Investigation into the circumstances surrounding the death of a prisoner at HMP and YOI Norwich in September 2004

Report by the Prisons and Probation Ombudsman for England and Wales

May 2005

This is a report of an investigation into the death of a prisoner who died in HMP Norwich in September 2004.

I would like to offer my sincere condolences to the man's wife and friends.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service, which came into effect on 1 April 2004. The bulk of the investigative work has been conducted on my behalf by a member of the Eastern Area Office. A clinical review was conducted by the Norwich Primary Care Trust. I am very grateful to all members of the team for their work. A colleague from my office liaised with the investigating team.

The man's death was the second apparently self inflicted death at Norwich prison since I became responsible for the investigation of deaths in custody. The first prisoner died in August 2004. Whilst the deaths were completely unrelated and the circumstances quite different, it is important that any lessons are learnt to try to prevent similar tragedies in the future. For this reason, I draw the attention of the authorities to the recommendations made in that earlier report, many of which are repeated here. In particular, I have now twice made recommendations regarding (i) the entry to cells by singleton night patrols and (ii) that they should routinely carry ligature cutters.

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PRISONS AND PROBATION OMBUDSMAN

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Summary

This is a report of an investigation into the circumstances surrounding the death of a prisoner at Norwich Prison in September 2004. He had been remanded into Norwich on 14 September following an appearance at Norwich Magistrates Court.

The Criminal Justice Mental Health Team assessment report conducted on 13 September describes the man as having been persistently abused by his father. The assessment report notes that he drank over 80 units of alcohol per week and that he posed a risk of violence towards men when intoxicated.

The reception cell sharing risk assessment on 14 September records his previous convictions for violence and concludes that he could pose a high risk to other prisoners. He was therefore assessed as being only suitable for a single cell.

The risk assessment also shows a risk of self-harm, the man having verbally expressed the desire to commit suicide. As a consequence, a prison service nurse (PSN) opened a F2052SH (a form used by the Prison Service as a mechanism of support and monitoring those at risk of self harm or suicide). The man was located on the Healthcare Centre.

The man made an application to the Counselling Assessment Referral Advice and Throughcare team (CARATs) with a view to addressing his alcohol problems. An initial assessment took place on 20 September.

He was moved from the Healthcare Centre to normal location on 21 September, still on an open F2052SH. However, the doctor did not complete the Healthcare Discharge report which is a requirement under PSO 2700. Once on normal location, officers referred the man who died to an “Insider”, a prisoner who helps new entrants and vulnerable prisoners through their more difficult times at Norwich. The man had been concerned about the future of his relationship with his wife, and the Insider and officers had written letters dictated by the man to his wife to try and resolve their relationship difficulties.

On 22 September, the first entries in his F2052SH indicate that he was much calmer and was settling down on the wing; during the afternoon his demeanour changed as he said he had received bad news in a letter. There is an entry in the F2052SH stating the letter is a “Dear John” (a letter indicating an end to his relationship). This information is confirmed by the Insider, who read the letter to the man and subsequently wrote a reply to his wife.

The man was referred to the Mental Health In-reach Team and an assessment took place on 23 September. The provisional diagnosis was that it was likely he was suffering from a Personality Disorder and probable Social Phobia. The assessment noted that he did not want to commence medication.

A case review on 24 September decided that the man was stable enough to be removed from his F2052SH. This was despite entries that make reference to his on-going worries about his relationship with his wife, and an entry of the day

before stating that he had received a “Dear John” letter from his wife. Present at the review was a senior officer, officer and the man who died himself. The review took place without a representative from Healthcare or the Mental Health In-reach Team. In my opinion, this case review should have been conducted more thoroughly and by a multi-disciplinary team.

There are no further entries in the man’s files. He was found hanging in his cell on the morning of 27 September by the night officer. Once assistance had arrived, staff entered his cell. Staff attempted to revive the man, but to no avail. It was felt by healthcare staff that rigor mortis had already set in.

Investigation process

Under transitional arrangements in place between 1 April and 30 November 2004, A member of HMPS staff was nominated by the Prison Service to investigate the man's death. He visited HMP Norwich with an investigator from the Prisons and Probation Ombudsman's office, and met the Governor.

