INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT HMP/YOI NORWICH IN SEPTEMBER 2005

Report by the Prisons and Probation Ombudsman for England and Wales

July 2006

This is the report of an investigation into the death of a prisoner who died in his cell on the Healthcare Centre at Norwich prison on 30 September 2005. He had been found hanging. The man had been diagnosed as suffering from severe and enduring mental illness at the time of his death.

I would like to offer my sincere condolences to his family and those affected by his death.

The man was acutely mentally ill and a prolific self-harmer. Staff in Norwich cared exceptionally well for him. However, his needs were too great for Norwich, or for any prison, and he required treatment in a secure mental health setting.

Prison staff worked tirelessly to ensure that he was transferred to such a mental health setting. However, there were significant obstacles to overcome. I believe the National Health Service failed to acknowledge their responsibilities towards the man who is the subject of this report. I am using this report to urge the Department of Health to review the pathways of care and performance standards to ensure such tragic circumstances do not recur.

The investigation was conducted on my behalf by two of my investigators. One of the investigators and a family liaison officer from my office, met the solicitor appointed by the man's family to discuss the investigation and to enable him to share the concerns the family had.

The Assistant Director of Quality and Organisational Development, Norwich Primary Care Trust, conducted a comprehensive clinical review into the clinical care afforded to the man during his time at Norwich. I am most grateful for her expert findings and opinions. They have provided an invaluable insight into the problems faced by HMP Norwich in caring for prisoners suffering severe mental illness.

I would also like to thank the Governor of Norwich and his staff for their cooperation during the investigation. I am particularly grateful to the Principal Officer and another officer who acted as the local liaison officers, and efficiently provided my investigators with all they required to conduct the investigation. The improvements Norwich has made in response to a series of deaths in custody have impressed me, as has the Governor's eagerness to learn from this exceptional tragedy.

Since April 2004, I have had the mournful duty of investigating around 200 self inflicted deaths in prisons and elsewhere. I regard this report as one of the most important I have prepared in that time.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN **JULY 2006**

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Summary

The was 40 years old when he died in the Healthcare Centre at Norwich prison on 30 September 2005. He had been found hanging.

The man had grown up in a travelling family and had two children himself. In the years prior to his death, he and his family had suffered much family bereavement. The man's father, two brothers, sister and his brother in law had all died.

In his teenage years, he began to misuse alcohol and drugs and got into trouble with the police.

Between 1989 and 1990, he was admitted to a psychiatric hospital on four occasions.

In 1992, the man was sentenced to life imprisonment for violent offences. He was transferred to a secure hospital in the early part of his sentence, but returned to prison. Psychiatric reports prepared for his trial had diagnosed him as having severe personality disorder, extensive paranoid delusions, depression and obsessive-compulsive disorder.

During the course of his sentence, the man was twice transferred to open prisons, but he failed to cope well and was returned to closed conditions.

The man was transferred to HMP Norwich on 5 March 2004, and spent most of his time in the Healthcare Centre. He was supported by various mental health professionals and with medication. In October 2004, he underwent a further psychiatric review by a visiting psychiatrist. She noted: *'At the present time, the most pressing aspect of his mental disorder is obsessive-compulsive disorder and associated depression with hopelessness and suicidal ideation. At the time of my assessment these symptoms were incapacitating and in my opinion the man urgently requires treatment'.* It was felt that the man *'would have no prospect of being able to improve sufficiently to be able to progress further in his sentence without such inpatient treatment.'* The man was at first accepted by an acute secure mental health facility. Later they decided they could not cope with his self-harming behaviour and told Norwich they could no longer take him.

The man's health deteriorated. He became increasingly paranoid, and was a prolific and extreme self-harmer. The man was subject to F2052SH procedures (a document used to monitor and support those at risk of suicide and self harm) for virtually all of his time at Norwich. The man's self-harming behaviour led to black eyes, lacerations to his face and wrists, and he would sometimes reopen these wounds. He twice took an overdose of prescribed medication. He also swallowed foreign objects which required removal at outside hospital.

Healthcare staff demonstrated great empathy with him. The Head of Healthcare and Mental Health Lead were tireless in their attempts to have him transferred to a secure mental health facility. They were operating in a system that worked against them. It appeared as though prisoner-patients dropped to the bottom of a long waiting list. Whilst in prison, their supervision was guaranteed, offering a degree of

protection. In all other respects, the prison environment was completely unsuitable for him.

