

**INVESTIGATION INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF MAN AT
HMP SHREWSBURY IN AUGUST 2004**

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

October 2005

This is the report of an investigation into the circumstances of the death of a man at HMP Shrewsbury in August 2004. I offer my sincere condolences to his relatives and friends.

Tragically, the man was the second of three men to hang themselves in HMP Shrewsbury during a sixteen day period. The first died on 19 August and the third died on 1 September. Their deaths share a number of common features – all died on A wing within a short period of arriving at Shrewsbury, and all were drug users who were not assessed as being at risk from suicide by the prison.

Shrewsbury is a small local prison and such a cluster of apparently self-inflicted deaths was profoundly shocking for all concerned. I would like to thank the acting Governor of Shrewsbury throughout the latter half of 2004, and his staff for their help and support during this investigation. I am also extremely grateful to colleagues in West Mercia police for their cooperation and helpfulness at all stages of our investigation.

Three of my investigators examined events at Shrewsbury, each paying particular attention to the death of one individual.

Shropshire County Primary Care Trust carried out a clinical review of the three deaths, and I am greatly obliged for their advice on the clinical factors in these cases. The Section Head, Substance Abuse, Prison Health at the Department of Health, also provided invaluable commentary on the clinical management of the three men's drug misuse.

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

The report makes a number of recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman
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SUMMARY

The man arrived at HMP Shrewsbury on the afternoon of Monday 30 August 2004. He had spent the two previous days in police custody during which time he had been prescribed symptomatic relief for heroin withdrawal.

Although he gave a full medical history outlining a previous suicide attempt, a diagnosed mental health problem (for which he may have been taking medication), and withdrawal from heroin, a further mental health assessment was not recommended as staff said he presented positively. He was located on the induction wing and placed in a cell with one other person. The doctor saw him later that day and, in line with his practice, a detoxification prescription was prepared to begin the following morning. The man was not given any symptomatic relief for withdrawal.

During the evening, he spoke briefly with his cellmate and told him he was suffering with stomach cramps. The following morning at 6.00 am, during routine cell checks, he was found suspended by shoelaces.

CONDUCT OF THE INVESTIGATION

The investigation team consisted of 3 investigators working for the Prisons and Probation Ombudsman. They visited Shrewsbury on a number of occasions in August and September 2004, when they were given access to all the documentation held by the prison on the man who is the subject of this report.

They met with members of the man's family.

Taped interviews were held with prison staff and prisoners who had had important contacts with any of the men who died. Notices to Staff and Prisoners were issued inviting anyone with relevant information to make contact with the investigation team. All staff were offered the opportunity of being accompanied by a friend or trade union colleague whilst being interviewed.

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

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

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

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

HMP SHREWSBURY

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

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

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

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

HER MAJESTY'S CHIEF INSPECTOR OF PRISONS

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

"Shrewsbury Prison has no inbuilt advantages. It is one of the oldest, most overcrowded and cramped local prisons in the country. It has to manage the great majority of its 330 prisoners on one wing, with no impatient healthcare, limited training space and no outdoor recreation facilities."

However, in the second paragraph of her preface, HMCIP remarks:

"Yet it has among the best staff/prisoner relationship of any prison we have inspected. From the Governor down, staff were visible and approachable."

The issue of self-harm also appears on the same page of the report. The HMCIP stated:

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

In the section of her report dealing with Substance Use, HMCIP wrote at Chapter 3.8.4:

"Apart from a recently written alcohol detoxification protocol, there were no current detoxification protocols for substance users. We were told that the normal practice was to prescribe up to three days of dihydrocodeine, diazepam and zimophain. Staff and prisoners verified this. The general opinion among them was that 'the detox is crap'. We agreed that the current detoxification practice was inadequate."

