authorising segregation.
121. We are also very concerned that an operational manager signed the segregation unit paperwork to authorise Mr Shirley's segregation without having read Nurse C's assessment – indeed, the paperwork indicates that he authorised Mr Shirley's segregation before Nurse C had completed the segregation health screen.
122. We also note errors in the health screen algorithm completed by the prison paramedic on 22 March, in particular that Mr Shirley was not receiving antipsychotic medication.
123. Another operational manager subsequently authorised Mr Shirley's continued segregation on the basis that he was demonstrating poor mental health and that the mental health team had deemed that the segregation unit was the safest place for him.
124. The basis for the belief that the segregation unit would be the safest place for Mr Shirley is not clear. There is no evidence to suggest that he was at risk from other prisoners on standard location, or that any other locations had been considered and discounted, and both HMIP and the IMB had said explicitly that the segregation unit was not an appropriate environment for prisoners with severe mental health problems.
125. We note that there were several other prisoners being held in the segregation unit at the same time as Mr Shirley who were also being held there either because of, or notwithstanding, problems with their mental health. This is a serious concern.
126. We are also concerned there were no radios available to prisoners in the segregation unit at Hewell. We were told that the segregation cells had no power points and that previous supply of wind-up radios had been damaged and taken out of use. This situation had apparently prevailed for some time.
127. We consider that this was wholly unacceptable. Prisoners who are segregated and are least able to access regime activities should have the opportunity to occupy or distract themselves. This is particularly necessary case for prisoners such as Mr Shirley, who was mentally unwell and who reported having limited literacy skills.
128. PSO 1700 also requires that prisoners held in segregation should have a designated personal officer and should have welfare checks once in the morning, once in the afternoon and once in the evening. Staff are required to record at least three quality conversations daily in the prisoner's segregation history sheet.

Despite repeated requests, Hewell has not provided any evidence to show that Mr Shirley had a designated officer or that he had three welfare checks and quality conversations a day.

129. We make the following recommendations:

**The Governor and Head of Healthcare should ensure that staff manage prisoners held in the segregation unit in line with national guidelines, including that:**

- **managers who authorise prisoners' continued segregation do so only after they have seen the health screen assessment algorithm and have spoken to relevant staff;**
- **nurses who complete health screen assessment algorithms have received mental health awareness training;**
- **the designated officer has purposeful conversations each day with his or her allocated prisoners; and**
- **a minimum of three quality entries are recorded each day for each prisoner.**

**The Governor should ensure that segregated prisoners are provided with radios and other appropriate distraction material as a matter of urgency.**

## **Emergency response**

130. Officer A went to check Mr Shirley after the prisoner in the neighbouring cell expressed concerns for him. She saw Mr Shirley's legs beneath the wash basin, saw something attached to the basin taps and then went to seek assistance from colleagues. It is clear that Officer A recognised that it might have been a life threatening emergency. However, we do not know whether Officer A made a dynamic risk assessment on whether she should have immediately entered the cell. Nor do we know why she went to call for assistance from staff rather than radioing a code blue emergency. We note that other staff entered the cell within around 45 seconds, so there was very little delay, but we nevertheless make the following recommendation:

**The Governor should ensure that all prison staff are made aware of, and understand their responsibilities during medical emergencies, including that staff:**

- **understand and use the appropriate emergency code when they discover a medical emergency;**
- **enter cells as quickly as possible in life-threatening situations where it is safe to do so.**

## **Post-incident support**

131. Support for staff after a death in custody is essential for ensuring personal wellbeing and ensuring that staff can continue to do their jobs effectively.

132. Several of the healthcare staff said at interview that they had not felt well-supported after Mr Shirley's death, which included one staff member who missed the opportunity of trauma-focussed peer support. Some of the officers interviewed also told the investigator that they felt unsupported by senior prison management after Mr Shirley's death. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff receive appropriate support following a death in custody.**

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