The man was turned down for a by two secure hospital placements before his death. He was due to be assessed by staff from Rampton special hospital.

At 00.50am on the 30 September 2005, staff performing checks of prisoners subject to F2052SH procedures found the man hanging in his cell. They cut the ligature, lowered him to the floor and attempted resuscitation. Efforts continued when the ambulance arrived, but to no avail. The man was pronounced dead at 1.20am.

My report draws attention to problems concerning staff radios. I also make recommendations relating to involving the family in a prisoner's care when they are subject to F2052SH procedures, to training in the use of the defibrillator, and to staffing during the night-time patrol state. I commend the work of three members of staff.

However, the most significant recommendations concern the relationship between the Prison Service and the Health Service in respect of prisoner-patients with severe mental health problems. There is a need for a fundamental review of the mental health pathway to ensure that prisoners receive the most appropriate care and treatment as quickly as possible.

During his time in HMP Norwich, staff showed great compassion and kindness to the deceased who was struggling to cope with his debilitating illnesses. The fact remains, however, that prison was not a suitable place for someone with his needs.

Investigation process

I appointed two colleagues to conduct the investigation into the circumstances surrounding the death of the man who is the subject of this report.

They made an initial visit to Norwich to collect documentation and meet the Governor. They visited the cell where the man died. They met with members of the Prison Officers' Association (POA) local branch committee and the Independent Monitoring Board (IMB).

Notices were issued to both prisoners and staff, inviting anyone whom might have information relating to the man's death to make themselves known to the inquiry.

The investigation team then returned to Norwich to interview prisoners and staff.

Along with one of the investigators, one of the Ombudsman's family liaison officers met the solicitor appointed by the man's family. They explained the purpose of the investigation and invited him to raise any concerns. The family's main issue was that they were unaware of how unwell the man was, and would have appreciated being contacted about his state of mind.

A clinical review of his health care whilst in prison custody was undertaken by Norwich Primary Care Trust.

The man's time at Norwich from March 2004

On 5 March 2004, the man arrived at Norwich from HMP Blundeston. He was initially placed in the Segregation Unit at his own request where he told staff that he was going on a "dirty protest" (a term used to describe when a prisoner deliberately soils himself or his cell with excrement or urine). A few days later, he attempted self-harm by swallowing an overdose of Amtriptyline that required treatment in an outside hospital. He was then transferred to the Healthcare Centre, where he remained until his death. In light of his mental condition and attempts at self-harm, he was placed on an open F2052SH. This was only closed once. It was reopened the day after it was closed as he had swallowed a television aerial.

Throughout his time in the Healthcare Centre, he was described as a paranoid man who felt that fellow prisoners were talking and laughing about him behind his back. The man spent a lot of time in his cell and did not associate with many prisoners. However, he did build up a rapport with some members of staff and would seek reassurances from them in respect of trying to secure a bed in a secure hospital.

The man was assessed by a visiting psychiatrist who prescribed an antidepressant (Cipramil). The man was closely monitored and supported and underwent various assessments from psychiatrists and mental health professionals. In October 2004, a forensic psychiatrist undertook an assessment of him. The consultation report describes *'depressive and obsessive compulsive symptoms but nothing obviously psychotic'*. She noted a physical deterioration including weight loss that was obvious from a previous prison photograph and written descriptions. She also stated that the man felt '*hopeless and feels that he cannot be helped*'. The psychiatrist noted: *'At the present time, the most pressing aspect of his mental disorder is obsessive-compulsive disorder and associated depression with hopelessness and suicidal ideation. At the time of my assessment these symptoms were incapacitating and in my opinion he urgently requires treatment'.* It was felt that he *'would have no prospect of being able to improve sufficiently to be able to progress further in his sentence without such inpatient treatment'*. The psychiatrist referred him to Three Bridges regional secure unit.

There was a long period of time (approximately six months) before Three Bridges eventually decided that they would not accept him for a bed. The reason behind the decision was his level of self-harming behaviour. Throughout this time, there is evidence that healthcare staff tried on many occasions to contact Three Bridges to determine the outcome for him and check that he was still being considered for a bed.

During this time, his behaviour continued to deteriorate. He kept his cell in darkness, hanging bed sheets and blankets from the window. When in the company of others, he usually wore a towel over his head. He sought reassurance from staff that they and prisoners were not talking about him. He was also paranoid about the food he was given. He was concerned it was being poisoned, particularly if food had been cut up. Healthcare staff contacted kitchen staff and arranged for him to be given food that was whole, such as tomatoes and apples. They also gave him food in sealed packets. This was often an arduous process, but the staff spent a great deal of time building his trust.

