Investigation into the circumstances surrounding the death of a man at HMP & YOI Norwich in July 2009

Report by the Prisons and Probation Ombudsman for England and Wales

June 2010

This is the report of an investigation into the death of an inmate at HMP & YOI Norwich. This man died after being transferred from HMP Norwich to a hospital in Norwich in July 2009. He was 38 years old. The man was only in prison for a few hours before he took his own life. He had been charged with murdering his estranged wife (an offence which is known to increase the risk of self harm). He was being monitored by the Prison Service's monitoring procedures at the time.

I would like to add my personal condolences to those already expressed to the man's family by one of our office's Family Liaison Officers. I apologise for the delay issuing my report, and hope this did not cause too much extra distress.

This investigation was undertaken a senior investigator. Both he and I would like to thank the Governor of HMP Norwich and his staff for their participation in the investigation.

A clinical reviewer was identified by NHS Norfolk to undertake a review of the man's clinical care, and I appreciate both her assistance throughout the investigation and her final report. The clinical reviewer makes several recommendations relating to healthcare procedures. In particular, I draw the Head of Healthcare's attention to the clinical reviewer's recommendations about training and the use of assessment tools. I am however satisfied that, even had any of these changes already been in place, that it would not have altered the outcome for this man. But if improvements are made, they may lessen the likelihood of a similar tragedy in the future.

I make five further recommendations. Two relate to identifying mental health concerns in reception, and effective communication between the healthcare and mental health teams at Norwich. Other recommendations relate to razors for prisoners who are subject to self harm monitoring, the supply of first aid materials and effective critical incident debriefs. I am pleased to see that the Prison Service accepted four of my recommendations and partially accepted the other. The man's family did not make any comments in relation to the draft report.

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

Jane Webb
Acting Prisons and Probation Ombudsman **June 2010**

CONTENTS

SUMMARY

The man was a Polish national who lived in the UK. He was arrested on suspicion of murdering his estranged wife on Friday 24 July 2009. Whilst in police custody, he suffered from alcohol withdrawal and required frequent medical monitoring. He was prescribed medication, and requests were made for his mental health to be assessed. However the psychiatrist, who made two attempts to see the man, was told that the assessment was no longer necessary and so did not see him.

On Tuesday 28 July, the man appeared in court and was remanded in custody. He was taken to HMP Norwich. It was his 38th birthday.

The psychiatrist contacted the head of the mental health team at the prison to pass on his concerns. The head of the mental health team at the prison tried to contact medical staff on A wing, where new prisoners enter the prison and are medically assessed, but was unable to do so.

The man was assessed at reception where staff judged that he was at risk of harming himself. He was therefore placed on special monitoring procedures. He underwent the standard medical screening, but was not judged to be in need of a mental health assessment. He was allocated to a cell which he shared with another prisoner. During the evening the man asked staff for extra razors, as he had not shaved for a few days and had grown a short beard.

As part of the monitoring arrangements, staff checked on the man through the evening. Although his English was poor, the man and his cellmate held basic conversations, and there were no signs of any problems.

Shortly after 1.00am on the morning of the man's death, the man's cellmate was awoken by some noise. He switched on the light, and saw that the man was lying on the cell floor, bleeding heavily. He activated the emergency bell, and staff came to the cell. They provided emergency first aid whilst an ambulance made its way to the prison. At one point the man stopped breathing, but staff managed to revive him. The ambulance arrived and paramedics continued to provide medical aid. He was transferred to hospital, but unfortunately the man died at 3.18am.

The man's cellmate was supported by several members of staff and other prisoners at risk of harming themselves were checked. A debrief was held with staff after the man was taken to hospital. Staff were offered support from the Care Team if they felt that they needed it. However, the subsequent critical incident debrief meeting was arranged when a number of those who had been involved were not available.

After some initial difficulty, the prison managed to make contact the man's family in Poland. The prison arranged his funeral, and provided his family with details of where he was buried.

I make five recommendations. Two relate to the identification of mental health issues in reception and communication between healthcare and mental health teams at Norwich. Other recommendations are made about providing at-risk prisoners with razors, the configuration of first aid boxes and attendance at debrief sessions.