At Chapter 3.2.4 of her report, HMCIP recorded:

"The most recent death in custody had been in August 2000. There had been an inquest in April 2001. The Governor of another prison had carried out an internal investigation and had reported that the prisoner belonged to that group of drug users who appear to be at risk in the first week or so after

reception. He commented that these were prisoners who were voluntarily coming off drugs or unable to renew medication and also said that they should merit special attention from the policy makers on suicide awareness and self-harm.”

HM Chief Inspector then recommends. “The Prison Service should ensure that the observations and recommendations of an investigation into a death in custody at HMP Shrewsbury (2001) are addressed and reflected in policy throughout the service.”

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

In the introduction to her 2004 report, HM Chief Inspector observed with pleasure that Shrewsbury had retained the very good staff/prisoner relationships and the commitment to continuous improvement which had impressed her on the previous inspection. She remarked that the great majority of her recommendations had been achieved and important areas of the prison had significantly improved “even though Shrewsbury has the dubious accolade of being the most overcrowded prison in an overcrowded prison system”.

However, in the same introduction, HMCIP indicated that some weaknesses needed attention and she highlighted the issue of detoxification as follows:

“In our last report, we expressed great concern about detoxification procedures, and these remained defective, in spite of the fact that nearly two-thirds of prisoners admitted to having injected heroin in the period immediately before imprisonment. More analysis of patterns of suicide and self-harm was needed, in a prison that had experienced three self-inflicted deaths that year (and has since had three more).”

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

“The replacement medical officer should receive adequate training in working with substance users to support and complement the work of the

substance misuse nurses and the specialist medical officer from the Psychiatric Hospital.”

The concluding paragraph in the Substance Use subsection of the 2004 new report reflects the recommendation made in March 2002 that a work plan for developing a comprehensive detoxification programme for prisoners should be developed in consultation with the area drugs strategy coordinator and the clinical adviser to the Prison Service Drugs Strategy Unit.

The 2004 report recorded:

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

Events prior to the man's death

The man was arrested at 1.10 pm on Saturday 28 August and taken to the police station. Police Bail was not granted and, since it was Saturday, he was held at the police station until the Monday when he appeared at the Magistrates' Court. Just after 10.00 pm on Saturday, he was seen by the Forensic Medical Examiner (FME) because he said he was withdrawing from heroin. The medical examiner notes that he was feeling depressed, had '*no suicidal ideation*' but that he had a history of self-harm. The record indicates that the examiner advised 30 minute checks and custody records show that these were adhered to for the duration of his time in the police station. The doctor prescribed Nitrazepam and Dihydrocodeine (for withdrawal symptoms), the last dose of which he was given at 8.00 am on the morning of Monday 30 August.

The man's Prisoner Escort Form (PER) indicated that he was regarded by the police as a risk under the categories of medical condition, violence, drugs/alcohol issues and suicide/self-harm. Further details were given as 'past history self-harm, asthma, suffers mental health problems'. This information would have been drawn from interviews he had with the police as part of their risk assessment process and from his consultation with the doctor. His property record indicates that he had a number of items retained including his shoes and laces which appears to be routine rather than because of specific concerns. The man was handed to the escort services at 8.10 am on Monday. A copy of the medical form was attached to his PER but not his medication form which would have listed the medication he had been given.

As a result of the information on the PER form, staff from Reliance Custodial Services deemed him a potential risk of suicide and self-harm and consequently checked him every 15 minutes. Although unable to recollect him in any detail, staff believe that nothing untoward happened whilst he was in their care. They said that details would have been recorded on the PER had this not been the case.

At court, the man was remanded into custody and his case was adjourned for one week. His solicitor, who had represented him for some time, told my investigator that his demeanour gave him no cause for concern and that the man spoke positively about the future.