The man's self-harming behaviour continued. He would sometimes beat himself up causing injuries, and healthcare staff reported that he frequently had black eyes. In February 2005, he took an overdose of paracetamol. There were also numerous incidents of him cutting his face and wrists. The man often reopened wounds, and on occasion he would make the wounds worse by inserting faeces. The man also swallowed objects, such as toothbrushes, television and radio aerials, pens, and sometimes razor blades.

On 30 May 2005, he told staff he had swallowed a television aerial that was approximately 15cm in length and a razor blade. He made it clear that the reason he kept swallowing items, was so that he would need abdominal surgery to remove them. This would give him a wound with sutures that he could then pull open to self-harm even further. The prison nurses and doctors monitored him and on 2 June he was taken to the Norwich and Norfolk Hospital for the aerial to be removed. However, he refused to have the procedure. The head of healthcare visited him and outlined the seriousness of the consequences of refusing surgery. The man told her that he was upset that Three Bridges had not accepted him. Throughout the conversation, he had a towel over his head. With the manager's gentle persuasion, the man agreed to have the procedure, but later when she had left he refused again. A doctor from the Norvic mental health unit visited him along with the healthcare manager. The man once again agreed to have the procedure. Once they left the hospital, he again refused. On 8 June, when he had finally agreed to proceed, the healthcare manager visited him in hospital again and sat with him throughout the procedure holding his hand. The hospital staff removed a 15cm aerial and a toothbrush via his throat.

The man also smashed items in his cell. At times, he also attempted to assault other prisoners on the rare occasions he left his cell. He said this was because he thought they were talking about him. When this happened, he was restrained and taken back to his cell even when he said he wanted to go to the segregation unit.

On 11 June, the man again swallowed aerials and was referred to the hospital for their removal. He refused, but eventually agreed after intervention from the healthcare manager. On 17 June, staff at the Norfolk and Norwich Hospital removed a television aerial, two toothbrushes and a pen.

During this time, the healthcare manager and the head of the mental health team, continued in their attempts to find him a mental health in-patient bed. They were in contact with social services and Norwich PCT.

At the end of June, the man again swallowed objects including aerials and a razor blade, and he was again transferred to hospital.

The healthcare manager visited him in hospital. She was later called to say that he was being discharged without undergoing a procedure to remove the objects. It appears that the hospital were unwilling to treat him for the same problem yet again, although on this occasion he was not refusing treatment. The x rays clearly showed that there were razor blades and three pieces of aerial lying transversely. The healthcare manager was concerned that he was at significant risk of perforating his stomach or bowel and suffering internal bleeding. The Healthcare Centre at Norwich

does not have acute hospital facilities in the event of a significant bleed. The hospital subsequently wrote a letter outlining their acceptance of responsibility for the potential consequence of not operating on him. The healthcare manager instigated a care plan informing staff how to deal with him in terms of observation. In the event of any deterioration or stomach pain he was to return to hospital immediately. If collapse or obvious bleeding occurred, a blue light ambulance was to be called. Furthermore, if he needed to be restrained, it was not safe for him to be bent over. An assessment was made by the healthcare manager in conjunction with the head of the mental health team restricting the man's access to objects, such as aerials, and to ensure he was given only polystyrene in his cell.

On 1 July, Hertford Primary Care Trust agreed to fund a placement for the man. the healthcare manager and the head of the mental health team kept up the pressure and on 13 July an arrangement was made for the man to be assessed for a placement at Redford Lodge. The man was anxious about the outcome of his assessment.

The man was not accepted at Redford Lodge, and was visited by two officers from Hertford PCT on 21 July. They assured him that they were looking for a placement but that the process took time. The man said he felt hopeless and wanted to kill himself.

On 26 July, the man cut his left wrist with a razor blade. The wound was cleaned and steristripped. He was tearful and needed a great deal of reassurance from staff. He later reopened the wound. He was found in his cell and had lost approximately 1.5 litres of blood. This was a potentially life threatening situation. An ambulance was called urgently and he was taken to hospital.

The healthcare manager once again chased up his placement and heard he was to be assessed by the Spinney Centre.

On 31 July, the man removed the stitches in his arm. He also threatened to harm himself with objects in his cell but eventually handed them over to staff. Over the next few days, he kept reopening the wound and expressing extremely paranoid thoughts and behaviour.

