

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Hallum Elgood, a prisoner at HMP Norwich, on 30 December 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

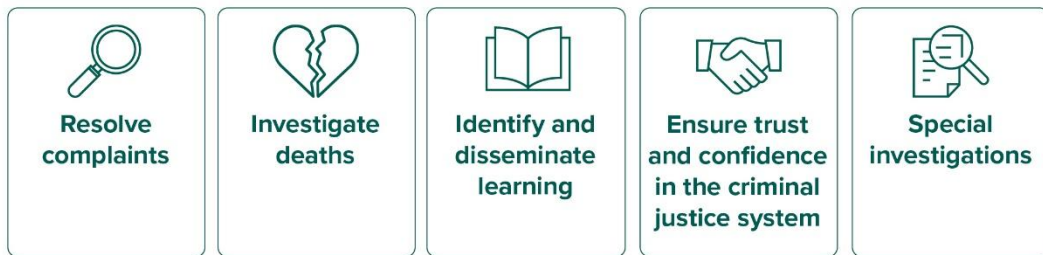
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Hallum Elgood died on 30 December 2024, after he was found hanging in his cell at HMP Norwich. Staff and paramedics tried to resuscitate him but were unsuccessful. He was 38 years old. I offer my condolences to Mr Elgood's family and friends.

On 18 December, the day after arriving at Norwich, Mr Elgood told staff he wanted to isolate and he spent most of his time in his cell over the next week. While there was no indication that Mr Elgood was at imminent risk of suicide, staff did not follow their local policy on isolating prisoners so Mr Elgood was not monitored and supported as he should have been.

I have expressed my concerns before about the cost of phone calls for prisoners. Mr Elgood had run out of phone credit before his death and would not, therefore, have been able to seek the support of family or friends during his period of crisis.

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

Adrian Usher
Prisons and Probation Ombudsman

November 2025

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Summary

Events

1. On 17 December 2024, Mr Hallum Elgood was sentenced to 16 weeks in prison for theft and breaching the terms of his licence. He was sent back to HMP Norwich (he had been released from there on 28 November).
2. Mr Elgood had anxiety and depression and a long history of drug use. When he arrived at Norwich, he told reception staff that he had no thoughts of suicide or self-harm but was worried about managing his anxiety.
3. On the evening Mr Elgood arrived, his ex-partner called the prison with concerns about him. She said that before he was sent to prison, he had been hearing voices and thought people were poisoning his food. A member of the prison's safety team checked on him and he said he was okay. The safety team reported the concerns to the mental health team who scheduled Mr Elgood for the next available triage on 29 December.
4. On 18 December, Mr Elgood told a wing officer that he was having issues with other prisoners and wanted to isolate as he feared for his safety. The same day, staff recorded on Mr Elgood's previous Challenge, Support and Intervention Plan (CSIP – a violence reduction case management model that is also used at Norwich for isolating prisoners), which had been opened in November 2024 during his previous sentence, that Mr Elgood was no longer isolating so a CSIP was not required. There is no evidence that a new CSIP referral was made.
5. On 19 December, Mr Elgood told staff that he had to isolate due to debt concerns. Staff noted that he was aggressive, paranoid and emotional. He destroyed a television and a kettle. That night, Mr Elgood repeatedly rang his emergency cell bell and kicked his cell door, demanding to be moved off the wing. The next day, he refused to leave his cell and staff described him as angry and agitated. He told staff that his food and vapes had been poisoned.
6. On 27 December, Mr Elgood said he was feeling better and no longer wanted to isolate.
7. On 29 December, Mr Elgood had an initial mental health assessment. The nurse noted that he presented as anxious and paranoid and, unlike on previous occasions when she had worked with him, he was hearing voices. She recommended further assessment and advised Mr Elgood to keep a journal of the voices he was hearing.
8. On 30 December, at 1.50pm, an officer went to Mr Elgood's cell to ask him if he needed to be unlocked. Initially he could not see him so he opened the door and stepped into the cell. He saw Mr Elgood had tied a ligature around his neck, made from a ripped bedsheet, which he had tied to a screw in the wall. The officer immediately radioed a medical emergency code and staff started CPR.
9. Ambulance paramedics arrived at 2.03pm and continued with the resuscitation attempts. However, these were unsuccessful and paramedics declared life extinct at 2.52pm.