At about 2.00 pm, soon after arriving at HMP Shrewsbury, he was seen by the duty nurse for the purpose of completing a First Reception Health Screen form. This is the primary means of assessing a new prisoner's health needs and whether or not they may represent a self-harm or suicide risk. The nurse had in her possession the PER and the medical form outlining his assessment at the police station. In response to questions in the first part of the health screen, he gave details of his GP and told the nurse that he was receiving prescribed medication of Largactil and Zispin and medication for asthma. The man also told the nurse that he did not

drink alcohol, but did use a gram of heroin intravenously per day. In interview, the nurse stated that in her experience this was consistent with being a heavy user of drugs.

Questions eight to ten of the health screen ask about mental health. The author is required to make an assessment about whether to refer someone for a more detailed assessment depending on the answers given. The man described having undergone psychiatric treatment due to having a breakdown in 2003 and suffering from 'impulsive disorder syndrome'. He went on to repeat details of the drugs prescribed for him and that he had been taking them for 12 months. In response to being asked about self-harming, he described having cut his wrists about 12 months previously. In interview, the nurse describes her practice as always examining the prisoner's scars and, although nothing of this nature is recorded on the form, she recalls that his injuries were not extensive. According to the guidance given on the form a 'yes' answer to one or more of the questions should trigger a referral for a mental health assessment. The nurse ticked 'yes' to all three questions. She did not, however, refer him for a mental health assessment.

Question 11 asks whether the prisoner feels like harming themselves and the duty nurse has indicated that the man did not. Finally, the interviewer is asked to comment on their impression of the prisoner and she has written "*states no problems. Feeling rough due to withdrawal*". At this point the form requires the author to consider opening a F2052SH if the prisoner has answered yes to either of the two questions about self-harm. The form does not ask for any explanation of the author's decision, but simply asks that it be considered. In interview, the duty nurse was asked whether she had considered opening a F2053SH. She explained that, in light of his self-harm history, she had considered it. However, when he stated that he did not have any problems and did not feel like harming himself, she did not feel the need to open one.

The final part of the screen requires the author to outline the planned action as a result of the assessment. The duty nurse indicated that the man would be referred to the doctor for his physical health and substance abuse and would be referred to drugs services. Contrary to the guidance given on the form, she did not refer him for a mental health assessment. In interview, the duty nurse explained that this would not necessarily be a barrier to receiving further help as referrals could be done verbally, or at a later stage, should the nurse think the prisoner requires help. It seems, however, that the man did not give the duty nurse any cause for concern during her assessment. The nurse went on to complete the part of the cell sharing risk assessment form where, again, she indicated that in her view there were no concerns regarding self-harm. She also carried out the urine samples which were positives for morphine, cannabis and benzodiazepines.

During the rest of the reception process, the man was seen by at least three officers, two of whom specifically asked him about self-harming. The first officer was responsible for completing the core record details and one of the

questions asks about self-harm and suicide. In interview, the first officer said he was able to specifically recall asking him the question because he said the man “chuckled” when asked and said he felt fine. The officer had no concerns about him.

The last member of staff who saw him was the first night officer. This officer is required to complete some sections of the cell sharing risk assessment form, and the prisoner profile form, and to begin to make the prisoner familiar with aspects of life at Shrewsbury. The officer recalls the man saying he was withdrawing and was tired, but he did not have any other concerns about him. The officer took him and other prisoners onto the wing where he was located by wing staff.

The man was located in cell A1 – 12 with another prisoner at about 4.00 pm. Cell A1 – 12 was one of a small number of cells that had less natural light than usual due to the temporary erection of tarpaulin covered scaffolding placed a few feet outside the cell windows. Both men had come into prison that day and first spoke to each other in the holding cell in reception. The man’s cellmate recalled that he thought it was strange that the man did not have any shoelaces in his shoes. Both men were withdrawing and were allocated a cell with bunk beds. Upon entering the cell, the cellmate asked the man if he could have the bottom bed which the man agreed. He recalls them just having a general conversation and that the man complained a lot about stomach cramps which his cellmate assumed were as a result of withdrawing and not getting any medication.