Notices were issued to prisoners and staff, inviting anyone who might have information relating to the man's death to make themselves known to the investigation team.

The Prison Service representative and my investigator met with representatives from the Independent Monitoring Board and the Prison Officers' Association to explain the circumstances of the investigation.

The Prison Service representative interviewed staff and prisoners who had known the man who died, or who were involved in attempting to revive the man.

The Prison Service representative met with the man's wife at Norwich Prison. Subsequently, a Family Liaison Officer from the Prisons and Probation Ombudsman's office, and my investigator visited the man's wife at her home to discuss any concerns she had. The family liaison officer remained in touch with the man's wife.

A separate Clinical Review of the man's time at Norwich was carried out by the Norwich Primary Care Trust.

The investigation team were given unlimited access to all documents relating to the man, and to his death, and to all policy documents relating the care of prisoners in custody.

Background Information

The man who died was born in Chesterfield and spent most of his childhood in Derbyshire. He married in 2002. The man did not maintain contact with other family members, apart from his wife.

The man had suffered serious abuse as a child, and this had affected his adult life greatly. His wife blames this abuse for his subsequent problems with alcohol and aggression. He had also attempted to take his own life prior to meeting his wife. The man had previously been in prison on another offence, and had found it difficult to find work as a result. The Criminal Justice Mental Health team assessment report described the man as drinking at least 80 units of alcohol per week, and being personality driven with little motivation to reduce his alcohol intake or introduce greater structure into his life. He also had poor literacy skills.

The man was arrested in Norwich on 12 September 2004 for alleged threats to kill and criminal damage against his wife. He was remanded into Norwich Prison on 14 September following an appearance in Norwich Magistrates Court. He was 45 years old.

Events leading up to the man's death

The man arrived at Norwich Prison Reception on 14 September around lunchtime and the usual reception screening took place. In his case, the process was straightforward.

There is an Initial Assessment Report made by the Criminal Justice Team dated 13 September 2004 and signed by a member of that team that arrived with the man at the prison. There was a stated action that should he receive a custodial sentence, his risk of self-harm and violence towards others would need reassessing. The report also states that the man had attempted asphyxiation in the recent past, and that his problems were alcohol related.

The report also adds within the risk assessment section that the man drank in excess of 80 units of alcohol per week, with minimal motivation to change, and was inclined towards violence against men when intoxicated. He had at this point declined specialist input.

During the reception screening, the man was assessed for suitability to share a cell with another prisoner. Due to his previous violent offences, it was decided through risk assessment that he could potentially present a risk to others and therefore a single cell was most appropriate for him.

The man had spoken to the reception nurse about his feelings of suicide, also expressing feelings of self-harm and hopelessness. The nurse decided there was a current risk, opened a F2052SH (a form used by the Prison Service for prisoners at risk of suicide or self-harm) and located him in the Healthcare centre.

The F2052SH Initiation Report expresses all the above. It also recommends extra support and supervision, and an assessment by the Mental Health In Reach Team. There is a note within the F2052SH, made by a Doctor for a referral to mental health services. That referral took place on 23 September with a provisional diagnosis of "*Personality disorder and probable Social Phobia"*, adding that the man did not want to commence medication.

Because of his short period in custody, the man's wing history is limited, with main sources of information being his F2052SH, an Insider, the HMP Norwich induction process and the man's brief encounters with those people associated with that process.

The man's induction was not conducted in a group. It was felt by the induction staff that he was too withdrawn and tearful for the process to be effective. An Induction Officer conducted the process on a one to one basis in the man's healthcare cell.

During the induction process, the man explained to the Induction Officer that he could not read or write. When asked whether he would be keeping in contact with his friends or family, the man confirmed that letters would be difficult but he would be using the telephone.

He then asked the officer to write a letter to his wife. The officer is used to such requests as part of the induction process. Following a routine check by the officer regarding child and witness protection measures, the man dictated a letter for the officer to write.

An interim case review dated 17 September within the man's F2052SH records states that he still felt suicidal due to *"people messing with my head".* It also records he felt comfortable in Healthcare and appreciated people talking to him. He also wanted to partake in exercise/education but found it difficult coping being around a lot of people.