Findings

10. The prison's local policy on isolating prisoners says that a CSIP referral should be made within 24 hours and a member of the safety team should then investigate the prisoner's reasons for isolation. If the prisoner is still isolating after 72 hours, the prisoner should be placed on CSIP and a case manager assigned. This policy was not followed for Mr Elgood as no CSIP referral was made.
11. The prison said that Mr Elgood stopped isolating on 21 December, which was why a CSIP was not opened. However, there is nothing in Mr Elgood's prison record to indicate that he had stopped isolating until 27 December. The Prison Safety Policy Framework and Norwich's local policy say that for each isolating prisoner, the prison must record details of the regime being offered and taken (e.g. association, shower, exercise, etc.) We have seen no evidence that these records were kept for Mr Elgood. It is unclear therefore what aspects of the regime he was accepting when he was isolating and when he resumed participation in the full regime. We are not satisfied that Mr Elgood was properly monitored or supported while he was isolating.
12. The clinical reviewer concluded that the care Mr Elgood received was equivalent to that which he could have expected to receive in the community. However, she found that there was a potential missed opportunity for the sharing of information between the primary care team and mental health team.

Recommendations

- The Governor should put in place robust and auditable measures to ensure that staff identify and support isolating individuals in line with local policy.
- The Head of Healthcare and the Specialist Service Manager of the Mental Health Team should review the systems and processes to enable integrated multidisciplinary working.

The Investigation Process

13. HMPPS notified us of Mr Elgood's death on 31 December 2024.
14. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
15. The investigator visited Norwich on 8 January 2025. She obtained copies of relevant extracts from Mr Elgood's prison and medical records.
16. The investigator interviewed seven members of staff at Norwich on 19 March 2025.
17. NHS England commissioned a clinical reviewer to review Mr Elgood's clinical care at the prison. She conducted joint interviews at the prison with the investigator.
18. We informed HM Coroner for Norfolk of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
19. The Ombudsman's office contacted Mr Elgood's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not raise any issues. Mr Elgood's ex-partner contacted us separately. She said she had contacted the prison on several occasions to raise concerns about Mr Elgood's deteriorating mental health and she asked for the details of his care in prison. We have addressed these issues in this report and the clinical review.
20. We shared our initial report with HMPPS. They found no factual inaccuracies. Their action plan is annexed to this report.
21. We sent a copy of our initial report to Mr Elgood's family and the solicitors representing Mr Elgood's ex-partner. They did not notify us of any factual inaccuracies.

Background Information

HMP Norwich

22. HMP Norwich is a multifunctional local prison and young offender institution (YOI) which holds remand and sentenced category B, C and D men. Health Care Resourcing Group Limited provides physical health services. Norfolk and Suffolk NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Norwich was in August and September 2022. Inspectors reported that the recorded number of self-harm incidents was higher than in similar prisons and increasing, although repeat self-harmers accounted for around 68% of incidents. Monthly safety meetings analysed a wide range of data, but actions to address and understand the causes of self-harm were too limited.
24. Inspectors reported that mental health services were provided by a skilled, experienced, and multidisciplinary team, which was well led. Any immediate mental health needs were identified during the initial reception screening and appropriate information was shared to ensure continuity of care. A duty worker was allocated daily within the team to respond to urgent applications, triage new referrals and attend ACCT case management reviews. Patients with urgent referrals were seen promptly, but there were 47 patients on the waiting list for a routine appointment, with a waiting time of up to four weeks. Managers had put in place an appropriate strategy to reduce the waiting list and patients were being offered assessment appointments.
25. HMIP conducted an independent review of progress from 30 May to 1 June 2023. Inspectors reported incidents of self-harm were still high. However, good progress had been made in efforts to reduce violence and prevent suicide and self-harm. Inspectors noted that comprehensive strategies, underpinned by in-depth data analysis and consultation with prisoners, had been completed, and care for prisoners had improved. Incidents of both violence and self-harm were on a downward trajectory, although levels were still higher than at similar prisons. Inspectors considered that the prison had made good progress to reduce levels of violence.
26. Inspectors said that a weekly document was emailed to all staff highlighting risks, triggers and behaviour targets for individual prisoners to raise awareness about those being supported through assessment, care in custody and teamwork (ACCT) case management (for risk of suicide or self-harm), and challenge, support and intervention plans (CSIPs).

Independent Monitoring Board

27. 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 29 February 2024, the IMB reported that healthcare was broadly equivalent to that available in the community.

28. The Board noted that the levels of self-harm were high. The mental health team was overstretched. Key workers were diverted to support prisoners suffering and with the greatest need.