The man was seen later that day by the medical officer. The doctor conducted an examination of him on the wing and had sight of the First Reception Health Screen. The doctor wrote up a standard detoxification prescription chart, to begin the next day. He would have had sight of the police medical form and therefore been aware that for two days the man had been receiving symptomatic relief for drug withdrawal. It is impossible to say what interpretation the doctor made of any of the other problems the man presented with. He did not complete an entry in the IMR and the medical form is incorrectly completed. He records, under the section headed ‘physical description’, that the man used Largactil and Zispin but no further details or assessment are given. He doctor’s writing is extremely difficult to read.

The man’s cellmate recalls that he watched television until about 9.00 pm and then went to sleep. At this time he believes that the man was lying on his bed and still complaining about stomach cramps. Twice during the night, the first time he thinks was about 1 am, he got up to go to the toilet and saw the man at the window. At night, the cellmate does not wear his glasses and describes his eyesight as very poor. He says that he asked the man if he was ‘ok’ on both occasions, but did not get any response from him. Not believing that there was anything suspicious, he returned to his bunk and went back to sleep.

Discovery of the man hanging

The man was discovered hanging at the window by the duty officer during the 6.00 am roll check. Having called for help, the officer entered the cell with the senior officer (SO) who was followed by a wing officer. The duty officer used scissors from his anti-ligature bag to cut the man down from the window wire meshing and, with the help of the SO, placed the man on the floor. It became apparent immediately that the man had been dead for some time and the officers did not attempt resuscitation. A wing nurse arrived on the scene shortly after but did not commence any treatment. His cellmate was removed from the cell by the wing officer and taken to the intervention suite. A senior Listener (a prisoner trained by the Samaritans to support other prisoners) was woken up to sit with the man's cellmate at this stage. The man was pronounced dead at 6.25 am by the doctor.

The man used shoelaces as a ligature but it remains unclear whose they were, or where, they came from. His cellmate commented that he noticed that he did not have laces in his shoes when he met him in reception. However, it has not been possible to confirm this. Given that the prison did not view him as a risk, there was no reason why he would not have been given new laces. The man did not leave a suicide note.

Contact with the man's next of kin

The man gave his ex-wife as his next of kin although it would appear that they were estranged. The police made contact with her in the first instance and the prison liaison officer contacted her a few days later. His ex-wife was invited to come to the prison, which she decided to do, and was collected from home by taxi which the prison arranged. The cell remained sealed and she was able to visit the wing and met with the Governor.

The investigators met with the man's ex-wife when she visited the prison and subsequently have spoken with her on the telephone. It would appear that, although divorced, she and the man had remained in contact until July 2004. She had no concerns about his treatment at that time.

Issues considered during the investigation

First Reception Health Screen

According to the instructions given on the health screen the duty nurse should have referred him for a mental health assessment. The guidance states '*If "yes" recorded to Questions 8, 9 or 10 (outside prison) refer for mental health assessment*'. The man answered 'yes' to all three questions. Although he presented well the combined features of a previous suicide attempt, a diagnosed mental health problem for which he had been prescribed medication and withdrawal from heroin should have prompted a mental health referral.

Questions 10 and 11 ask about self-harm and suicide and the guidance states '*If "yes" recorded to Question 10 or 11 consider opening a F2052SH*'. The man gave a 'yes' response to question 10 and a 'no' to 11. The form does not require the author to explain their rationale for not opening a F2052SH. In interview, the duty nurse stated that she did not feel that the man was at risk and consequently did not open a F2052SH.

The prison's GP

When the man saw the doctor he completed a medical in confidence record. However, the form is completed incorrectly and the writing is very difficult to decipher. In addition, the doctor did not write an entry in the medical record and it is impossible to know what assessment, if any, he made of the man's history and presenting problems.

Detoxification regime

The doctor prescribed a standard detoxification regime to begin the next day and he was not given any symptomatic relief for that night. However, the man apparently hung himself before the regime began. The Dihydrocodeine detoxification programme that was used in Shrewsbury at the time of the man's death is not in line with national guidelines.