On 10 August, the head of the mental health team wrote a somewhat desperately worded letter to the Spinney Centre asking for their urgent assessment.

Throughout August, the man was extremely paranoid. On 16 August, he asked staff to call his sister in law to check his family were okay. Staff did this and reassured him. His sister in law said she would write to him and he seemed happy with this. On the same day, he handed two razor blades to staff and admitted to swallowing six toothbrushes. The man was seen by the doctor and monitored over the following days.

On 17 August, the healthcare manager chased up his placement again and requested acknowledgement of the head of the mental health team's letter. In the following days, the man thought his medication and food were being tampered with

and became convinced that other prisoners were calling him names. Despite reassurance, he harmed himself by giving himself two black eyes.

On 24 August, the man was assessed by the Spinney centre. In the following days, his thoughts were pre-occupied by the assessment and he was anxious about what would happen if he were to be turned down.

On 5 September, the head of the mental health team and the healthcare manager and were informed that the man had been rejected by the Spinney Centre. As he had reacted badly to previous rejections, they devised a care plan which included increasing his observations to every 15 minutes. They broke the news to him together to explain the rejection and to say that attempts would be made to find another placement. The man appeared quite accepting of the decision. Entries in his records in the following few days indicate that the man appears to have taken the news relatively well.

During his time at Norwich, his F2052SH was regularly reviewed. In the review that took place on 9 September, it was decided that the level of observations could be reduced to hourly. In order to prevent him planning to self-harm around the observation times, staff ensured that the checks were not at the same time each hour. Further reviews were conducted on 17 and 25 September. Both concluded that the man was still at a high risk of self-harm, and kept the support plan in place including the hourly observations.

From this point until his death, the man seemed to have some good days, and some bad days. On 22 September, the staff nurse noted that the man said he *"feels like the light has gone out at the end of the tunnel. Doesn't think he will be accepted anywhere."* However, there were times when he seemed quite positive. One prisoner who helps run the library, reported that in the week before the man died he appeared more upbeat. He said that: *"The man came out of his cell a bit more; he came to the library and even took the towel off his head. He seemed more at peace with himself."* He reported that the man liked the company of the prisoner opposite. This prisoner had come to the Healthcare Centre long after him and had been accepted to a mental health unit.

Another prisoner said that the man did not mix with others so he had felt it a real privilege that he had allowed him to cut his hair for him in his cell the week before his death. The man had removed the towel and he saw this as a big step forward.

However, staff who knew him well said that he would have a few days where he was more upbeat and would come out of his cell, but then have a few days when he was low. There was no pattern to his behaviour. The head of healthcare said that in the last week of the man's life she would see him on a daily basis. The man was anxious and she would try to reassure him. The head of healthcare did not really notice a significant change in his behaviour. It was decided that the head of healthcare or the head of the mental health team would meet him weekly to update him on any progress in finding him a placement.

On the days leading up to the man's death, the F2052SH shows that he often felt physically and mentally unwell. He was in a low mood, hearing voices, exhibiting

paranoid behaviour and crying. He was worried about what would happen to him after being rejected by the Spinney centre.

On 27 September, a wing nurse spent a large amount of time talking to and reassuring him. He was very distressed and claimed that *'he would self-harm although he did not want to'*. He rang his buzzer at 2am and the nurse responded. He said that *'he had had enough and wanted to do a test run on hanging himself'.* She talked to him and eventually persuaded him to hand over some strips of sheets that he had in his cell. Over the next two days, he was seeking regular reassurance from staff. It is evident that staff spent a great deal of time with him trying to relieve his anxiety. The wing nurse and the staff nurse in particular demonstrated a high level of engagement with him and concern for him.

Events from 29 September 2005

On 29 September, the man's F2052SH shows that he declined to remove a bed sheet he had hung up from the window. He was therefore sitting in darkness, but appeared in quite a good mood.

The wing officer checked on him at 9.15pm and again at 10.30pm, and commented that the man had been joking with him but seemed to experience mood swings. At 11.30pm, the wing nurse went to see him. The man was concerned that he was going to be transferred to another prison. The wing nurse reassured him that this was not the case. The man then asked her not to come to the hatch again, as he wanted to be alone.

At 00.30am on 30 September, the wing officer started to conduct another set of routine checks. The man's cell was the last cell that needed to be checked, so he arrived there at approximately 00.50am. There was some green sheet hung over the observation hatch and the wing officer moved it to one side. He saw the man facing out the window and thought he was hanging.

