

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shane Stroughton a prisoner at HMP Nottingham on 13 September 2017

A report by the Prisons and Probation Ombudsman

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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*



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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.

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

Mr Shane Stroughton was found hanged in his cell at HMP Nottingham on 13 September 2017. He was 29 years old. We offer our condolences to Mr Stroughton's family and friends.

Mr Stroughton had a history of depression, illicit drug use and attempted suicide. He had already made two attempts on his life in the prison before he killed himself. We are concerned that this is not the first time that we have found deficiencies in the operation of suicide and self-harm prevention procedures at Nottingham. The investigation also found that Mr Stroughton did not receive the appropriate mental health care while at Nottingham.

Following its inspection of Nottingham in January 2018, HM Inspectorate of Prisons (HMIP) concluded that the prison was 'fundamentally unsafe' and invoked the Urgent Notification process to alert Ministers to their concerns. We welcome HMIP's decision to do this. Several of the significant failings identified by HMIP featured in this investigation. HMIP also noted that there had been repeated failures by Nottingham to implement our recommendations following previous deaths in custody.

Urgent action needs to be taken to address these 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.

Elizabeth Moody
Acting Prisons and Probation Ombudsman

May 2018

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Summary

Events

1. Mr Shane Stroughton had a history of depression, illicit drug use and attempted suicide. On 13 June 2017, Mr Stroughton, who was subject to the provisions of an indeterminate sentence for public protection (IPP), was released on licence from HMP Stocken to live at an Approved Premises. On 3 July 2017, he was recalled to custody at HMP Nottingham after a breach of his licence conditions when he failed to live at the Approved Premises.
2. On Mr Stroughton's arrival at Nottingham, staff immediately monitored him under Prison Service suicide and self-harm prevention procedures (known as ACCT) as he had attempted to hang himself while in police custody. Mr Stroughton made two further attempts at taking his own life on 7 and 9 July, and he was managed under suicide and self-harm prevention procedures until 2 August.
3. On 13 September, at 4.54pm, an officer found Mr Stroughton hanged in his cell. The officer requested an ambulance and began cardiopulmonary resuscitation (CPR). Both officers and medical staff attended and CPR was continued until paramedics arrived. The paramedics took over emergency treatment but at 5.33pm pronounced Mr Stroughton dead.

Findings

Management of risk of suicide and self harm

4. We found that ACCT procedures at Nottingham were not conducted in line with mandatory national instructions. Some reviews were not completed when specifically required, not all case reviews were multidisciplinary, and there were some inappropriate assessments of Mr Stroughton's risk of self-harm. After the ACCT was closed, the post closure procedure was not completed within seven days as required. Mr Stroughton had made two attempts at ending his life while he was being monitored under the ACCT. Staff did not consider enhanced monitoring for Mr Stroughton as a complex needs prisoner.
5. After the ACCT was closed on 2 August, Mr Stroughton made no further attempts at self-harm and gave staff no further indication that he had thoughts of suicide. However, on 31 August, his mother contacted Nottingham with concerns about Mr Stroughton's mental health and physical well-being. Officers passed this information to the mental health team but no one from the team followed these concerns up.

Clinical care

6. The clinical review concluded that the physical care provided to Mr Stroughton was equivalent to that which he could have expected to receive in the community.
7. However, the investigation identified concerns over Mr Stroughton's mental health care while in custody. The clinical review concluded that the mental health care provided to Mr Stroughton was not equivalent to that which he could have expected to receive in the community. Despite three attempts at suicide

within seven days, Mr Stroughton was not referred to a psychiatrist. Anti-depressant medication was first prescribed for him, then stopped, without his seeing a doctor face to face. After the initial mental health assessment on 11 July, Mr Stroughton was not seen by a member of the mental health team again.