The man complained to his cellmate that he was experiencing stomach cramps. According to the health screen, he told the duty nurse that he '*feeling rough due to withdrawing*'. Although there is no evidence that his death was related to the withdrawal symptoms he was experiencing, the heightened risk of suicide in those withdrawing from opiates is well documented.

Clinical review

Shropshire Primary Care Trust undertook a clinical review of the man's care whilst in Shrewsbury. The review panel share the concern that the duty nurse did not follow the guidance given regarding a mental health assessment. They take the view that given that the man was withdrawing

from heroin, and known to have a history of mental health problems, a F2052SH should have been opened until he had had a mental health assessment. In addition, they felt that if a nurse does not open a F2052SH, when there is evidence of past self-harm/suicidal intention, then the form should record their reason for not doing so. They also comment on the standard of record keeping by the doctor.

The panel state that any prisoner withdrawing from opiates should be identified as at an increased risk of self-harm or suicide until they have been more fully assessed. They recommend that symptomatic relief be routinely available, especially in the time between reception and the start of any detoxification. The detoxification regime at Shrewsbury at the time was not supported by the panel and was not in line with national guidelines.

In addition, the Section Head for Substance Misuse at Prison Health undertook a review of the clinical management of the man's substance misuse programme. He agreed with the recommendations made by the panel and made further comments on the notes made by the prison doctor and the detoxification regime.

Dark cells

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

On 14 September 2004, the acting Governor told his manager that he had consulted widely across the establishment following the recent deaths and that one recurring theme deserved the Area Manager's consideration. He wrote that cells facing west on A1 and A2 landings looked directly towards the fencing that had been erected around the demolished gymnasium site and new education block extension. He said *"The prisoners believe the lack of light is oppressive and has contributed to the depression that led to all three suicides. The fencing is less than a metre from the cells. Prisoners located in the A1 cells cannot see anything but the fence, irrespective of where they stand."*

The acting Governor suggested that cells A1-12 to A1-20 should be taken out of commission, and that affected cells on A2 landing should only be occupied by prisoners on the enhanced level of the Incentives and Earned Privileges Scheme, as such prisoners are confined to their cells for shorter periods of time. The Area Manager accepted the governor's suggestion.

The cellmate

In interview, he spoke of receiving considerable attention in the immediate aftermath of the man's death. At that time, he felt he was coping with the trauma. However, as time went by he spoke of his increasing distress. It appears, however, that staff were not monitoring him to the same level as

before and he spoke of one officer being very unsympathetic when he asked for a Listener. His request to see a Listener was not followed up. It is imperative that prisoners, and staff, are offered support over a number of weeks rather than just days after being involved in a death.

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

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

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

Detoxification

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

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

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

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

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

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

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

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

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

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

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

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

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

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

He further recommends:

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

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

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

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

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

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

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

Clusters of three deaths

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

He has supplied a table showing all cases since 1978 where three self-inflicted deaths have occurred in less than 30 days. This table shows the Shrewsbury cluster as being the third worst in Prison Service records. At HMP Manchester three deaths occurred within two days in 1982 and at HMP Leicester three deaths occurred within 11 days in March/April 2000. At HMP Gloucester, another relatively small local prison like Shrewsbury, three deaths occurred within 18 days in February 2004. In his e-mail he observes that: “only local prisons seem to experience significant clusters” and that “the risk of having additional suicides does increase after an initial death”.

F2052SH Procedures at Shrewsbury

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

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

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

On the day of the audit, it was noticeable that an officer had been detailed to F2052SH duties but the entries over several days in all the booklets examined suggested observation of the men at risk, rather than much interaction with them. My investigators were informed by staff that it was

rare for booklets to be opened on men located on the second and third levels of A Wing and rarer still on the fourth (topmost level) of the wing. I am aware that the staff at Shrewsbury have already been exhorted to write more detailed entries in at-risk documents, but it may well be that further training is required, backed up by regular and vigorous management checks on this matter.