THE INVESTIGATION PROCESS

1. My colleague formally opened the investigation at HMP Norwich on 30 July 2009. He spoke to a number of staff, including the Governor, and was shown extensively around the prison. He later returned to the prison and formally interviewed six members of staff. The interviews were recorded and interviewees were asked to sign a copy of their transcripts confirming the accuracy of the record. Three signed copies were returned. My colleague also spoke to the head of the mental health team on the telephone. Copies of all the transcripts and a note of the telephone conversation are annexed to this report.

2. Notices were posted to staff and prisoners about the investigation, inviting contributions. No responses were received.

3. My colleague studied all available relevant prison records relating to the man, including medical records and statements made by staff.

4. NHS Norfolk identified the clinical reviewer to review the man's clinical care. I am grateful to her for undertaking the review. My colleague discussed aspects of the man's treatment with the clinical reviewer, and they conducted joint interviews of staff. My colleague also attended the clinical review panel which NHS Norfolk held to discuss the man's clinical care.

5. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist his enquiries into the man's death.

6. The man was a Polish national. One of the Ombudsman's family liaison officers wrote to the man's parents in Poland to offer the opportunity to raise any questions or concerns for the investigation to consider. The man's parents asked if the report could clarify how their son had died. They also asked for details of where he was buried, and we have arranged for that information to be passed on to them. They requested a copy of my report when available, and a translated copy will be provided for them.

HMP & YOI NORWICH

7. HMP & YOI Norwich is a multi-functional prison, predominantly serving the courts of Norfolk and Suffolk. The prison has occupied its current site overlooking the city of Norwich since 1887. The prison accepts adult men and young offenders, both convicted or on remand. It has an operating capacity of 557 prisoners. A wing includes the induction unit, First Night Centre, and drug treatment areas. B and C wings contain category C prisoners. D wing is the resettlement unit. E wing is the vulnerable prisoner unit. F and G wings are the local discharge unit for low risk prisoners serving shorter sentences. L wing is the Elderly Lifer Unit, and M wing holds prisoners serving sentences of two years or less. There is also a segregation unit, and a healthcare centre which provides 24-hour nursing cover.

Mental health services

8. The mental health in-reach service provides staff cover in the prison from 9.00am to 5.00pm on weekdays. There is no out-of-hours service for mental health.

Assessment, Care in Custody and Teamwork (ACCT)

9. Assessment, Care in Custody and Teamwork (ACCT) procedures are used by the Prison Service to monitor and support prisoners assessed as at risk of suicide or self-harm. Once placed on ACCT, the prisoner is observed at pre-determined intervals according to the perceived level of risk. Each prisoner should be assessed within 24 hours of the ACCT being opened, and then reviewed at intervals decided on a case by case basis.

Night state

10. When prisoners are locked in their cells in the evening, the prison is in what is known as night state. Staffing levels are reduced, with patrols on each wing. The Night Orderly Officer is in charge of the operation of the prison, and is the only one with keys to access all areas. Staff carry keys, held in sealed pouches, which they can use to access cells in the event of an emergency.

Cell call bells

11. Each cell has an emergency call bell. Prisoners push a button in the cell, and a buzzer goes on in the wing office to alert staff. In addition, a light goes on to let staff know which landing the emergency is on. It does not specify which cell has had its emergency bell activated. Once staff go to the landing indicated, a light outside the door indicates the cell with the emergency. Staff can only cancel the call by using a button outside the cell door and it cannot be cancelled from the office. In July 2009, there were no records maintained of cell bell activation in E wing.

Previous deaths at Norwich

12. Before this gentleman, 31 prisoners had died in Norwich since the Ombudsman became responsible for investigating deaths in custody in 2004. There have been a further two deaths there since. The prison contains the country's only unit adapted for older prisoners and, as a consequence, has a high number of deaths due to natural causes. But of these deaths, 10 prisoners died, like this man, after apparently harming themselves. Two of these prisoners were on special monitoring measures when they took their own lives, and two others died less than 30 hours after arriving in prison.

13. A number of previous reports from this office have contained recommendations about the healthcare provision in the prison. These recommendations include issues around the reception process, mental health services including triggers for assessments.

Her Majesty's Inspectorate of Prisons

14. The last report on Norwich published by Her Majesty's Chief Inspector of Prisons was the report on an unannounced follow-up inspection in November 2006. The report found that previous criticisms relating to suicide and self-harm procedures had been fully addressed by senior managers.