The wing officer proceeded to run down the stairs to L wing to alert the prison officer and the two healthcare staff who were on duty, the wing nurse and the nursing assistant. They were all on L wing whilst the nursing staff were carrying out their night duties.

They all ran back up the stairs. The prison and the wing officers entered the man's cell, followed by the nursing staff, and confirmed he was hanging from the window bars facing out of the window. He had used part of a bed sheet as a ligature. The wing nurse sent the nursing assistant to fetch the resuscitation equipment, and the wing nurse informed the communications room via her radio that they had someone hanging. In her interview, the wing nurse said her mind went blank when she radioed through and reported that there was a hanging rather than using the coding system (code blue to indicate a prisoner was not breathing).

The prison officer supported the man while the wing officer cut him down using ligature cutters. (The cutters are carried on their person as part of a standard issue to night staff.) The nursing staff then proceeded with resuscitation. For a very short time (whilst the nursing assistant returned with the resuscitation equipment), the prison officer began chest compressions.

The wing officer left the room to contact the communications room by phone to check they had received the information, an ambulance had been requested, and the duty governor informed.

At 1.04am, the ambulance arrived and paramedics took over the resuscitation process. Sadly, this was unsuccessful and the man was pronounced dead at 1.20am.

Norwich has comprehensive contingency plans in place to respond to a death in custody. These were implemented and systematic recording of events took place.

Contact with the man's family

The duty governor arrived at the prison at approximately 1.40am. He accessed the man's records to identify the address of his next of kin.

The duty governor identified that the man's next of kin lived in Hertfordshire. Good practice was observed when he contacted the duty governor at HMP The Mount to ask if they would visit the family to break the news. This was the closest prison to the family's home and would therefore be able to break the news quicker. The duty governor at The Mount, agreed, and in conjunction with Hertfordshire Police he informed the man's nephew. The duty governor at HMP/YOI Norwich spoke to the man's sister the following day.

The Governor took the role of the family liaison officer. He arranged for the man's property to be returned, and offered financial assistance with the funeral. I am very impressed that the Governor took on this responsibility himself.

Findings and conclusions

Care afforded to the man who died

The man had a dual diagnosis of personality disorder and depressive mental health problems. This led to a complicated pattern of self-harm. He was given a lot of time and reassurance from staff who delivered individualised care. He was prescribed medication by qualified psychiatrists and this was administered as prescribed.

The medical records are well kept, with comprehensive entries. These entries demonstrated the high level of care, interaction and multi agency working afforded to him.

Staff considered his individual needs and took steps to try to meet them. Good examples are the attempts to provide him food that had not been cut, and not automatically taking him to the segregation unit when he demonstrated violent behaviour towards others.

Some individual members of the healthcare team showed exceptional dedication in caring for him. I would like the wing nurse, the head of the mental health team and the head of healthcare to be recognised for their work and commitment. It can be clearly seen from the health records their compassion for the man. Although his behaviour was very difficult at times, they dealt with him extremely sensitively. In particular, the healthcare manager went beyond the call of duty, especially in relation to his treatment in hospital outside the prison. This can be seen in the quality of record keeping. The level of detailed documentation in the medical records is to be commended. The head of the mental health team and the healthcare manager also worked extremely hard to cut through the barriers preventing his placement in an appropriate mental health setting.

I recommend that the Governor commends the wing nurse, the head of healthcare and the head of the mental health team for their exceptional work with and on behalf of the man who died.

F2052SH

It was entirely appropriate that the man was subject to F2052SH procedures for the vast majority of his time in Norwich, as he remained at significant risk of self-harming. The documentation shows a mixture of observation and quality entries, demonstrating considerable interaction with him.

The man was subject to hourly observations. I believe this too was appropriate. The man was a prolific self-harmer, but it had been over two months since an incident of self-harm had endangered his life. However, my investigators noted that in the afternoon there was often a gap two to three hours between checks. Comparisons were made with other F2052SH documents on the Healthcare Centre, and this seemed to be the case across the board. When my investigators asked the Head of Healthcare if there could be any reasonable explanation for this, she acknowledged the checks should have been made. Whilst I do not believe this affected his care, I

urge the prison to address this matter and formally monitor the timing of interactions and observations in the F2052SH as part of a local audit programme.

I recommend that the Governor reminds staff of their responsibility to conduct checks on prisoners subject to suicide and self harm procedures and in accordance with the individualised care plan. The timing and quality of these entries should be regularly audited by managers.