My investigators also observed that the prison did not have readily accessible information about prisoners who had previously been subject to Self-Harm at Risk Procedures. I was informed that such information generally disappeared from the Local Inmate Data System (LIDS) computer system 12 weeks after a man left the prison. Reference to previous F2052SHs seemed a matter of chance, or due to the good memory of a particular officer or nurse in Reception. The opening of an F2052SH does not of itself ensure that a potentially suicidal prisoner will remain alive, but it is critical that staff should be aware of recent periods when prisoners were thought to be at risk.

The absence of “organisational memory” in respect of prisoners who have previously been on F2052SH is disturbing and I draw this issue to the attention of the National Offender Management System (NOMS) Safer Custody Group. It is not desirable that the only source of information about a prisoner’s recent history should be the prisoner himself, and I **recommend that the Governor of Shrewsbury attempts to devise a more reliable and robust system for retaining information about previous Forms 2052SH.** The introduction of the integrated case management system, NOMIS, will capture this information in the future.

Action taken at Shrewsbury following the three deaths

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

Their report, entitled *Common Themes and Learning Points from Recent Deaths in Custody at HMP Shrewsbury*, was completed on 2 September 2004. They examined Reception, First Night Centre and induction procedures at the prison. They also included a section on drug strategy and detoxification, pointing out that the establishment did not have a dedicated drug detoxification unit. They quoted a staff member who felt there was not a proper system for drug detoxification.

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

Their review made eight recommendations. On 14 September 2004, the acting Deputy Governor at Shrewsbury, wrote to the principal psychologist and to the outreach support coordinator to update them on some of the recommendations they had highlighted.

In the First Night Centre section of their report, the principal psychologist and the outreach support co-ordinator refer to the impression that A Wing is poorly lit and dark with little natural light.

The acting Governor initiative in writing to his Area Manager about the cells facing west on A1 and A2 landings mirrored concern expressed to my investigators by a prisoner at Shrewsbury. He asked to see my investigation team and said he had noticed that the people who were committing suicide (his expression) were on the side of A Wing where all the windows had been covered up by sheeting outside. The prisoner understood that all the windows on one side of the wing were covered with corrugated sheeting because "gym was supposed to be falling down, there's been structural damage or something, so they have had to knock the building down".

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

RECOMMENDATIONS

CLINICAL

The Governor and Chief Executive of the PCT are invited to consider establishing a disciplinary enquiry in view of the duty nurse's apparent failure to comply with the requirements at page 6 and 7 of the First Reception Health Screen.

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

I note that half of the 12 recommendations listed in the Action Plan resulting from a clinical review of Deaths in Custody at HMP Shrewsbury have already been accepted and achieved. I urge the Governor to ensure that remaining actions are accomplished by the dates stipulated in the Action Plan.

Consideration should be given to revising page 7 of F2169 so that the author is required to explain their decision-making progress in relation to opening a F2052SH.

SUBSTANCE MISUSE

I endorse the recommendations made by the substance misuse specialist from the Department of Health. If they are accepted by the Area Manager and PCT, then I recommend that an expanded Action Plan be drawn up as soon as possible.

OPERATIONAL

A training needs analysis should be undertaken to include the training needs identified in the course of this investigation and the clinical review.

Anti-ligature knives should be introduced to individual members of staff.

The Governor should meet with senior police and escort contract colleagues with the aim of improving the quality of information recorded on Prisoner Escort Record forms.

Consideration should be given to the appointment of a full-time Suicide Prevention Coordinator.

Any new or locum Medical Officers at Shrewsbury should receive training in F2052SH procedures within a week of taking up post.

A more reliable and robust system for retaining and retrieving information about prisoners previously on F2052SH should be introduced.