15. The report recommended that the PCT and healthcare should undertake a full review of all healthcare services to ensure that appropriate services are provided. The report also recommended that the mental health team should be involved in the care of prisoners subject to self-harm monitoring procedures.

Independent Monitoring Board

16. Every prison in England and Wales has an Independent Monitoring Board (IMB) responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The Norwich IMB annual report for 2009 does not contain anything which is relevant to the death of the man.

KEY FINDINGS

Previous imprisonment in HMP Norwich

17. On 11 March 2009, the man was convicted of drink driving and common assault. He was sentenced to two months and 23 days imprisonment. Initially in HMP Hollesley Bay, he was transferred to Norwich on 13 April. The Prisoner Escort Record (PER) contained a warning that the man was potentially at risk of harming himself, so an ACCT document was opened. The man told staff that he was depressed. He remained on the ACCT until 16 April. Staff noted that his mood fluctuated, and felt that he would need to be monitored if he was at "a very low point". He told staff that he had considered harming himself.

18. Bailed on 24 April, the man was again remanded to Norwich prison on 4 May. An entry on his medical record shows that the man said he was upset to be back in prison after such a short period. A note on his medical record shows that he said he had previously been prescribed anti-depressants. He told staff that whilst he had no thoughts of harming himself at the time, he did not feel able to say how he might feel about this the next day. He was once again placed on ACCT observations on 4 May and they remained in place until 13 May. He was released on bail on 24 May.

In police custody

19. The man was arrested on 24 July on suspicion of murdering his wife. Whilst still in police custody, he was medically reviewed and, complaining of chest pain, was sent to hospital for further assessment and treatment. He returned to the police station just after midnight. He was seen by a doctor at 9.40am who noted that the man was probably alcohol dependent, and was showing signs of withdrawal. He was not known to the local psychiatric services, but declared mental health issues in the past. The doctor advised that he should undergo a mental health assessment. In the meantime, he was prescribed diazepam. (Diazepam is a sedative and is a common medication given to those withdrawing from heavy alcohol usage.)

20. A further review was held at midday by another doctor. The man told the doctor that he had a history of depression, suicidal thoughts, and auditory and visual hallucinations. He was not, however, suffering any current hallucinations and said that he had no intention of taking his own life. The doctor concluded that the man was not suffering from any acute psychiatric problems which required urgent action. Having discussed the case with a community psychiatric nurse from the local emergency psychiatric care team, the doctor advised that the team would arrange a psychiatric review the following Monday 27 July.

21. Another doctor assessed the man later that day. The doctor noted the risk of self-harm as high/medium, and recommended that he should continue to be prescribed diazepam, and be constantly observed by police staff.

22. On Monday 27 July, whilst still in police custody, the man was given a further medical review. He complained of abdominal pain, and the doctor said that he would need to go to hospital the following morning, either before or after his court appearance. The man was prescribed painkillers.

23. At 7.15pm, a nurse from the mental health service's criminal justice liaison team received a telephone request to assess the man at the police station. However, when the nurse and a forensic consultant psychiatrist arrived at the police station they were told that an assessment was no longer required.

24. A police medical report at 9.10am the following morning, 28 July, noted that the man was showing signs of depression. He admitted that in the past he had tried to harm himself, and the form was marked "constant cell watch suicide risk". The man also said that he still had abdominal pain, and the next dose of painkillers was administered early. He was advised to speak to the prison doctor when he arrived.

25. Another request was received by the mental health team for an assessment of the man at the police station. However, on arrival at the station they were told that the assessment should take place at court. They went to the court, but were once again unable to obtain access to the man.

26. The man was remanded to HMP Norwich. The court's Prisoner Custody Officer completed the man's prisoner escort record (PER), and one section of the form asks if the prisoner is exhibiting signs of "bizarre behaviour, or other signs of mental disorder". The Custody Officer indicated that he was, and that he had had a reaction to the outcome of his court appearance. The form also shows that he had threatened to harm himself in police custody.