Items in cell

There was one occasion when a risk assessment regarding what the man might or might not have in his cell was carried out. However, one area of concern surrounds the practice of giving prisoners like him, who are known to be prolific self-harmers, access to blades. On more than one occasion he harmed himself using blades. It seems reasonable, therefore, that access to blades should have been prohibited or supervised. Whilst items should not routinely be withheld, and it is probable that he would have used other implements to harm himself, few things are as potentially life threatening as a blade. I suggest that consideration is given to issuing electric razors to prolific self-harmers, particularly those located in the Healthcare Centre.

Mental health placement

The head of healthcare reported that, in the past year, 19 patients had been transferred from HMP Norwich to secure mental health beds. She described the process as "frustrating". It involves the prison's mental health staff identifying a patient's need for a secure mental health bed and then referring them to the appropriate Mental Health Trust. The Mental Health Act Commission is then engaged with a view to a visit by the relevant area psychiatrist, who will then assess the patient. The head of healthcare said that in some instances it is difficult to get an area psychiatrist to visit Norwich, however local assessments are relatively easy. Once a patient has been assessed, the Mental Health Act Commission is notified. There then is a period of waiting until a bed becomes available and the transfer can take place. It is not unusual for a prisoner to wait for more than three months for a bed. Furthermore, there does not seem to be a time limit on securing a bed, despite the assessment determining that the patient has an immediate need for transfer to a mental health setting.

The man was initially accepted by Three Bridges regional secure unit but was subsequently 'knocked back'. This was because the unit believed they could not cope with his level of self-harm. Furthermore, there was no duty upon them to find him another placement, as he was beyond their catchment area. Healthcare staff told him this was the reason for their decision and he accepted this. It was the opinion of many healthcare staff that mental health units only accept patients they can easily treat and that high levels of deliberate self-harm are not felt conducive to unit's success. The head of healthcare recalled that the man understood that his high levels of self-harm were undermining the efforts to get him a secure bed. He was also acutely aware that there were some prisoners who had been assessed after him and had managed to obtain a secure placement. This fuelled his paranoia. They included a prisoner in the cell opposite him who was due to transfer to a secure

unit on 30 September. The man would become extremely anxious about obtaining a secure bed.

tHe head of healthcare told the investigators what benefits she thought the man would have obtained from a placement in a specialist mental health unit. Whilst all of his problems might not have been treatable, some of the symptoms could have been. For example, he was extremely conscious of his eyes and took to wearing a towel over his head to prevent him 'glancing inappropriately' at people. If this obsessive behaviour could have been treated, this might have significantly improved his quality of life and given him a sense of hope for the future. She believes that he would have been receptive to treatment.

The man was due to have an assessment by Rampton special hospital in mid October. The head of healthcare said he was anxious about this, believing that Rampton was the end of the line for him. The man had been at Ashworth special hospital some years before and believed there was stigma attached to those transferred to Rampton.

The clinical reviewer found it was evident from the notes and professional opinions that his mental health care needs could not be met within HMP Norwich. The Healthcare staff tried on numerous occasions to have him transferred to a secure hospital setting, but a range of factors prevented this occurring. These included excessively long periods of time between referral and assessment, and from the point of assessment to making a final decision. There was also an unacceptable delay (six months) for Three Bridges to decide that the man could not be accepted.

The clinical reviewer examined this further and found that there appeared to be a reluctance on the part of psychiatrists from outside of the area to travel to Norwich to undertake an assessment. However, the local Norvic clinic seemed very accommodating and often undertook assessments on prisoners at the request of the Norwich Mental Health In-reach Team. However, this seems to be an informal arrangement rather than a formal one and is made possible through the personal networks of key staff.

There are also wider questions about moving prisoners like him, with significant mental health problems, around the prison system. This must impair the ability to treat mental health problems effectively and consistently. The impact on someone as ill as this man of being moved from people who knew him well, and enduring the stress of travel, would have been great.

The circumstances surrounding his death were tragic. He was desperate for help, and prison staff were trying extremely hard to help him. But prison simply was not the right place for him. Unfortunately, his death is symptomatic of a wider issue. There are a significant number of seriously mentally ill prisoners within the prison system, all of whom would greatly benefit from specialist care in a mental health unit.