The man made an application to the Counselling Assessment Referral Advice and Throughcare team (CARATs) with a view to addressing his alcohol problems. An initial assessment took place on 20 September. The CARAT worker noted in his F2052SH that the man had described to him a preferred method of suicide through electrocution.

There are copies of three letters in the man's file that we have retrieved from the Coroners Office. They are all written to his wife and all seek clarity about their future relationship and express remorse for his offence. One is written on the man's behalf by the Induction Officer and is undated. The second is written on the man's behalf by the insider and is dated 22 September. The third is by another hand and is undated. The content indicates that it is after the man's final court appearance and seeks clarification as to the couple's future.

He attended court on 21 September. On his return, he was assessed fit for normal location by healthcare staff and relocated to C wing. However, no reasons for this decision are documented in the IMR. Furthermore, the Healthcare Discharge Report had not been completed in the F2052SH by the doctor. This is a requirement in Prison Service Order 2700.

On 22 September, early entries in the man's F2052SH indicate that he was much calmer and continuing to settle down on the wing. During the afternoon he received a letter from his wife indicating that their relationship could not continue, and the man's demeanour changed. There is an entry in the F2052SH describing the letter as a "Dear John". This information is confirmed by the insider, who read the letter to the man and subsequently wrote a reply on the man's behalf.

He was seen by the visiting psychiatrist from the Norvic Clinic on 23 September. He noted "impulsive type personality disorder" and that the man refused the idea of medication. The psychiatrist also scheduled a further meeting.

The man's IMR indicates that all medication was stopped on 23 September at his request.

On 23 September there is another entry in the F2052SH by an officer. It states that the man was still in a *"bit of a state following his letter from his wife"*, and that she asked the insider to help him with some reading and writing. The officer also asked another officer to have a word with him about embarking on a

Rehabilitation of Addicted Prisoners Trust (RAPT – a voluntary agency) course to address his alcohol problem.

The following day, a review of the man's F2052SH took place on the wing. The review was conducted by a senior officer, alongside a wing officer and the man himself. The notes of the case review are sketchy. It states: *"The prisoner states he is no longer suicidal and does not really want to mix, and will be placed on top of the list for single cell accommodation on B2/B3 where there are less inmates"* There is no reference to the very comprehensive entries of the day before about his bad news from his wife, or the man being in a bit of a state. No member of Healthcare staff was present at the review.

There are no further entries in the man’s file until the accounts of when he was found hanging a morning in late September.

The Crisis Management

At approximately 6.30am on the day the man died, a night officer was patrolling B and C Wing. As he approached the man's cell, C1-05, he could see that he was hanging from the window bars by a ligature made from bed sheets. The night officer radioed for urgent assistance, a code 1. This officer recalls this being at approximately 6.30am. The three staff who responded to the code 1 recall this as being approximately 6.40am.

At approximately 6.43am, the night officer was joined by a senior officer (Night Manager), another officer and a nurse. Together they entered the cell. The senior officer and the second officer lifted the man to support his weight. The officer who found the man went to the wing office to fetch the self-harm box which contains a ligature knife. He cut the ligature from around the man's neck and the nurse, the second officer and the senior officer commenced CPR. The nurse felt that rigor mortis had set in. CPR continued until the ambulance crew arrived at approximately 6.57am.

The paramedics took an ECG reading, and a paramedic of the East Anglian Ambulance Trust pronounced that the man was dead at 7am.

The incident log records that the prison’s contingency plans for a death in custody were activated fully. A hot debrief was conducted and staff offered support. Staff also broke the news in person to the insider and offered him support.

Notifying the man's wife

The prison asked the police to make the initial contact with the man's wife and break the news of hiss death. The man's wife was not visited until approximately 11am.

The Governor and members of the Chaplaincy team facilitated a visit by the man's wife to view his cell. A small service was conducted and the personal effects belonging to her husband were returned.

Norwich's Suicide Prevention Strategy

Norwich Prison's Suicide Prevention Policy Agreement is well written and the Guidance Notes to assist the management of F2052SHs is comprehensive. However, the common sense approach in the document, and the need to write understandable, clear, concise instructions on case conferences and entries, was not always transmitted through to the "care document". Samples of other F2052SHs as well as the man's F2052SH show a great variation in quality of entries despite the Guidance notes.