HMP Norwich

27. According to the PER form, the man arrived at HMP Norwich at 3.15pm. It was his 38th birthday. He was seen on reception by a female officer, and she noted the risks contained in the PER form. In addition to this, the female officer noted that the man was charged with the murder of his wife (which has been identified as a factor in prisoners attempting to harm themselves), and appeared agitated. She therefore opened an ACCT document. He was to be observed by staff at least once an hour and would be reviewed within 24 hours. Norwich's Safer Custody Policy states that the safer custody team will inform mental health services when an ACCT is opened, but due to the lateness of the ACCT being opened on the man, Safer Custody were not informed (they would have been informed the next morning). The man underwent a cell sharing risk assessment, and was judged to present a low risk of harm to anyone else.

28. Having twice been unable to gain access to the man to conduct a mental health assessment, the forensic consultant psychiatrist from the mental health service's criminal justice liaison team telephoned the head of the prison's mental health team. The call was made at approximately 4.00pm. The forensic consultant psychiatrist explained what had happened and told the head of the prison's mental health team that the man may have in the past suffered from depression.

Believing the man to not yet have arrived in the prison, the head of the prison's mental health team telephoned the treatment room in the prison's reception wing to pass on the information. However, there was no answer. The head of the prison's mental health team knew that the man would be assessed on arrival at the prison and was confident that any risk would be identified. He or one of the mental health team would visit the man the following day.

29. As part of the reception process, prisoners at Norwich undergo a health screening by a member of the healthcare team. The man was seen by a nurse who shall be referred to in this report as Nurse A. In interview, Nurse A mentioned the time-pressured environment that reception staff work in. Prisoners often arrive late in the afternoon, after appearing in court, which can mean a large influx of people shortly before staff shifts are due to end.

30. The reception screening is conducted using the prison's medical computer system, SystemOne. Using this system, Nurse A had access to the man's medical records from his previous stay in Norwich. Nurse A also had access to his medical forms from his detention in police custody. She noted his threats to harm himself whilst he had been in police custody, and that he had been placed on an ACCT in reception. As the man's first language was Polish, and his English was limited, Nurse A communicated with him using a telephone interpreting service. She noted that he appeared calm, was co-operative and good-humoured. He made no mention of wanting to harm himself. He told her that he had no history of mental health problems. He said that he had suffered chest pains for two days over the previous weekend. He had a Salbutamol inhaler, which he said he was given in police custody. He claimed not to drink alcohol, but Nurse A noticed from the medical record that one of his previous periods in Norwich was due to a charge of drink driving. She also made a note that no medical or psychiatric report was required, and she did not request a mental health assessment. A referral was made for the man to see a doctor about insomnia.

31. A fellow inmate arrived in Norwich at the same time as the man. The two men did not know each other, but in interview for this investigation the fellow inmate said that he noticed the man whilst they were in the reception area. After the reception process they found themselves in the same room (along with some other prisoners) when served their evening meal. The fellow inmate did not want his food, and gave it to the man. In interview, the fellow inmate said that he remembered the man wondering aloud about how heavily a person would bleed if they cut their wrist with a razor blade. The fellow inmate was then taken to cell E1-03 on E wing (which is the wing where prisoners spend their first night in prison). A few minutes later, the man was allocated to the same cell and joined him. An entry on the man's ACCT document notes at 7.00pm that there were "no issues".

32. The fellow inmate said that the man's English made communication difficult, but they talked a little as best they could. As part of the kit provided to prisoners, they were each given two disposable razors. The fellow inmate said that the man had a short beard, so asked if he could have more, and staff brought him another two. At one point the fellow inmate noticed that the man was prising

open one of his razors with a plastic knife, and advised him that he would be in trouble if he was seen. The man said that he wanted to cut some paper and was making an implement with which to do so.

33. The day staff on the wings went off duty at 8.00pm, and night shifts began. On E wing, the night shift consists of one officer and one operational support grade (OSG). The staff on E wing that night were an officer, who shall be referred to as Officer B in this report, and an OSG. They were briefed about any issues on the wing that evening, including being made aware of any prisoners subject to ACCT procedures. They noted that the man was subject to ACCT monitoring and was to be checked at least once an hour.

34. E wing has two landings, and staff patrol each of these, including a check on all prisoners in their cells, at least once an hour. As they complete each check, they record it on an electronic logging point at the end of each landing. This is known as pegging. Observations of prisoners on the ACCT procedures are carried out in addition to the standard checks. Moreover, they are made at irregular intervals, so that prisoners cannot predict when they will be checked.