Previous deaths at HMP Norwich

29. Mr Elgood was the 11th prisoner to die at Norwich since December 2021. Eight of the previous deaths were from natural causes and two were self-inflicted. There are no similarities between the findings in our investigation into Mr Elgood's death and the findings from the previous deaths. Up to the end of July 2025, there have been three further deaths, all from natural causes.

Incentives Scheme

30. Each prison has an incentives scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

Key Events

31. On 17 December 2024, Mr Hallum Elgood was sentenced to 16 weeks in prison for theft and breaching the terms of his licence. He had failed to attend his hostel and drug and alcohol recovery appointments and had failed to let his probation officer know his whereabouts. He was sent back to HMP Norwich (he had been released from there on licence on 28 November).
32. Mr Elgood had a long history of alcohol and drug use and a history of anxiety and depression. When he arrived back at Norwich, he told the reception officer that he had no thoughts of suicide or self-harm. (Mr Elgood had been managed under prison service suicide and self-harm support procedures, known as ACCT, once before in 2021.)
33. At his healthcare reception screen, he told the nurse he was worried about managing his anxiety. He said he had used crack cocaine, heroin and cannabis after his release on 28 November, but had not drunk alcohol. A drug urine test was positive for benzodiazepines (prescription medication used to treat anxiety but widely abused for its euphoric effects) and methadone (used to treat heroin withdrawal). The nurse referred him to the prison's substance misuse service, Phoenix Futures.
34. Dr A, a GP at Norwich, completed an assessment of substance withdrawal and a medication review. Mr Elgood told him he no longer wanted to take methadone. Dr A noted that Mr Elgood had not displayed any symptoms of substance withdrawal. With agreement from Mr Elgood, Dr A prescribed medication for pain, anxiety, and depression. He was allowed his medication in possession.
35. Mr Elgood was allocated a single cell on A Wing, the Integrated Drug Treatment System (IDTS) wing. That evening, Officer A from the safety team carried out a welfare check on Mr Elgood following a call from his ex-partner who was concerned about him. Officer A noted that Mr Elgood appeared level in mood and said he was feeling okay but was "up in the air" about being back in prison. He said he was able to keep himself safe. Officer A told him to use his cell bell to speak to staff if needed.
36. On 18 December, Ms A from Phoenix Futures met Mr Elgood and gave him advice about harm reduction. Mr Elgood told her he did not use any substances and did not wish to engage with the service. Ms A told him how he could engage with them if he changed his mind.
37. Ms B from the resettlement team also visited Mr Elgood that day, as she noted that his scheduled release date was 14 March 2025. Mr Elgood told her that on release he would be homeless and needed support to try to secure accommodation. He told her that he had previously self-harmed/attempted suicide but said he had no current thoughts or intentions of harming himself. He said he was a recovering alcoholic and was using drugs in the community. However, he had been engaging with Change Grow Live (CGL, an integrated drug and alcohol service in the community) and wanted to engage with Phoenix Futures in prison.