Actions following a death in custody

8. We found that following Mr Stroughton's death, procedures at Nottingham were not correctly conducted in line with mandatory national instructions. There was no debrief of the staff involved in the emergency response and staff were not instructed to complete incident report forms.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - conducting ACCT reviews as specified in the national instructions;
 - assessing the level of risk and recording the reasons for decisions;
 - setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes;
 - conducting ACCT post-closure interviews as specified in the national instructions; and
 - considering information from all sources and record all the known risk factors of a prisoner when determining their risk of suicide or self-harm.
- The Head of Healthcare, the healthcare Commissioners and the Governor should review the mental health care provision at HMP Nottingham. The review should consider the capacity to deliver a seven-day service of mental health assessments and ongoing interventions effectively, and the availability of staff to support the ACCT process.
- The Governor should ensure that all relevant mandatory actions in PSI 64/2011 are completed after a prisoner's death.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and asking anyone with relevant information to contact him. No prisoners responded.
10. He visited Nottingham on 21 September. He obtained copies of relevant extracts from Mr Stroughton's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Stroughton's clinical care at the prison.
12. The investigator interviewed 11 members of staff at Nottingham in October. Five interviews were conducted jointly with the clinical reviewer.
13. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. She gave us the results of the post-mortem examination and toxicology results and we have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Stroughton's mother to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. Mr Stroughton's mother wanted to know:
 - how her son's mental health was assessed and managed;
 - why he was not transferred to hospital when he was not eating and drinking;
 - what level of checks he was on; and
 - why he was in his cell for most of the day.

Mr Stroughton's family received a copy of the draft report. The solicitor representing Mr Stroughton's family wrote to us and raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Nottingham

15. HMP Nottingham is a local prison holding a maximum of 1060 men and young adult prisoners on remand, convicted or sentenced. The prison serves the courts of Nottinghamshire and Derbyshire. Nottinghamshire Healthcare NHS Foundation Trust provides health services, including mental health services. The prison has 24-hour primary healthcare cover. Mental health care is available Monday to Friday, 8.00am to 5.00pm.
16. D Wing at HMP Nottingham functions as the Induction wing. The wing can hold a maximum capacity of 155 prisoners. All cells are suitable for double occupancy, although prisoners assessed as at raised risk occupy a cell on their own. The 4's landing acts as the overspill for the vulnerable prisoner (VP) unit, G Wing. On occasions the 3's landing is also used when there is a high number of vulnerable prisoners. Prisoners granted VP status remain on D Wing until a space becomes available on G Wing. On average there are 15 to 20 prisoners monitored under self-harm prevention measures on D Wing at any one time.
17. The regime on the wing allows half of the prisoners association in the morning and the remainder in the afternoon. At other times, unless unlocked for appointments or visits, prisoners remain in their cells. There are two meals served: lunch and an evening meal. Prisoners are issued with breakfast packs with their evening meal. The majority of prisoners, apart from prison orderlies, are locked in their cells by 6.00pm, and all prisoners are in their cells by 7.00pm until the following morning. As a consequence of the regime, prisoners remain in their cells for more than 50% of their day.

HM Inspectorate of Prisons

18. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Nottingham during the week of 8 January 2018, which found the prison to be fundamentally unsafe. On 18 January 2018, HMIP invoked the Urgent Notification (UN) process which committed the Secretary of State to respond publicly to the concerns raised within 28 calendar days. The Secretary of State responded on 12 February.
19. Key findings from the inspection included:
 - Over two thirds of prisoners told inspectors they had felt unsafe at some point during their stay at the prison.
 - Over a third of prisoners said they felt unsafe at the time of the inspection.
 - Levels of self-harm remained very high and had increased since the last inspection in February 2016. In a survey, 30% of prisoners said that they had been subject to case management interventions (ACCT) at some point during their stay, but too many prisoners felt the support and engagement offered was either insufficient or inconsistent.

- Levels of violence overall were higher than in comparable prisons and had not reduced since the last inspection in February 2016.
- There were repeated failures to achieve or embed improvements following previous recommendations made by the Prisons and Probation Ombudsman (PPO).

Independent Monitoring Board

20. 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 annual report, published in July 2017, the IMB was very concerned about the levels of self-harm and violence and believed that staff shortages and the availability of illicit drugs were a factor in this. The IMB noted that the restricted regime meant all landings were unlocked for domestic activity in either the morning or afternoon, but those prisoners not allocated a regime activity were locked in their cells for the rest of the day.