35. On taking over from the day staff, the OSG undertook a roll-check, looking in on the prisoners on the wing and ensuring that the correct number of prisoners were present. He did this at 8.30pm, and noted on the ACCT form that the man was making his bed. The OSG asked him if he was okay, and the man replied that he was. The OSG noticed that his English was not very good.

36. The OSG and Officer B made a number of further checks on the man. At 9.15pm he was sitting in a chair watching television, and at 10.00pm he was moving about his cell, talking to his fellow inmate and watching television.

37. At 10.55pm the man was in bed, and the OSG noted movement. He was still in bed at 11.52pm, and again at 12.30am, when once again the OSG noted movement.

38. At some time shortly after 1.00am, the fellow inmate was awoken by a sudden noise. Being on the top bunk, he looked over the edge of his bed, and saw the man rocking and mumbling in Polish. He told him to be quiet and lay back down. He had noticed that the man had an inhaler and wondered if he was having some sort of fit. The man continued to make noise, and after approximately five minutes the fellow inmate heard him drop to the floor. At this stage he switched on the cell light, and was able to see that the cell was heavily bloodstained and the man was lying on the floor.

39. The fellow inmate pressed the cell call bell. He said in interview that there was a delay of some minutes before staff attended the cell. There were no means of recording the times that cell bells were activated on E wing, but Officer B estimated that it was approximately 1.15am. The OSG went immediately to the cell. He looked through the observation panel and saw the man sitting on the floor with his back against the door. There was a lot of blood in the cell. The OSG called to Officer B that this was a Code Red emergency (indicating that a prisoner was suffering from blood loss).

40. All staff in the prison during night state carry radios. Emergency requests for assistance can be made via the radio or telephone. When the OSG said that there was an emergency, Officer B was very close to the telephone in the office. She telephoned the control room to say that there was a code red emergency. This call was made at 1.16am. A call was then put out over the radio network. Officer B quickly joined the OSG at the cell.

41. Having tried and failed to get a verbal response from the man, the OSG broke the seal on his cell key pouch and unlocked the door. The man was leaning back against the door so they had to push hard to gain entry, but they managed to get the door open and enter the cell.

42. The OSG propped the man up on the side of his bed and saw a large wound on the side of his neck. He told Officer B that he needed a pad or something similar to stem the flow of blood, and she went to the office and opened the sealed self-harm kit. In interview, she said that she could not find any dressings appropriate for an incident involving heavy bleeding in the kit. She therefore picked up a towel and took that back to the cell. The OSG pressed the towel on the wound, and then he and Officer B checked the man for other wounds. It was obvious to them that there were other wounds, and this was a very serious incident. Officer B saw numerous cuts to the man's wrists, inside his elbows, face and chest. However, because of the amount of blood loss he had already suffered, he was not bleeding much at this stage. He mumbled incoherently and tried to get up, so the OSG and Officer B tried to calm him and keep him lying down. His breathing was very laboured, and his skin pale.

43. A nurse, who shall be referred to in this report as Nurse D, was the member of the medical team on emergency response, and was in the treatment room. When the prison is in night state, the only member of staff carrying keys to access all parts of the prison is the Night Orderly Officer. On this occasion this was a Principal Officer, who shall be referred to in this report as Principal Officer E. On hearing the emergency call, Nurse D picked up the self-harm emergency bag and made his way to the door. At the same time Principal Officer E also responded to the emergency call and made his way from his office to collect Nurse D and escort him to E wing. Principal Officer E estimated that this would have taken about three minutes before they arrived at the man's cell.

44. Nurse D went into the cell and immediately saw that the man had lost a large amount of blood. Principal Officer E instantly saw the seriousness of the situation and radioed to the control room to call an emergency ambulance. The control centre requested it at 1.17am. Principal Officer E radioed for another member of staff to go to the main gate to escort the ambulance. He went to the gate to organise the necessary keys. He also identified two members of staff to escort the man to hospital.

45. Nurse D went to the wing office and collected the wing's emergency bag, containing further medical equipment including an oxygen cylinder and machines to monitor blood pressure, oxygen saturation levels, and heart rate. He and the OSG continued to provide first aid, but whilst they were doing so, the man

stopped breathing. They therefore commenced cardio-pulmonary resuscitation (CPR), with the OSG managing the man's breathing and Nurse D providing heart massage. They managed to restart the man's breathing and continued to provide first aid.