The minutes of the last three Suicide Prevention Meetings indicate a diverse standing agenda encompassing most areas of vulnerability with regard to prisoners at risk, and some comprehension of preventative measures to be taken. There does, however, seem to be a dearth of "front-line" Prison Officers and Mental Health In-reach Team representatives on the attendance list.

HMP Norwich Emergency Order No.30 is very comprehensive in describing staff action should a prisoner be found who has attempted suicide. There is, however, a case for reworking Para. 1 (b) regarding entering the cell. It simply says "Enter the cell *(staff may do so alone)"*. A review of the policy for unlocking prisoners during patrol states should be undertaken to ensure that there is timely access in life threatening situations. The Emergency Order can then be expanded to make it clear what is expected of staff, particularly at night where there are singleton patrols and decisions need to be made quickly.

The training records show that, out of a staff of 692, only 85 have completed Suicide Prevention training. All staff interviewed were aware that training was available. The clinical review also identified a need for CPR training.

The two previous audits for Suicide and Self Harm Prevention were carried out in 2003 and 2004. The result in June 2003 was an 'Unacceptable' 52% rating. The follow up audit in July 2004 showed significant improvement to an 'Acceptable' 72% rating.

The Independent Monitoring Board (IMB) Annual Report for the period January 2003 to February 2004 notes that, with regard to F2052SH procedures, while these had been problematic, "*there have been definite signs of improvement in the last 2 to 3 months"*.

Findings

On admission to Norwich, the man who died expressed a desire to commit suicide. A F2052SH was opened appropriately and he was located in the Healthcare centre. A referral was made to the Mental Health In-reach Team.

A medical assessment of the man was carried out, prior to his court appearance on 14 September, by the Norwich Criminal Justice Medical Health Team. Further assessments were made at Norwich Prison by healthcare staff and subsequently by a visiting psychiatrist.

During his stay in Norwich, he was referred to CARATs and RAPT. He had undergone an initial assessment prior to taking his life.

Between being "signed off" an active F2052SH following a case review on 24 September and being found hanging on the morning of 27 September, there are no entries in the man's prison record, medical record or occurrence books.

During his time at Norwich between 17 and 27 September, it is difficult to find a member of staff or prisoner who knew the man well. An extended interview with the Insider is the most comprehensive account of the man's short stay.

The reception process made referrals, carried out risk assessments and identified risk, both to others and to the man in a timely, humane and understanding manner. His vulnerability was identified early on and he was managed within national guidelines.

The first case review of hiss F2052SH on 17 September decided that he was in need of continued support, was still feeling suicidal and needed to remain on the F2052SH.

He was moved to B wing from Healthcare on 21 September. No reasons to support this decision are documented and the Healthcare Discharge Report within the F2052SH has not been completed by the Doctor.

It is recorded in the man's medical record that he refused to commence any medication. There is another entry stating that all medication was stopped at the prisoner's request on 22 September.

A case review carried out on 24 September recommended that he be taken off his F2052SH, and that he would await a single cell on B2/B3. There is no reference within this review to the very comprehensive entries made the day before about the man receiving a "Dear John" letter from his wife or his mood change. There was no member of healthcare staff or a representative from the Mental Health In-Reach Team present at the review. This review was superficial in several respects.

The man appeared to be having difficulty coming to terms with the break-down of the relationship with his wife. This is documented in letters sent during the first

days of his custody. Communication with his wife was difficult because of his lack of writing skills, and he was reliant on others to write letters on his behalf.

The training records show that out of a staff of 692 only 85 have completed Suicide Prevention training. The clinical review also identified a need for CPR training.

The Monthly Suicide Prevention Meeting minutes show a comprehensive and diverse agenda, and it appears to be well run. There is, however, a lack of wing staff, healthcare staff, and representatives from the Mental Health In-reach Team on the attendance lists.

The crisis management appears to have been conducted well, contingency plans followed and all statutory requirements complied with including the involvement of the Norfolk Police and Norwich's Coroner's Office.

HMP Norwich left the police to contact the man's wife. The Norfolk Constabulary notified the man's wife of her husband's death at approximately 11am on the day he died.

Conclusions.