Previous deaths at HMP Nottingham

21. Mr Stroughton's was the sixth death to occur at Nottingham since 1 January 2016. Four of the previous deaths were self-inflicted and one was due to natural causes. Between 13 September and 12 October 2017, five prisoners died at Nottingham, including Mr Stroughton, and four of these deaths were self-inflicted. There was a further self-inflicted death in February 2018.

Assessment, Care in Custody and Teamwork (ACCT)

22. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.
23. Those prisoners whose behaviour is particularly challenging and disruptive can be managed with enhanced ACCT case management in order to manage their risk within the normal prison regime. Enhanced case reviews will involve all relevant disciplines and include more specialists and a higher level of operational management than a typical ACCT review. The aim of enhanced case management is to provide flexible, consistent and integrated care by all staff involved with the prisoner. Involving families can also prove beneficial as they can provide vital insights into a prisoner's behaviour and motivations.
24. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI)

64/2011, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

25. Mr Shane Stroughton had been in custody since 2008, convicted of grievous bodily harm. He had received an indeterminate sentence for public protection (IPP). On 13 June 2017, he was released on licence from HMP Stocken. His licence conditions required him to live at Hucknall Approved Premises. On 30 June, Mr Stroughton signed in at the Approved Premises as required but left after 9.00pm and did not return. On 1 July, his licence was revoked, he was arrested and taken into police custody at Mansfield Police Station and, on 3 July, he was returned to prison custody at HMP Nottingham.
26. Before Mr Stroughton's transfer from police custody to Nottingham, a prison custody officer (PCO) completed a Person Escort Report (PER) and a Suicide and Self-Harm Warning (SSHW) form. These documents are intended to alert staff in all criminal justice agencies who come into contact with a prisoner, about his or her risk of suicide and self-harm. The PCO noted on the forms that Mr Stroughton had attempted to hang himself with a t-shirt while in police custody. The escort record and the SSHW form accompanied Mr Stroughton to Nottingham.
27. A supervising officer (SO), saw Mr Stroughton when he arrived at Nottingham. The SO signed both the PER and SSHW forms and immediately opened an ACCT. He assessed that Mr Stroughton presented a high risk of self-harm, and the level of observations was set at hourly throughout the day and night until the first case review.
28. A nurse saw Mr Stroughton in reception. She recorded that Mr Stroughton was on an ACCT and had recently attempted to hang himself. She noted that Mr Stroughton was not on any prescribed medication but had a history depression and anxiety. Mr Stroughton tested negative for any cannabinoids, opiates, amphetamines and alcohol, but he said he had used illicit drugs in the past. She referred Mr Stroughton to the mental health team and the substance misuse team.
29. She told the investigator she had not been given, or seen, the SSHW form. She said this was why the form was signed by a SO and had not been signed by a member of healthcare. The nurse said that if she had seen the form she would have signed it and immediately opened an ACCT, if one had not already been opened by prison staff in reception.
30. On 4 July, a member of the chaplaincy assessed Mr Stroughton as part of ACCT procedures. Mr Stroughton said he was disappointed to be recalled to prison and, after nine years already spent in prison, he seriously questioned his future. He said he suffered from depression and had self-harmed for a number of years. He said that when he had been in prison in the past he had been visited frequently by his family. Mr Stroughton said he had no current suicidal thoughts.
31. On 5 July, a SO chaired the first ACCT case review with a nurse, a member of the mental health team, and a member of the chaplaincy and Mr Stroughton present. (It is mandatory for first case reviews to be held within 24 hours of an ACCT being opened. This first case review should have taken place on 4 July).