46. The fellow inmate asked if he could do anything to help. But, seeing that he was in a fair amount of distress, Officer B took him out of the cell and away from what was happening. Principal Officer E had identified a cell for the fellow inmate, and Officer B took him there. She waited a while with him, reassuring him. She offered him the opportunity to use the Samaritans' telephone, but he declined. Officer B told him that she would check on him through the rest of the night. She then went back onto the wing, and made a precautionary check on the other prisoners who were on ACCT documents.

47. A first response paramedic arrived at 1.30am and was taken straight to the man's cell. He was appraised of the situation and radioed to the ambulance service to provide an emergency ambulance as soon as possible. He then provided medical treatment, assisted by the OSG and Nurse D. Principal Officer E ensured that staff remained in position to escort the ambulance through to E wing on arrival.

48. The ambulance arrived at 1.40am, and the crew were taken directly to the man's cell. Medical staff continued to provide emergency treatment to the man until they decided to try to take him to hospital. He was transferred to the ambulance, which left at 2.10am. Nurse D obtained the man's medical records so they could accompany him to hospital. Two prison officers went with him, but no handcuffs or other physical restraints were used.

49. At 2.40am, Principal Officer E held a debrief with staff involved, although Nurse D was not present. Staff were offered support from the care team if they felt that they needed it. (Nurse D said that he also was offered support, even though he was not at the debrief.) Staff noted that neither the self-harm response box nor the first aid box on E wing contained any large pads that could have been used to stem the man's bleeding. Staff then returned to their duties.

50. Sadly, the emergency team at the hospital were unable to revive the man. Principal Officer E received a telephone call from one of the escorting officers at the Norfolk and Norwich Hospital informing him that the man had died at 3.18am.

51. Staff remained concerned about the fellow inmate. Officer B went and spoke to him, and a member of the chaplaincy also spoke to him. An ACCT document was opened the following day, and in the following weeks the fellow inmate was visited and informally counselled by members of the chaplaincy team. He was also offered formal sessions with a counsellor.

52. When Principal Officer E heard that the man had died, staff began to implement the procedures required when someone dies in custody which include informing the Independent Monitoring Board (IMB). There seems to have been some confusion on this occasion. A telephone call was made to a gentleman at

3.30am. The call was not answered, so staff left a message. They then tried to contact the same gentleman via his mobile telephone, but the number had been noted on the records incorrectly. The IMB were therefore not aware of the man's death until it was mentioned in a meeting at the prison later in the day.

53. Staff at the prison initially had some difficulty obtaining contact information for the man's family. But, after contacting the Polish Embassy, they managed to contact the man's mother. The man's family were unable to come to the United Kingdom, so the prison arranged his funeral.

54. The prison subsequently arranged a further critical incident debriefing meeting. However, the session was set for a date when the OSG was not in the prison, and Officer B was on annual leave. Nurse D received a letter notifying him of the meeting a week after the event.

ISSUES

At reception

55. Escort papers which arrived in prison with the man were marked to indicate that he had exhibited signs of bizarre behaviour or mental disorder. He had threatened to harm himself whilst in police custody, and been remanded to prison on a serious charge. He was identified as vulnerable and an ACCT document had correctly been opened.

56. It does appear, though, that this was based largely, if not solely, on the information received from the court. An ACCT was opened, so I do not make a recommendation. But I would suggest that there is a learning point for reception staff. Prisoners accused of certain offences, including domestic murders, are particularly vulnerable to self-harm. Moreover, the papers do not indicate that staff realised that he arrived in prison on his birthday. Personal anniversaries can be another trigger for emotionally vulnerable prisoners. Reception staff must be aware of, and sensitive to, potential warning signs that might indicate newly-arrived prisoners are at risk. As the ACCT was opened, I have not made a recommendation, but the Governor might wish to remind staff of the need to be aware of potential trigger points for self harm.

57. It is always of concern if a prisoner who is subject to special monitoring procedures is nevertheless able to take their own life. I have considered the procedures put in place for this man. In the circumstances I think that the opening of the ACCT document was correct and the level of monitoring, which was carried out as instructed, was reasonable in the circumstances.

58. As the man had previously been in Norwich, his electronic medical record was available to reception staff during his initial healthcare screening. This included details of his having previously been subject to ACCT procedures, mention of his depression, and of his use of alcohol. Nurse A assessed him but even with the information available did not feel that there were any mental health issues to necessitate referral for mental health assessment. Although he had been prescribed diazepam whilst in police custody, the papers do not show that he was assessed as to whether he required further medication.