The man who died was received into Norwich Prison on 14 September at which time it was accurately identified that he was vulnerable and could possibly be a suicide risk. He was promptly placed on a F2052SH and located on the Healthcare centre. Staff acted in a responsible way, balancing the risk of allocating a single cell against the likelihood of him causing harm to another prisoner. The man's history includes violence with indications in his record that adult males are a likely target of his aggression.

The man indicated to reception staff that he felt suicidal. The entry in the F2052SH by the initiating member of staff is comprehensive and recommended support and referral to the mental health team. This was the trigger for appointments being made and, by the time of his death, initial assessments had been made by the Mental Health visiting Psychiatrist, and the CARATs worker, and he was awaiting assessment by RAPT to address his alcohol problems. The reception and induction process at Norwich looked after the man and settled him into the prison routine.

During the induction process a Prison Officer penned a letter on behalf of the man to his wife. He seemed to be very concerned about where he stood regarding his relationship with his wife. The Induction Officer says he checked the man's record for any reasons not to write on his behalf. During the interview, the officer stated that there were no child protection or victim issues. There is, however, a letter on the man's prison file indicating that Norfolk Police were unhappy for his wife to receive a letter from her husband as he was her alleged assailant. Whilst I understand the issues here, I believe the officer acted correctly and in good faith as the letter was important to the continued welfare of the man. It helped him through those first few nights when he was most vulnerable. The letter did not ask his wife about dropping any charges.

The man was managed well by staff and other prison and healthcare professionals during the first ten days of his imprisonment at Norwich, with all the referrals and planning for the future being carried out diligently. However, some professionals did not meet the recognised standards for record keeping.

Staff acted appropriately and compassionately by referring him to an Insider. The Insider wrote letters for the man, advised him of his entitlements, filled in his menus and pointed him in the direction of education and RAPT.

All the documentation and interviews indicate that, although he was becoming used to the prison environment, his relationship worries were growing. There are three letters in the file to his wife, all by different hands, asking where they stood with their relationship.

On 21 September, he was moved to B wing from Healthcare, still on an open F2052SH. Healthcare staff had assessed him as fit for normal location. Although this may well have been the correct decision, the rationale behind it is not documented in the medical record. Furthermore, the doctor did not complete the Healthcare Discharge report which is a requirement under PSO 2700.

On 22 September, staff noticed that he was upset because he had received a letter from his wife. At this point I conclude that the man was at his most vulnerable, as this problem had dominated his life since arrival.

He was "signed off" his F2052SH two days after two very comprehensive entries describing the man as still "*being very upset*" following the letter on 22 September from his wife stating their relationship was over. I find it worrying that the closing case review makes no mention of those entries. Furthermore, there is no Healthcare, Mental Health In-reach Team or other discipline involved. The decision is based on the man stating that he was no longer suicidal. The man was found hanged in his cell three days after the F2052SH was closed. It is impossible to say that remaining on the F2052SH would have saved his life. It is also impossible to say whether he engineered the closure in order to take his own life. What is certain, however, is that closure of a F2052SH should be conducted with more care, with healthcare involvement and with reference made to recent entries of note, both positive and negative.

The standard of all entries in both the man's F2052SH and a sample of others leave room for improvement. There are good and comprehensive entries, but on the whole they are uninformative and give little indication of the prisoner's demeanour and emotional state.

After finding him, staff acted professionally and made every effort to resuscitate him. In general terms, Norwich prison's protocol for entering cells as a singleton Night Patrol if it is believed a prisoner has attempted to take his own life says "you can enter the cell alone". On this occasion the Night Patrol summoned assistance and waited for them to arrive. Following the arrival of help, the Night Patrol was sent to the wing office for a ligature cutter. I believe ligature cutters should be standard personal issue for night staff, and the "you can enter the cell alone" explained in more detail because seconds could save lives. On this occasion it seems that more speedy intervention would not have saved the man.

Staff interviewed during the course of this inquiry were aware of the Suicide Prevention meetings as the minutes were published on the intranet. They were also aware of the training programme but none had been refreshed recently. Some had not been trained at all. There is room for improvement in Suicide Prevention Training. There is also a need for more CPR training.

Norwich's contingency plans were good and followed appropriately.