32. Mr Stroughton said he had tried to hang himself while in police custody and his acts of self-harm were impulsive. He said he felt he had let his family down. He said he had no current thoughts of self-harm, felt okay about being back in prison and knew that he had “messed up”. The SO and a nurse assessed Mr Stroughton as being at raised risk of suicide and self-harm, and the level of observations remained unchanged. The SO completed the ACCT caremap which contained two actions: for Mr Stroughton to have a mental health assessment, and to remain in contact with his family. The next case review was set for 12 July.
33. On 6 July, at 8.45pm, a custodial manager chaired an immediate case review with a nurse, an officer and Mr Stroughton present. This was because Mr Stroughton had rung his cell bell and said he would set fire to his cell if he was not moved. Mr Stroughton said that being recalled was a step backwards for him and he was unsure what to think about it. He said he had a close relationship with his mother. He said he had no thoughts of killing himself. The custodial manager and nurse assessed Mr Stroughton as being at raised risk of suicide and self-harm, and increased the level of observations to every 30 minutes. Mr Stroughton was moved to another cell. A further review was scheduled for 7 July. The nurse made no entry in Mr Stroughton’s medical records.
34. On 7 July, at 11.00am, a member of the substance misuse team saw Mr Stroughton for a substance misuse assessment. Mr Stroughton said he had been drinking every day while out on licence. He asked for help to manage his alcohol use and use of buprenorphine (known as subutex, used to treat opioid addiction) which he had used illicitly while at HMP Stocken. Mr Stroughton agreed to work with the substance misuse team to address his alcohol and illicit drug use and to focus on the triggers and cravings to minimise a relapse. She recorded that a follow-up appointment was scheduled for 14 July 2017, and the substance misuse team would liaise with community substance misuse services prior to Mr Stroughton’s release.
35. At 11.30am, a SO chaired an ACCT case review with an officer and Mr Stroughton present. No one from healthcare was present or provided any input into the review. Mr Stroughton said he felt better in himself, was in a better frame of mind and had no thoughts of self-harm at that time. The SO assessed Mr Stroughton as being at a low risk of suicide and self-harm, and reduced the level of observations from half hourly to hourly throughout the day and night. The SO did not update the ACCT caremap.
36. At 6.48pm, staff noticed smoke coming from Mr Stroughton’s cell. The fire alarm was raised and staff immediately responded. Mr Stroughton was removed from the cell and the fire was extinguished. A custodial manager and a SO attended the cell. The custodial manager used his body-worn camera to record the incident and the investigator has viewed this footage. He asked Mr Stroughton why he had started a fire in his cell. Mr Stroughton said he did it because “I want to kill myself”. He was moved to another cell and given fresh clothing.
37. A nurse who had responded to the fire alarm, recorded that the fire had been burning in a cupboard and Mr Stroughton had no direct contact with the fire. The nurse also recorded that she had examined Mr Stroughton and his physical

observations were all within normal limits. He had not received any burns and there was no sign he had suffered from smoke inhalation.

38. A custodial manager told the investigator that he had asked a SO to review Mr Stroughton's ACCT document. (It is mandatory for an immediate case review to be held following an incident of attempted suicide.) The SO did not conduct an immediate ACCT review. He recorded in the ACCT ongoing record that the level of observations had been increased from hourly to half hourly.
39. On 8 July, at 11.30am, a SO held an ACCT case review with Mr Stroughton. No one else was present and healthcare had no input into the review. Mr Stroughton said that as he was an IPP prisoner he did not know how long he would be at Nottingham. He said he had no thoughts of self-harm at that time. The SO updated the ACCT caremap with an action for Mr Stroughton's offender supervisor to provide an update on his sentence plan. He assessed Mr Stroughton as being at a low risk of suicide and self-harm, and reduced the level of observations from half hourly to hourly over the course of the day and night. The next review was scheduled for 10 July.
40. On 9 July, at 6.00pm, staff found Mr Stroughton hanging in his cell with a ligature made from bedding. Staff immediately entered the cell, cut the ligature and immediately radioed an emergency code blue (which indicates a prisoner is unconscious, or having difficulty breathing).
41. A nurse responded to the code blue. She recorded that when she arrived at the cell, Mr Stroughton was sitting on a chair. Staff told the nurse that Mr Stroughton had lost consciousness. She recorded that she had examined Mr Stroughton: there were ligature marks around his neck, but he had no other physical issues as a consequence of the attempted hanging.
42. The Head of Reducing Reoffending, chaired an immediate case review with, a custodial manager, a nurse and Mr Stroughton present. Mr Stroughton would not say why he had tried to hang himself. He said it did not matter what the levels of observations was; he intended to kill himself. All three, agreed that Mr Stroughton was at high risk of self-harm, and he was placed under constant supervision.
43. Between 10 July and 16 July, five ACCT case reviews were held. Each review was multidisciplinary and the assessment on each occasion considered that Mr Stroughton remained at high risk and that the constant supervision should remain in place. Staff recorded in the ACCT ongoing record that Mr Stroughton chose his food from the menu each day and it was brought to his cell. However, he would frequently either flush it down the toilet or choose not to eat it.
44. On 11 July, a member of the mental health team, conducted a mental health assessment with Mr Stroughton. He said his appetite was poor and he was not sleeping well. He was not concerned about whether he lived or died. The nurse recorded that Mr Stroughton was at risk of suicide and self-harm, did not engage in the assessment and only responded with brief words.
45. A nurse told the investigator it was a difficult assessment as Mr Stroughton did not fully engage. She did not use any assessment tools to support her clinical