38. That day, a member of healthcare staff recorded in Mr Elgood's medical record that they had been informed of two voicemail messages left by his ex-partner on the prison's safer custody line. She said she was very concerned about him as before being sent to prison, he had been hearing voices and thought people were poisoning his food. She had been trying to get him sectioned under the Mental Health Act. Healthcare staff listed Mr Elgood for the next available triage, which was 29 December.
39. The same day, Mr Elgood told staff that he had lost his medication that had been issued in possession the previous day. Later, Mr Elgood told Officer A that he wanted to isolate as he was "having issues" with others on his landing. In the wing observation book, Officer A noted that Mr Elgood said that he was isolating as he believed contract killers were trying to kill him because he had mistakenly provided information. Mr Elgood wrote a letter addressed to staff in which he said that the prisoner in the cell next door was trying to get into his cell. He said that a lot of people in the prison had been paid to kill him and he would be dead that night if he was not moved. He did not name anyone.
40. Prison staff reviewed the Challenge, Support and Intervention Plan (CSIP) that had been started in November 2024, during Mr Elgood's previous sentence when he said he was under threat from other prisoners. (CSIP is the violence reduction case management model used to manage perpetrators of violence, which can also be used to support victims. At Norwich, they also use CSIP to manage isolating prisoners though it is not designed for this purpose.) Staff noted on the form that Mr Elgood was no longer isolating so a CSIP was not required.
41. On 19 December, staff found Mr Elgood's missing medication. As he was no longer allowed the medication in possession, staff told him he had to collect it from the medication hatch each day. Mr Elgood told Officer B that he was isolating and would not be leaving his cell for any reason. The same day, Ms C was appointed as his prison offender manager (POM) and she had a meeting with him. Mr Elgood told her he was isolating as he had debt concerns. He said he had no thoughts of suicide or self-harm. There is no evidence that a CSIP, or any other plan to monitor Mr Elgood as an isolating prisoner, was considered again.
42. The same day, Supervising Officer (SO) A completed an incentive level review after Mr Elgood destroyed his television and kettle. Staff noted Mr Elgood was aggressive, paranoid and emotional. Mr Elgood told SO A that he was suffering with poor mental health. SO A told Mr Elgood that due to the damage caused, he would be downgraded to the basic level (where a prisoner loses access to certain privileges) and he placed him on report (a disciplinary charge) for damaging prison property. Mr Elgood pleaded guilty and refused to attend the hearing. The charge was found proven and Mr Elgood was required to pay £82 to the prison. SO A did not refer Mr Elgood to the mental health team.
43. Later that afternoon, Officer C recorded that Mr Elgood had not attended purposeful activity as he said he was isolating and was DNU (Do Not Unlock).
44. During the night, Mr Elgood rang his emergency cell bell and kicked his cell door multiple times. He told staff he needed to move off the wing immediately. Staff told him he would have to wait until the morning.

45. On 20 December, Mr Elgood asked Officer B for his medication. Officer B said that he needed to leave his cell to collect his medication and staff could arrange for this to be when no other prisoners were out of their cells. Mr Elgood became angry and remained so for the rest of the day. (The clinical reviewer found no evidence to suggest that Mr Elgood was not collecting his medication each day.)
46. Officer D noted that she saw Mr Elgood throw away his new vapes and he told her they tasted “weird” and he believed they were poisoned. He said he needed to move off the wing as he was under threat and people were going to kill him. After collecting his meal and taking it back to his cell, he rang his emergency cell bell and said that his food was also being tampered with.
47. The minutes from that day’s Daily Safety Intervention Meeting (SIM) say, “If Mr Hallum Elgood A2-25 is isolating then he needs adding to the isolator log and a CSIP referral made – CM A informed and will take back to the wing to action.” The next Daily SIM minutes from Monday 23 December make no mention of Mr Elgood and his name does not appear in the list of isolating prisoners. The prison told us that Mr Elgood stopped isolating on 21 December, though there are no entries in his prison record on 21,22 or 23 December to confirm this.
48. On 24 December, SO A completed an incentive level review and noted that there was no reason to keep Mr Elgood on the basic level as for the past seven days he had not had any negative entries and he should be upgraded to standard (when certain privileges would be reinstated). SO A said after he spoke to Mr Elgood at the cell door, he updated Mr Elgood’s prison record and he asked prison officers to supply a replacement television and kettle. However, he could not find any documentation to confirm this had been actioned. (We know Mr Elgood was subsequently given another television due to later entries in his record.)
49. The same day, Nurse A recorded that Mr Elgood had told her that he normally self-medicated with diazepam for anxiety and asked for something similar. Nurse A advised him to attend the drop-in clinic on Sunday (29 December).
50. On 26 December, Mr Elgood reported to staff that he had eaten rat poison which had been served in his lunch. Ms D, a healthcare assistant, checked his observations which were all within normal range, apart from his heart rate which was high at 112 beats per minute. She arranged for another check to be completed later in the day. Later that day, Ms E repeated the checks and noted that Mr Elgood’s heart rate was still high at 110 beats per minute and arranged for another check the next day.
51. On 27 December, Ms C visited Mr Elgood to collect some completed paperwork for his release. Mr Elgood said he had misplaced the paperwork, was feeling better and was no longer isolating. Ms C said she would return to help him complete the paperwork.
52. Later that day, Ms D saw Mr Elgood at the medications hatch when he collected his medication. He said his food was being spiked with rat poison. Ms D noted that he engaged well and there were no signs of confusion. She took his physical observations which showed that his blood pressure was low and his pulse rate was high. She arranged for a welfare check later that day. Nurse B completed the welfare check and took Mr Elgood’s observations. He noted that Mr Elgood said he

felt fine and his pulse rate and blood pressure had improved. Mr Elgood asked for a blood test to check for rat poison.

