Investigation into the circumstances surrounding the death of a male prisoner at HMP Norwich in December 2008

Report by the Prisons and Probation Ombudsman for England and Wales

December 2010

This is the report of an investigation into the death of a man who was found in his cell at HMP Norwich with a ligature around his neck on 20 December 2008. He had been in the prison for just a few hours.

I wish to offer my sincere sympathy and condolences to his family and friends for their sad loss.

This investigation was conducted by one of my senior investigators. I would like to thank the governor of Norwich and his staff for their help and co-operation. Unfortunately there was a long delay between the issue of the draft report and this final report, I am sorry for any added distress caused to the deceased's family as a result.

The deceased was a young man sentenced to 14 days imprisonment just before Christmas. In practice, he would have had to serve only seven days in custody before his release. He was a heroin user starting to experience withdrawal symptoms. Although he was concerned about detoxification, Norwich did not at the time have the protocols in place to offer him an opiate stabilisation and drug maintenance programme.

I have made five recommendations.

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

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SUMMARY

The man appeared at a local Magistrates Court on Saturday 20 December 2008, and was sentenced to 14 days imprisonment. He was taken to HMP Norwich by an escort service. The only risk category marked on the Prisoner Escort Risk (PER) form was the ‘drugs/alcohol issues’ box.

The man arrived at the prison and went through the standard induction procedure which involved checking the paperwork from the court, completing the Cell Sharing Risk Assessment (CSRA) and a first health screen.

Two officers were in Reception that Saturday afternoon and they did not have any concerns about the man during the induction procedure. At 2.35pm, the man saw a nurse for the first health screen. He told the nurse that he injected £40 worth of heroin daily and that he had been using the drug for a year. He also admitted to using crack cocaine occasionally. The man denied any thoughts of self-harm but told the nurse that he was concerned about detoxing. The nurse referred him to see the duty doctor regarding detoxification.

The man saw a doctor who started him on a ten day lofexidine detoxification programme for his heroin addiction.

An officer saw the man on E wing and completed the initial induction process. The man was then allocated cell E2-02. During the afternoon the man pressed his cell bell four or five times. The officer responded each time and each time the man asked to see the nurse again regarding medication. The officer contacted healthcare and was told that a nurse would come to see the man.

At about 6.30pm, a nurse went to the man’s cell with the officer that saw him earlier on E wing and a senior officer. The man asked the nurse for Subutex and methadone as the medication he had been given was not enough. The nurse did not see any visible signs of drug withdrawal and told the man that he should give the medication he had been prescribed a chance to work. The man threatened to hang himself if he was not given Subutex or methadone.

The nurse and the officers took the man’s threat seriously and opened an Assessment, Care in Custody and Teamwork (ACCT) document. (This is a document designed to monitor and support prisoners thought to be at risk of self harm or suicide through a period of crisis.) It was decided that hourly observations of the man were appropriate.

Just after 7.00pm, the officer that saw him on E wing decided to return to the man’s cell and talk with him. He saw that the man was hanging by a piece of torn bed sheet from the window bars and raised the alarm over his radio. Subsequently, the man was cut down and the nurse that had previously seen him to give him some more medication and another nurse started Cardio Pulmonary Resuscitation (CPR).

Paramedics arrived at 7.10pm and took over the CPR. Despite their best efforts the man was pronounced dead by the paramedics at 7.32pm.

Just after midnight, the man's mother was told of his death by staff from a prison near to her home. There was an unfortunate misunderstanding which meant that she waited for contact from Norwich the rest of that day (Sunday 21 December). The lack of contact was aggravated by the fact that the prison's Family Liaison Officer was not told of the man's death until Monday morning.

My investigation has highlighted certain staff training requirements, and this report should be read in conjunction with the clinical review which also makes a number of recommendations.

THE INVESTIGATION PROCESS

1. The investigation was opened by one of my family liaison officers (FLOs), on 23 December 2008. The governor and his staff produced the man's core record and a number of other documents for examination. Notices were displayed around the prison to inform both staff and prisoners of the investigation.

2. The investigator from my office formally interviewed a number of members of staff and one prisoner regarding the man's death.

3. Another of my FLOs, contacted the man's mother. She offered the opportunity to meet with her and the investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored or addressed. The FLO that contacted the man's mother and the investigator met with the man's mother and her partner on 3 February 2009.

4. The man's mother and her partner raised a number of concerns:

   - Why had the nurse walked away after the man said that he would hang himself?

   - The family felt strongly that the protocols to monitor prisoners at risk of self-harm or suicide were clearly not right and not working.

   - Staff should have taken the man's threat seriously and put him into a padded or safer cell as a precaution.