- opinion. She recommended Mr Stroughton be allocated to the primary mental health team and that he should be prescribed anti-depressant medication. She said, in her clinical opinion, Mr Stroughton suffered from depression, and not psychosis, therefore the primary mental health service was more appropriate. She did not consider that Mr Stroughton needed to see a psychiatrist. This was the only direct mental health engagement with Mr Stroughton before his death. Mental health nurses had attended the majority of ACCT reviews.
46. On 13 July, a prison doctor prescribed sertraline (an anti-depressant) following the nurse recommendation. He did not see Mr Stroughton in person. Two nurses, told the investigator that mental health medication was routinely prescribed by a prison doctor on their advice, without the prisoner being seen. They both confirmed that this was custom and practice at Nottingham, however, they also said that they did not think that this was acceptable practice.
 47. On 17 July, the Head of Reducing Reoffending chaired an ACCT case review with a nurse, a substance misuse support worker, a SO and Mr Stroughton present. Mr Stroughton said he felt much better and had no thoughts of killing himself. He said that he had started to eat his meals but was unsure if he would continue to take his anti-depressants. He said he had taken them in the past and felt they did not work. All present at the review assessed Mr Stroughton as being at a low risk of suicide and self-harm, and reduced the level of observations from constant to hourly over the course of the day, and to half-hourly over the course of the night. The next review was scheduled for 19 July.
 48. On 19 July, a SO chaired an ACCT case review with a nurse and Mr Stroughton present. Mr Stroughton said he felt fine and had not thought of harming himself since attempting to hang himself. He said he had been eating his meals and had been out on association on the wing. He said he had decided not to take his anti-depressant medication and was in contact with his family. The SO and nurse, assessed that Mr Stroughton was a low risk of self-harm and reduced the level of observations to two recorded conversations during the day and hourly observations during the night. The next review was scheduled for 26 July.
 49. On 21 July, a psychologist attempted to see Mr Stroughton on the wing but he was not in his cell. There is no evidence in Mr Stroughton's medical record that she made any further attempts to see him. However, on 14 August, she recorded in Mr Stroughton's medical record that she had discharged him from the psychology service.
 50. On 24 July, Mr Stroughton's medical records were updated to show that he no longer wished to take the anti-depressant medication. There was no consultation or follow-up by a prison doctor.
 51. On 26 July, a SO chaired an ACCT review with a nurse from the member of the mental health team, and Mr Stroughton present. Mr Stroughton said he had occasional thoughts of self-harm. They assessed that Mr Stroughton was a low risk of self-harm and kept the level of observations unchanged at two recorded conversations during the day and hourly observations during the night. The next review was scheduled for 2 August.