I strongly endorse the following recommendations from the clinical reviewer:

I recommend that the Department of Health use this man's case as the basis for a fundamental mental health pathway review. This review should include

relevant clinicians from both prison and health providers. This review will enable the identification of the specific 'bottlenecks' and 'hurdles' that this type of prisoner and the Prison Service face in managing those with severe mental health and personality disorders. Actions should be taken to address the bottlenecks and hurdles faced, ensuring that prisoners with mental health needs get the most appropriate service at the time that they most need it.

I recommend that the Department of Health should formalise the target response times of the Mental Health Trusts to include: *time of referral to assessment, point of assessment to acceptance, and acceptance to admission*.

This would reduce a great deal of anxiety and frustration for both the prisoner and the healthcare staff concerned. These response times should be used as performance targets to monitor the care afforded to those in prison with treatable severe and enduring mental illness.

I recommend that the Department of Health should review and reduce the three month (good practice) standard waiting time for obtaining a mental health bed, and implement formalised time targets for the various stages of the referral and assessment process. There is a need for clarification of the language used i.e. there is a difference between accepting a prisoner for a bed and saying you are finding a bed. This is can potentially be used as a stalling method.

There appears to be some ambiguity and lack of clarity about the responsible Primary Care Trust for prisoners identified with secondary and tertiary mental health needs. The Department of Health is clear that, in the case of mental health this responsibility rests with the Primary Care Trust where the prisoner resided at the time of their arrest and not the local PCT responsible for the establishment.

I recommend that Primary Care Trusts are reminded of their responsibilities towards prisoners identified with mental health needs, resident in their catchment area at the time of their arrest, even if located in a prison outside their geographical location.

Family concerns

The man's family said through their solicitor that they were not aware of how unwell he was, and did not know about his self-harming behaviour. The man did not share this information in his telephone calls. There was one occasion when he asked staff to contact his sister in law to ask how his children were. However, there is no documented evidence that staff encouraged him to contact his family, or asked if they could contact them on his behalf. The man's family said they would have arranged a visit had they known, and would have appreciated that opportunity.

Prison Service Order (PSO) 2700, 3.4 Follow-up actions, and care for prisoners who have self-harmed states:

3.4.3 After consultation with the prisoner, the nominated next of kin must be notified, unless:

- *There is a clinical reason not to, or;*
- *If aged 18 and over, the prisoner does not consent, or;*
- *The prisoner's support plan indicates* otherwise (e.g. in the case of a prisoner who repetitively self-harms).

3.4.4 Where appropriate, after serious incidents of self-harm consideration should be given to allowing the prisoner themselves the opportunity to notify the next of kin by a phone call and/or an extra exceptional visit.

I recommend that the Governor should ensure that the local self-harm and suicide awareness policy reflects PSO 2700 and encourages and supports the informing of the prisoners next of kin.

The duty governor observed good practice by contacting the duty governor of the prison closest to the family address to break the news of the man's death. I welcome the actions of governors from HMP Norwich and HMP the Mount in ensuring that the man's family were told in person by a representative of the Prison Service. The Governor may wish to consider sending a copy of this report to the governor at The Mount. (Unfortunately, some confusion around the spelling of the address led to a delay in the man's family being notified.)

Emergency response

When the wing officer attended the man's cell, he believed it was a possible fatality. He chose to run downstairs to alert the assistant night orderly officer and nurses instead of using his radio. In the event, the alarm was raised promptly, and staff were in the man's cell in seconds.

The wing nurse instructed the healthcare assistant to collect the emergency bag. She entered the cell with the officers, and then called the communications room via her radio to alert them that there was a hanging on healthcare, and an ambulance was required. Once resuscitation attempts had started, the wing officer left the cell to phone the communications room, and although they had called an ambulance they reported that the radio message was unclear.

The deputy governor reported that there had been problems with some radios, in that their battery life and reception had been poor. There has been considerable investment in this area. However, it still appears that staff do not have full confidence in their radios.

Running down the stairs, not entering the cell and not contacting the communications room immediately by radio could have created unnecessary delays in treatment. Staff must have confidence that radios will transmit a clear message to the communications room staff.

I recommend that the Governor arrange for a test of radio reception and ensure batteries of all radios are checked regularly and rectify any problems.

The wing nurse commenced Cardio Pulmonary Resuscitation (CPR) and was assisted by the nursing assistant. When asked if they had a defibrillator, the wing nurse replied *"we do but they are somewhat temperamental and I am afraid the majority of staff are not trained to use them".* The head of healthcare was asked about the defribrillator and whether this was working. She said that the equipment was in full working order and not temperamental. It has a self-testing device. In her previous role in the NHS, she had worked in resuscitation. Although not used when the man was discovered, the head of healthcare is adamant that use of the defribrillator would not have affected the outcome.