The level of care extended to the man's widow demonstrated concern and compassion. She visited Norwich, met with the Governor and Chaplaincy. She was shown his cell and at her wish, was part of a small private service in that location. However, it is good practice for Prison Service staff to inform the next of kin of the news of the death. Prison Service staff often have more information, and can advise on the next steps. It would have been possible for a Governor grade from Norwich prison to visit the man's wife as she also lived in Norwich.

Staff and prisoners have all been appropriately supported during the difficult period following the man’s death.

Recommendations

Although a higher volume of Suicide Awareness trained staff would not have prevented the death of the man, the percentage of front line staff who have been Suicide Awareness trained has fallen to a low level.

I recommend that wing staff, and other front-line specialists are targeted for Suicide Awareness training. The Mental Health In-reach Team should be involved in this training.

The Suicide Prevention Committee would benefit from the experience of front line staff. They are the important interface between policy and practice.

I recommend that officer grades, and either healthcare staff or staff from the Mental Health In Reach team, are represented on the Suicide Prevention Committee.

The clinical review by Norwich Primary Care Trust also identified that healthcare staff need training in CPR.

I recommend that all Healthcare Staff should be updated in CPR annually.

Some healthcare professionals did not meet the recognised standards for record keeping. The following recommendations are taken from the clinical review by Norwich PCT.

I recommend that all people admitted as healthcare inpatients have care plans in place relevant to their needs.

I recommend training for healthcare staff at all levels in record keeping and their professional responsibilities.

I recommend that a record keeping audit should be conducted if one has not been completed within the last six months.

The HMP Norwich Suicide Prevention Strategy is very comprehensive and easy to read. However, the section regarding singleton staff entering cells needs to be expanded to reflect that in any suicide attempt it is seconds that save lives.

I recommend a review of the policy for unlocking prisoners during patrol states should be undertaken to ensure that there is timely access in life threatening situations. Following this, I recommend that the paragraph in Norwich's Suicide Prevention Strategy concerning entering cells alone is re-written to give more information to patrols, in particular, that speed is of the essence when confronted by a hanging prisoner.

It is good practice for singleton patrols to carry ligature cutters on their person as a personal issue. Cutters located in the wing office may waste precious seconds.

I recommend that ligature cutters be carried as personal issue by singleton patrols.

The entries in both the man's F2052SH, and others sampled are of variable quality. There is a training/sampling issue with F2052SHs.

I recommend that there is a short F2052SH completion awareness course and a greater emphasis on regular sampling by management.

The closure of his F2052SH appears to have been completed without much regard for previous comprehensive entries by others. The review would have benefited from having a Healthcare professional or representative from the Mental Health In Reach team involved in the review.

I recommend that first-line managers have additional training in the completion of F2052SH reviews.

I recommend that a member of healthcare staff, or a representative from the Mental Health In Reach team, be present at all F2052SH reviews where they have been involved in giving care to the individual concerned.

Breaking the news of a self-inflicted death in custody is both sensitive and demanding. The way in which it is carried out may well colour a bereaved family's whole relationship with the Prison Service. The two main objectives should be to break the news speedily and to do so in a way that emphasises the Prison Service's accountability, sense of shared loss, and commitment to the family as members of the public that the Service serves. I appreciate that speed and personal involvement of the Prison Service may sometimes be in conflict.

If at all possible, the governor or other member of senior management in the prison where the prisoner has died should personally break the news. Where this is not possible, I do not think that the Prison Service should routinely rely on the police.

I recommend that where the next of kin of the deceased lives locally, the Governor or other member of senior management in the prison where the prisoner died should personally break the news.

I recommend that where the next of kin does not live locally, a policy is adopted by the Prison Service whereby a Governor at the prison closest to where the deceased's next of kin lives, breaks the news of the death.

List of Recommendations

National

I recommend that ligature cutters be carried as personal issue by singleton patrols.

I recommend that where the next of kin of the deceased lives locally, the Governor or other member of senior management in the prison where the prisoner died should personally break the news.

I recommend that where the next of kin does not live locally, a policy is adopted by the Prison Service whereby a Governor at the prison closest to where the deceased's next of kin lives, breaks the news of the death.

Local

I recommend that wing staff, and other front-line specialists are targeted for Suicide Awareness training. The Mental Health In-reach team should be involved in this training.

I recommend that officer grades, and either healthcare staff or staff from the Mental Health In Reach team are represented on the Suicide Prevention Committee.

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