52. On 2 August, a SO chaired an ACCT review with a nurse and Mr Stroughton present. Mr Stroughton said he felt fine and had no thoughts of self-harm and was aware of how to obtain support. They agreed that Mr Stroughton's risk of suicide and self-harm was low and agreed to close the ACCT. He updated the caremap as all the actions had been completed. They set a post-closure review for 9 August.
53. A nurse told the investigator that Mr Stroughton's mood had improved, he was looking after himself and eating, and gave no indication that he had any thoughts of self-harm or suicide.
54. A manager of D wing, told the investigator that the regime on the wing meant that half of the prisoners were allowed association in the morning and the remainder in the afternoon. At other times, unless unlocked for appointments or visits, prisoners remained in their cells. He said that on average there were 15 to 20 ACCT documents open on D Wing at any time.
55. A D wing officer, told the investigator that Mr Stroughton occupied a cell on his own and kept himself to himself. He said he first had contact with Mr Stroughton when he was under constant supervision. At that time, he would not eat his food and frequently flushed it down the toilet. He said after the ACCT was closed Mr Stroughton would collect and eat his meals.
56. The Head of Security, told the investigator she had first met Mr Stroughton when he was under constant supervision. She said there was no evidence or intelligence to suggest that Mr Stroughton had used illicit drugs since he arrived at Nottingham on 3 July, or was in debt or had been bullied.
57. On 12 August, a SO conducted the ACCT post-closure interview with Mr Stroughton. (This should have been completed on or before the 9 August.) Mr Stroughton said that he had no thoughts of self-harm and got support from his parents and siblings. He said he knew he could get support from staff and the chaplaincy.
58. On 31 August, a custodial manager recorded in Mr Stroughton's prison computer record that he had listened to a message left by Mr Stroughton's mother on Nottingham's safer custody telephone number. This raised some concerns about her son. Mr Stroughton's mother said she had visited him and was very concerned that he appeared to have lost a lot of weight. She said he was not eating and she wanted to know if he was under the care of the mental health team. A custodial manager (CM) recorded that he had contacted the wing and asked staff to check on Mr Stroughton. He also emailed the mental health team to inform them of Mr Stroughton's mother's concerns. The CM also recorded that he had called Mr Stroughton's mother back to inform her that her message had been received and what action he had taken.
59. The CM emailed a clinical matron for integrated mental health, at 11.31am, and attached a copy of his case note from Mr Stroughton's prison computer record. The clinical matron sent an email to a nurse at 11.55am that day, and due to the concerns raised about Mr Stroughton's wellbeing, asked the nurse, as Mr Stroughton's allocated mental health nurse, to follow this up. The custodial manager was copied into the email sent to the nurse.

60. The nurse told the investigator he could not remember exactly but thought he had attempted to see Mr Stroughton on 8 or 9 September but Mr Stroughton had not been available. However, there is no evidence in Mr Stroughton's medical record of the concerns raised by Mr Stroughton's mother, of the clinical matron's request to the nurse or of his apparent attempted mental health intervention with Mr Stroughton.
61. Mr Stroughton's prison phone records show that he called his brother on 4 September and his father on 5 and 6 September. The investigator has listened to each of these calls and at no time did Mr Stroughton say, or give any indication, that he had thoughts of harming himself. Mr Stroughton made no further calls after the call to his father on 6 September.
62. On 11 September, an offender supervisor saw Mr Stroughton on the wing to inform him that he had been granted release on licence by the Parole Board subject to a place becoming available at a suitable Approved Premises. He recorded that there was no change in Mr Stroughton's demeanour and he did not appear pleased at hearing the news. Mr Stroughton said that he did not want to go back to Hucknall Approved Premises. He told Mr Stroughton that because he had set a fire in his cell, this restricted the options of Approved Premises he could be released to. He told Mr Stroughton he would be informed of his release date as soon as it was known.
63. On 13 September, at 4.55pm, a SO was unlocking prisoners so they could collect their evening meal. He told the investigator that when he got to Mr Stroughton's cell, he opened the door and found Mr Stroughton hanging from the window bars in his cell by a ligature made from bedding. He shouted for staff, immediately entered the cell, cut the ligature and lowered Mr Stroughton to the floor. By this time two officers had arrived at the cell. An officer immediately radioed an emergency code blue, which indicates a prisoner is unable, or having difficulty breathing. The other officer and SO began cardiopulmonary resuscitation (CPR). The control room log shows the code blue was called over the radio at 4.55pm and an ambulance was called immediately.
64. Four Nurse's immediately responded to the code blue call. The nurses continued with the resuscitation and used an automated external defibrillator, which administers electrical shocks to restore a normal rhythm to the heart if any is found. The defibrillator found no shockable rhythm, so the nurses continued with CPR.
65. Paramedics arrived at 5.05pm and took over Mr Stroughton's care. They continued CPR and administered four doses of adrenaline (a drug to stimulate the heart). Naloxone (a drug to counteract any possible opiate-based drug that may have been taken) was also given due to Mr Stroughton's substance misuse history. At 5.33pm, the paramedics pronounced Mr Stroughton dead.
66. Staff noticed that Mr Stroughton had written on his cell wall: "I will always love you. I will always miss you you was and amazing brother. Take it izy up there bro. Shane Stroughton RIP (sic)".