There are two defribrillators at Norwich, one in the YOI and one in the main prison although not all staff had been trained in its use. This has been highlighted by the Healthcare Manager to the PCT and there will be training in the future.

I endorse the following recommendation from the clinical review:

I recommend that all relevant healthcare staff should undertake training in use of the defibrillator machines.

Crisis Management

Norwich prison is on a split site divided by a car park and a road. One section of the prison accommodates young offenders in the YOI and houses the Healthcare Centre, including an elderly prisoner unit. The remainder of the population is accommodated in the main prison complex.

At night, the night orderly officer and assistant night orderly officer are in charge of the prison. Individual officers carry a cell key in a sealed pouch which they can open in cases of emergency. But the orderly officers are the only people with access to keys around the prison, and only they can order the opening of the gate for an ambulance to enter.

The night orderly officer was in charge of the main prison. The prison officer/ assistant night orderly officer, was in charge of the section of the prison holding young offenders and the Healthcare Centre. The prison officer left the man's cell whilst CPR was underway to facilitate the arrival of the ambulance. He went to the young offender part of the prison and obtained the keys from a safe. He also collected an officer from the YOI. He then went to the gate and explained the situation. The prison officer gave the key to another officer instructing him to open the main gate for the ambulance, and ensure all gates between the main gate and Healthcare Centre were open to allow immediate access. The prison officer then returned to the man's cell where CPR was still underway.

In the meantime, the night orderly officer left the main prison and made his way to the Healthcare Centre and took control of the situation.

The main part of HMP Norwich holds approximately 750 prisoners. In this part of the prison, there are wings which hold prisoners on remand and those who are sentenced. There is a first night centre and a detoxifcation unit. The other part of the prison holds approximately 230 prisoners, including young offenders aged 18-21,

the Healthcare Centre with in-patients, and the elderly prisoner unit. It appears to me that a great deal is expected of one senior officer, as night orderly officer, and one officer as his assistant based on the other part of the prison. I do not believe that the care that the man received, or the speed in which it was delivered, was affected in any way. However, I can envisage a situation arising where the officer in charge has to leave the scene, potentially resulting in more serious consequences.

I recommend that the Governor considers re-profiling the management needs of Norwich at night state.

Recommendations

Clinical

I recommend that the Governor reminds staff of their responsibility to conduct checks on prisoners subject to suicide and self-harm procedures and in accordance with the individualised care plan. The timing and quality of these entries should be regularly audited by managers.

I recommend that the Department of Health use this man's case as the basis for a fundamental mental health pathway review. This review should include relevant clinicians from both prison and health providers. This review will enable to identification of the specific 'bottlenecks' and 'hurdles' that this type of prisoner and the Prison Service face in managing those with severe mental health and personality disorders. Actions should be taken to address the bottlenecks and hurdles faced, ensuring that prisoners with mental health needs get the most appropriate service at the time that they most need it.

I recommend that the Department of Health should formalise the target response times of the Mental Health Trusts to include: *time of referral to assessment, point of assessment to acceptance, and acceptance to admission*.

I recommend that the Department of Health should review and reduce the three month (good practice) standard waiting time for obtaining a mental health bed, and implement formalised time targets for the various stages of the referral and assessment process. There is a need for clarification of the language used i.e. there is a difference between accepting a prisoner for a bed and saying you are finding a bed. This is can potentially be used as a stalling method.

I recommend that Primary Care Trusts are reminded of their responsibilities towards prisoners identified with mental health needs, resident in their catchment area at the time of their arrest, even if located in a prison outside their geographical location.

Local

I recommend that the Governor ensures that the local self-harm and suicide awareness policy reflects PSO 2700 and encourages and supports the informing of the prisoners' next of kin.

I recommend that the Governor arranges for a test of radio reception and ensures batteries of all radios are checked regularly and rectifies any problems.

I recommend that all relevant healthcare staff should undertake training in use of the defibrillator machines.

I recommend that the Governor considers re-profiling the management needs of Norwich at night state.

All recommendations have been accepted by the Prison Service and the Department of Health.

Good Practice

I recommend that the Governor commends the wing nurse, the head of healthcare and the head of the mental health team and for their exceptional work with the man who died.

I am very impressed that the Governor took on the role of family liaison officer himself