59. Although the man arrived at Norwich at 3.15pm, reception was busy and a number of prisoners had to be booked in. All prisoners have to go through the reception process, and prisoners often arrive from court near to the end of staff shifts. This obviously causes some pressure. I do not make a formal recommendation, but the Governor may wish to consider the shift patterns of staff working in reception areas to ensure that all prisoners receive the proper time in reception without staff having to work beyond their scheduled shifts.

60. Mental health services are only available in the prison from 9.00am to 5.00pm, and it was after 6.00pm when Nurse A signed the man's ACCT form. Mental health services would therefore not have been available to assess the man that evening even if he had been referred for assessment.

61. In her clinical review, the clinical reviewer notes that there was no structured use of a mental health assessment tool at reception. It was at the discretion of the member of healthcare staff who saw the prisoner, and whether or not they had any mental health training. Whilst I do not think it likely that it made any difference to the sad outcome in this situation, the mental health assessments at reception seemed to be quite arbitrary. The man was on an ACCT, charged with a serious offence, with indications of previous depression. The clinical reviewer recommends that a holistic approach be taken into consideration of the triggers for mental health assessment. I would agree that a more coherent approach to mental health assessment should be in place, in particular for prisoners subject to ACCT procedures.

    The Head of Healthcare should make sure that vulnerable prisoners, like this man, are referred for mental health assessment.

Passing on information

62. Whilst the man was in police custody, the criminal justice mental health team made two attempts to assess him. On being unable to do so, when the man was remanded to Norwich the team contacted the head of the prison's mental health team to pass on their concerns. The head of the prison's mental health team noted the information and attempted to contact reception healthcare staff by telephone. However, he was unable to gain a response.

63. The head of the prison's mental health team was unaware that the man was in the prison at that time, and knew that he would be assessed by medical staff at reception. He told my colleague that he was confident that any risks would be identified there, and he or one of his team would assess the man the following day.

64. In this instance, I do not think that, even had the head of the prison's mental health team been able to speak to a member of healthcare staff at reception, it would have made any difference to the man. But the lack of communication is worrying. The Governor and the Head of Healthcare may wish to consider the flow of information between the mental health team and healthcare staff in reception. If there are mental health concerns about a new prisoner, it is obviously important that the chances of such a breakdown in communication recurring are minimised.

    The Governor and the Head of Healthcare should consider the means of communication between the mental health team and healthcare staff at reception.

Supplying razors

65. The induction pack provided to prisoners includes razors. I have to consider whether it was reasonable to issue razors to a prisoner on ACCT procedures because of the risk of him harming himself.

66. Sadly, if a person wishes to harm themself then there are a number of ways that they could do so. It would not be reasonable to expect the prison to remove any possible means that a prisoner could use. Additionally, there are questions that could be asked about the effect on a prisoner's morale if he were not allowed basic toiletries. Unless there are specific indications that a prisoner may use a razor to harm himself, or if a prisoner on an ACCT has used razors to do so in the past, I do not think that the prison should withhold them.

67. However, the fellow inmate said in interview that the man had requested, and was given, extra razors once he was in his cell. He also said that the man was tampering with one of his razors. Amongst the man's property removed from the cell by the police were pieces of broken razor, a razor handle, a blade and two more razors.

68. Whilst it appears reasonable not to withhold ordinary supplies from prisoners, I am a little more concerned that a prisoner on an ACCT requested extra razors and appears to have been given them without question. The papers do not show that extra razors were provided, but the fellow inmate's statement and the police property records do point to at least one extra razor being given to the man. The fact that the man already had razors in his possession, which as I say above I consider reasonable, means that this probably did not have a great bearing on what happened later in the night. But the fact that he was on an ACCT and asked for extra razors should have raised some questions. Requests for extra razors by prisoners on ACCT documents need to be carefully considered, and not just handed out as routine.

    The Governor should ensure that staff are advised to carefully consider and document requests for extra razors from prisoners on ACCT documents.