Contact with Mr Stroughton's family

67. Two prison family liaison officers (FLO), visited Mr Stroughton's mother at her home address at 9.45pm. They informed her of Mr Stroughton's death and offered their condolences and support. In the days that followed, Nottingham maintained contact with Mr Stroughton's family and, in line with Prison Service guidance, the prison contributed to the costs of the funeral.

Support for prisoners and staff

68. A SO, officer and nurse each told the investigator that they had not been involved in a debrief following the incident. The investigator has not been provided with a copy of any minutes of a debrief. In addition, staff members were not asked to complete incident report forms. (It is a mandatory requirement to hold a debrief for staff involved in an emergency response, including healthcare staff, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support, and for staff to complete incident report forms as soon as practicable.) The SO and officer said the staff care team offered support.
69. The prison posted notices informing staff and prisoners of Mr Stroughton's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Stroughton's death.

Post-mortem report

70. A post-mortem examination, conducted by a consultant histopathologist, confirmed that the cause of Mr Stroughton's death was hanging. The doctor noted that the toxicology results confirmed that Mr Stroughton was not under the influence of alcohol or any illicit drugs at the time of his death.

Findings

Management of risk of suicide and self harm

71. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include a prisoner's first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse, and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.
72. It is clear that Mr Stroughton presented with significant risks, possibly compounded by his IPP status, and staff correctly opened an ACCT on 3 July immediately on Mr Stroughton's arrival at Nottingham. However, national instructions explicitly state it is mandatory that the ACCT first case review should be completed within 24 hours of an ACCT being opened. This did not happen. A SO and nurse held the first case review on 5 July.
73. On the morning of 7 July, a SO assessed Mr Stroughton as being at low risk of self-harm less than 24 hours after a custodial manager had recorded that Mr Stroughton was at raised risk of self-harm as he had said he intended to kill himself. We do not consider that there was sufficient evidence available to justify this conclusion, given the circumstances. We therefore regard this assessment as inappropriate and consider it more likely that Mr Stroughton remained at high risk.
74. Later that evening, after Mr Stroughton had set fire to his cell and said he wanted to kill himself, neither a custodial manager nor a SO, held an immediate case review - a mandatory requirement of PSI 64/2011 following any incident of attempted suicide. We consider that the assessment of Mr Stroughton's risk should have been more rigorous and should have considered actions to address his evidently heightened risk, up to and including constant observations and enhanced procedures.
75. On the morning of 8 July, a SO held the case review on his own. He assessed Mr Stroughton as being at a low risk of suicide and self-harm, and reduced the level of observations. After such a recent incident of deliberate attempted suicide, it is hard to understand the basis for this decision. Again, it is hard not to conclude that the assessment was inappropriate and more likely that Mr Stroughton was at high risk of self-harm and the level of observations should, at least, have remained unchanged. Furthermore, we consider that this should have been a multidisciplinary review.
76. We consider that Nottingham correctly placed Mr Stroughton under constant supervision on 9 July, after his attempt to hang himself. This decision was reviewed in accordance with the instructions contained in PSI 64/2011.