53. In the early hours of 28 December, Nurse A reviewed Mr Elgood as he said that he was feeling dizzy, his food had been poisoned and he had no means to purchase canteen (items from the prison shop). She arranged for a colleague to review him later that morning. Nurse B arranged for blood tests. He checked his observations and noted there had been little change from his previous check.
54. Mr Elgood made his last phone call on 28 December, to his ex-partner. The call lasted 33 minutes and was cut off when Mr Elgood ran out of credit. The prison told us that Mr Elgood told his ex-partner that he would speak to her when he had put more credit onto his phone. They said that he expressed some paranoid thoughts but that they also spoke about family and friends and other topics. The prison did not initially provide us with a recording of the call and when we requested it, they said it had been deleted from their system.
55. On 29 December, Mr Elgood attended the drop-in clinic and asked for a medication review. The nurse added him to the GP list.
56. The same day, Nurse C, a mental health nurse, completed an initial mental health assessment following the referral on 18 December. Mr Elgood said he felt his overall mental health was poor. He heard voices planning to hurt him and he believed his food was poisoned. Nurse C noted that he was on edge during the review and said he had no current thoughts of self-harm. He said that previously he had had fleeting thoughts, but his family kept him focused and positive. He said he had no history of suicide attempts, self-harm or hospital admissions for mental health. Nurse C noted that having worked with Mr Elgood before, this was the first episode he had reported of hearing voices and he was fearful, paranoid and anxious. She also noted that his partner had contacted the prison with concerns and she had said that this had also been an issue in the community. Nurse C decided that this needed further exploration which would begin with Mr Elgood completing a voices diary. At interview, she said that her plan was to review him once the diary was complete and then add him to the team's caseload.
57. During lunchtime on 29 December, Mr Elgood told staff he felt dizzy. Nurse D attended and advised him to increase his fluid intake. Later that afternoon, Nurse D checked his observations and noted he was satisfied these were at a satisfactory level. Mr Elgood complained about back pain so Nurse D added him to the GP appointment list.

Events of 30 December 2024

58. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 30 December.
59. Nurse B completed a welfare check in the morning, following on from the previous day's report that Mr Elgood felt dizzy. Mr Elgood said he felt better and had no complaints. Nurse B checked his observations and they were within normal range. At interview, Nurse B said there was nothing of concern in his behaviour during their meeting.

60. At 1.14pm, Mr Elgood pressed his emergency cell bell. Officer E went to the cell and spoke to Mr Elgood. In her written statement she said that he asked to speak to a SO. She said she asked him if she could help as it was lunchtime, but he said he would wait. She said she asked him if he was okay and he said he was fine. She said she had known Mr Elgood from previous sentences and there was nothing in his demeanour that raised any concerns with her.
61. At 1.50pm, Officer F went to Mr Elgood's cell to ask him if needed to be unlocked. In his statement, he said when he first looked through the observation panel, he could not see him, but then thought he saw him beside the toilet so he opened the door and stepped into the cell. He saw Mr Elgood had tied a ripped bedsheet around his neck, and tied it to a screw in the wall. He immediately radioed a medical emergency code blue and activated his BWVC.
62. One of the first officers to arrive was Officer G. In his statement, he said he saw Mr Elgood hanging by a piece of green fabric, connected to the wall. He used his anti-ligature knife to cut the ligature. When Mr Elgood was on the floor he said he struggled to find a pulse. However, he saw his lips were pursed and air was escaping and the saliva on his lips was moving. Healthcare staff then arrived and staff rolled Mr Elgood onto his back and Officer G began chest compressions. Healthcare staff removed Mr Elgood's shirt and attached defibrillator patches to his chest. Officer G continued with chest compressions as the defibrillator indicated no shock required. After around four minutes, Officer G swapped doing chest compressions with Officer F.
63. Prison and healthcare staff assisted with resuscitation attempts. Ambulance paramedics arrived at 2.03pm, a rapid response helicopter arrived shortly afterwards and continued with the resuscitation attempts. Paramedics declared life extinct at 2.52pm.
64. An intelligence report submitted after Mr Elgood's death said that Mr Elgood was at risk of bullying and threats as he had accrued a large debt. (The investigation did not uncover any evidence to confirm that Mr Elgood was in debt, or what any debt might have been related to.)