First aid equipment

69. When staff needed medical equipment to treat the man, the first aid packs did not contain anything that could be used to stop the bleeding. Officer B had to use a towel to stem the man's bleeding. Also, once the packs had been opened and some equipment removed, they were not replenished until the morning. Had there been another emergency before then, there would have been even less equipment available for staff to use. I appreciate that most prisoners who harm themselves do so by using a ligature and that wounds such as the man's are unusual. Nevertheless I suggest that the composition of first aid boxes is reviewed.

    The Head of Healthcare should review the contents and restocking of all first aid boxes.

70. In other respects I have found that the response to the emergency was excellent. The staff actions were swift, proficient and co-ordinated. In what must have been difficult circumstances, staff acted with the utmost professionalism.

Informing the Independent Monitoring Board of a death in custody

71. There was a problem relating to the IMB being informed of the man's death. Staff at the prison did attempt to contact a board member, leaving an answerphone message on his landline. But when they followed this up with a call to a cellphone they found that they had the wrong number on their records. I do not make a recommendation, but would suggest that the Governor ensures that staff have sufficient contact information for members of the IMB for use when necessary.

Support for staff

72. The post-incident debrief session was scheduled for a time when key members of staff were unavailable or had not yet received notification. I note that Nurse D was also not involved in the hot debrief session held when the man was taken to hospital. Dealing with an incident such as this can be extremely traumatic. It is important that staff have the opportunity to both raise any issues they feel need to be considered, and to be offered support if they feel they would benefit from it.

    The Governor should ensure that debrief sessions include all necessary staff.

CONCLUSION

73. The man was brought to Norwich prison having been charged with a serious offence. He was identified as possibly posing a risk of harming himself, and placed on the ACCT suicide and self harm monitoring procedures. Attempts to conduct a mental health assessment on him had failed whilst he was in police custody, and these concerns were passed on to prison medical staff. However, a breakdown in communication meant that their concerns were not reported at the time.

74. He was seen by healthcare staff, who found no immediate concerns about the man's health. He was not referred for mental health assessment. He was put in a shared cell, where he was monitored frequently by staff in accordance with the requirements of his ACCT assessment. Although there was a language barrier, his cellmate said that he gave no indication of being depressed.

75. In the early hours of the morning, the man's cellmate was awoken by a noise. On switching on the cell light, he saw that the man was bleeding heavily. The cellmate alerted wing staff who, in my view, responded quickly and efficiently in their attempts to save him. From the staff providing first aid in such difficult circumstances, to the arrangements which gave the paramedics swift access, to those looking after the welfare of his cellmate, I believe that the staff acquitted themselves in an exemplary manner.

76. The investigation and clinical review identify some areas in which there might be some improvements. However, I find it unlikely that they would have prevented the man from taking his own life.

RECOMMENDATIONS

1. The Head of Healthcare should make sure that vulnerable prisoners, like this man, are referred for mental health assessment.

The Prison Service accepted this recommendation. All new receptions now undertake a Mental Health risk assessment as part of their reception screening. Depending on the score, they may then be referred to Primary Care or Mental health In-Reach Team by the nurse.

2. The Governor and the Head of Healthcare should consider the means of communication between the mental health team and healthcare staff at reception.

The Prison Service accepted this recommendation. Any information from any area regarding new reception prisoners can now be given to the reception nurse or the discipline reception team at any time. If there is no response, information must be left with the duty manager or the response nurse.

3. The Governor should ensure that staff are advised to carefully consider and document requests for extra razors from prisoners on ACCT documents.

The Prison Service accepted this recommendation. A Governor's Notice to Staff has been issued, directing that no prisoner on an ACCT document should be given more than one razor at a time. If another razor is requested, this will be given on a one-to-one exchange basis. Such requests must be noted on the history sheet and on the ACCT document itself.

4. The Head of Healthcare should review the contents and restocking of all first aid boxes.

The Prison Service partially accepted this recommendation. They have said that the provision of first aid boxes on the wings is the responsibility of the prison health and safety department.. This issue will be discussed at the next Health and Safety Meeting. The prison point out that in audits in November 2009 the self-harm boxes and the grab-bags used by staff in emergencies were found to contain all the elements required by Prison Service Order 2700.

5. The Governor should ensure that debrief sessions include all necessary staff.

The Prison Service accepted this recommendation. Contingency plans will be updated to show that all staff involved in a serious incident should be notified of debrief sessions, whether they are in the prison or not. The Care Team will make sure that staff are aware of debriefs before they are held.