77. We consider that the decision to end constant observation on 17 July was appropriate, and judge that Mr Stroughton received appropriate ongoing support from staff thereafter. However, we judge that the decision to close the ACCT on 2 August, would only have been appropriate if Mr Stroughton had continued to receive ongoing support from the mental health team.

78. PSI 64/2011, also specifically states the following mandatory action:

“Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form”

79. We are concerned that an ACCT was not opened on 31 August after Mr Stroughton’s mother contacted Nottingham with serious concerns for his physical and mental wellbeing, especially given Mr Stroughton’s well documented recent history of suicidal attempts. Mr Stroughton’s mother could have been invited to participate in the ACCT process as a means of additional support. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **conducting ACCT reviews as specified in the national instructions;**
- **assessing the level of risk and recording the reasons for decisions;**
- **setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes;**
- **conducting ACCT post-closure interviews as specified in the national instructions; and**
- **considering information from all sources and recording all the known risk factors of a prisoner when determining their risk of suicide or self-harm.**

Clinical Care

80. The clinical reviewer, considered that the physical care that Mr Stroughton received from healthcare staff at HMP Nottingham was equivalent to that which he could have expected to receive in the community.

81. However, the clinical reviewer had serious concerns about the standard of mental health care and considered that this was not equivalent to that which he could have expected to receive in the community.

82. He commented that Mr Stroughton appeared to be significantly depressed. He was an IPP prisoner, recently recalled to custody, had three recent attempts at suicide, was speaking in monosyllables, not eating, not drinking, was in low mood and continued to express suicidal thoughts and intent. A mental health nurse did not consider he was psychotic and therefore did not refer him to a psychiatrist or any other secondary care mental health services.

83. Mr Stroughton was prescribed an anti-depressant by a prison doctor without a direct consultation, and when he refused to take his medication it was

discontinued without a face to face consultation. The clinical reviewer judged this was not equivalent to the care which Mr Stroughton could have expected to receive in the community.

84. A psychologist, made one attempt to see Mr Stroughton for a psychology assessment on 21 July. However, she discharged him from the psychology service on 14 August, without any assessment or reason for the discharge being documented.
85. The clinical reviewer was also concerned that on 31 August 2017, when a custodial manager, referred Mr Stroughton's mother's concerns to a clinical matron who, in turn, instructed a nurse to see Mr Stroughton. There is no documented record that a nurse made any attempt to see Mr Stroughton. When interviewed, the nurse was unable to say with any certainty if and when he had attempted to review Mr Stroughton.
86. Two nurse's said prisoners referred to the mental health service should be seen within five working days, or within 24 hours if it is deemed urgent. A nurse said at the time of Mr Stroughton's death it took two to three weeks for a prisoner to be seen after a referral had been received. Both Nurses also said the requirement to support ACCT processes had a serious impact on mental health service delivery at Nottingham.
87. We agree with the clinical reviewer's conclusion that the mental health care that Mr Stroughton received was not equivalent to that which he could have expected to receive in the community. It is impossible to know if Mr Stroughton had received appropriate mental health care whether staff at Nottingham may have prevented his actions. We make the following recommendation:

The Head of Healthcare, the healthcare Commissioners and the Governor should review the mental health care provision at HMP Nottingham. The review should consider the capacity to deliver a seven-day service of mental health assessments and ongoing interventions effectively, and the availability of staff to support the ACCT process.

Actions following a death in custody

88. PSI 64/2011 sets out the actions that prisons should undertake after a prisoner's death. Chapter 12 of the PSI contains a mandatory action that a 'Hot Debrief' must be held immediately after a death in custody. A senior member of staff must act as a debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited. Staff told the investigator they did not attend a debrief and there is no record of a debrief taking place.
89. In addition, staff directly involved in an incident, particularly those who were first on scene, must complete Incident Report Forms as soon as practicable. No members of staff were asked to complete the forms after Mr Stroughton died. We make the following recommendation:

The Governor should ensure that all relevant mandatory actions in PSI 64/2011 are completed after a prisoner's death.

**Prisons &
Probation**

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