Contact with Mr Elgood's family

65. On 30 December, Ms F, a prison manager, SO B and Ms G, a safer custody administrator, visited Mr Elgood's father to break the news of his son's death and offer support.
66. The prison appointed SO B as the lead family liaison officer and Ms G as the deputy on 2 January. Mr Elgood's father said he would like his daughter to be the next of kin. Ms G rang her and offered condolences and support. On 3 January, Mr A, a prison offender manager, took over as the lead family liaison officer and contacted Mr Elgood's next of kin to introduce himself and offer support.
67. The prison contributed to the cost of Mr Elgood's funeral, in line with national guidelines.

Support for prisoners and staff

68. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.
69. After Mr Elgood's death, Mr B, a prison manager, debriefed the prison and healthcare staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The healthcare staff we interviewed also said they had a separate debrief and they thought they had received good support.
70. The prison posted notices informing other prisoners of Mr Elgood'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 Elgood's death.

Post-mortem

71. The post-mortem report concluded that the cause of Mr Elgood's death was hanging. The toxicology examination found only Mr Elgood's prescribed medications in his system.

Findings

Assessment of Mr Elgood's risk of suicide and self-harm

72. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), which was in force at the time of Mr Elgood's death, set out the processes (known as ACCT) that staff should follow when they identified that a prisoner was at risk of suicide and self-harm. It also set out guidance to staff on the risk factors and triggers that might indicate an increased risk. (The policy has since been superseded by the Prison Safety Policy Framework though ACCT processes remain broadly the same.)
73. Mr Elgood had a history of anxiety and depression along with alcohol and drug use, but he did not have risk factors that alone would have prompted management under ACCT. His partner advised the prison of her concerns about Mr Elgood's paranoia, and staff were also aware of this. We consider that Mr Elgood gave no indication to staff that he was at imminent risk of suicide during his time at Norwich.

Mr Elgood's isolation

74. Norwich's Isolating Individuals Policy sets out how staff should identify isolating prisoners, how they should monitor them and the support that can be offered to encourage them to resume participation in the prison regime. It says:
- "An isolating individual is a prisoner who withdraws from the regime and is often confined to their cell; this is a decision that is made by the individual and there are several reasons why a prisoner would choose too [sic] self-isolate. Prisoners may feel unsafe due to debt, gang issues, external issues, bullying, offence related issues or mental health issues. It is important to quickly recognise the reasons behind the isolation."
75. The policy says that any prisoner identified as isolating should be referred for a CSIP within the first 24 hours. A member of the safety team will then investigate their reasons for isolation, including interviewing the prisoner, and if the prisoner remains isolating after 72 hours, they will be placed on CSIP and a case manager assigned.
76. The policy also advises staff to complete the regime and facilities tracker to show the regime offered and accepted by the isolating prisoner.
77. Mr Elgood told staff that he wanted to isolate on 18 December due to issues with others on the wing (though this may have been due to paranoia rather than actual threats). Staff recorded that Mr Elgood remained isolating on 19 and 20 December, yet there is no evidence that he was referred for a CSIP or that a member of the safety team investigated his reasons for isolating. Nor is there any evidence that the regime and facilities tracker was completed.
78. The Daily SIM minutes from 20 December recorded that CM A would action the CSIP referral if Mr Elgood was still isolating but there is no evidence he did so. The prison told us that Mr Elgood accepted the regime on 21 December and was no longer isolating after that. However, there are no entries at all in Mr Elgood's prison

record on 21,22 and 23 December. It is not until 27 December that staff recorded that Mr Elgood felt better and was no longer isolating.

79. Staff failed to follow the prison's policy for Mr Elgood when he began isolating. He therefore did not receive proper monitoring and support. We recommend:

The Governor should put in place robust and auditable measures to ensure that staff identify and support isolating individuals in line with local policy.

Clinical care

80. The clinical reviewer noted that Mr Elgood did not have a mental health diagnosis. It was not clear if the paranoia he was experiencing was the result of illicit substances he had taken in the community or if there was further enduring mental illness. Arrangements were underway for him to complete a voice diary which mental health staff would review. The clinical reviewer concluded that the clinical care Mr Elgood received was of a good standard and equivalent to that which he could have expected to receive in the community.
81. However, the clinical reviewer considered that there was a potential missed opportunity for the sharing of information between the primary care team and mental health team, with no joined-up safety huddle to share concerns. We recommend:

The Head of Healthcare and the Specialist Service Manager of the Mental Health Team should review the systems and processes to enable integrated multidisciplinary working.

Inquest

82. At the inquest, held on 13 April 2026, the jury concluded that Mr Elgood died by hanging.

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100