   - They were aware that the man used a sheet as a ligature and questioned why these were not replaced with paper sheets, or sheets that tore easily under pressure.

   - They had been advised that the governor of Norwich would contact them the day following the man's death (i.e. the Sunday) to provide more information. However, this did not happen. The man's mother and partner were forced to contact the prison themselves on the Monday. The man's mother said it had been very distressing to have been left for an entire day with no further information and not knowing the detail of what had happened.

5. My investigator was able to answer the majority of these concerns during their meeting. I hope this report helps the man's mother and her partner to further understand the events and actions taken during the afternoon and evening of 20 December.

6. My 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, this investigation report will be sent to the Coroner to assist with the inquest into the man's death.

7. Norwich Primary Care Trust (PCT) was asked to prepare a clinical review of the care that the man received whilst at Norwich. The trust appointed a clinical reviewer to undertake the review. The clinical reviewer interviewed staff jointly with my investigator, and then reported back to a panel which the PCT had convened before completing her report.

HMP NORWICH

8. HMP Norwich is a multi-functional local and training prison, holding both adult men and young offenders. It also has a remand unit, resettlement unit and is one of the few prisons in England and Wales with a dedicated Older Prisoners Unit (the Nelson Unit). Norwich serves the east of England and accepts both convicted and unconvicted prisoners. It has an operational capacity of 824.

9. Between 1996 and 2004, Norwich underwent substantial reorganisation of its wings, some of which were converted into dedicated units. As a result, the resettlement unit, young offender units and the Nelson Unit (on the ground floor of the healthcare centre) are all located outside the main prison.

10. There were 25 deaths at Norwich, prior to that of the man, since my office was entrusted responsibility for investigating all deaths in prison custody in April 2004. Of these, eight were apparently self-inflicted and 17 were from natural causes. (It should be noted that because of the age profile and purpose of the Nelson Unit, Norwich inevitably has a high number of natural cause deaths.) One of the issues raised by my investigation into the death of a man who died at Norwich in March 2008 was the unavailability of methadone based detoxification. The issue of detoxification was also raised in the March 2007 inspection report from Her Majesty's Chief Inspector of Prisons. In the healthy prison summary section of her report, she wrote:

    "Detoxification was limited to an inflexible 7-to-14-day non-opiate-based rapid intervention. Despite there being an average of 32 detoxifications a month on the adult side, no opiate-based alternative (for example methadone) was available on reception, even if the individual had been subject to a maintenance programme in the community…"

11. Her Majesty's Chief Inspector of Prisons's report made a number of recommendations in relation to substance misuse. One of the most relevant to this investigation is listed below along with the prison's response:

    "The prison should update its policy for the clinical management of substance misuse to incorporate national guidance regarding stabilisation, detoxification and maintenance."

    Feb 09: An interim service for the management of substance misuse was introduced in Oct 2008 providing maintenance for prisoners on community substitute prescribing. This is managed in a dedicated area of the prison, and is supported by the Trust Alcohol & Drugs Service (TADS).
    Feb 09: ONGOING. Substitute opiate prescribing - In place for prisoners on confirmed community prescriptions. Full Integrated Drug Treatment System (IDTS) will be introduced when 'A' wing opens in Aug/Sept 09.

12. Each prison has an Independent Monitoring Board (IMB). IMB members are lay members of the public and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. In the latest published annual report (February 2008) the Norwich IMB also

comments on the problems encountered by prisoners addicted to heroin arriving at Norwich.

KEY FINDINGS

13. On Friday 19 December 2008, the man was arrested in an ASDA supermarket for stealing £216 worth of alcohol. He was held overnight at a local police station. The next day, the custody officer, completed a Prisoner Escort Record (PER). He ticked the box on the form indicating that the man had drugs/alcohol issues and wrote "heroin user, on own admission" in the section entitled 'Further information about risk'. There were no other risk factors identified on the form.

14. The man was transferred to a local Magistrates Court where he pleaded guilty to the charge of theft. He was sentenced to 14 days imprisonment and sent to HMP Norwich.

15. Two officers started the induction process in Reception. They checked that the paperwork from court was in order and started to complete the Cell Sharing Risk Assessment. One of the officers recorded that the man said he used heroin and was dependent on it. He also noted that the man did not have any concerns about sharing a cell and that he would not describe himself as a person who got angry or frustrated quickly. The same officer decided that the man's risk of harm to others was low and ticked the 'low' box, meaning 'no current indication/evidence of risk, suitable for multi-cell location'.

16. My office was contacted in March 2009 by a prisoner at HMP Wayland. The prisoner said that he had been a reception orderly and a Listener at Norwich on Saturday 20 December and had information relevant to this investigation. (A reception orderly is a prisoner employed to work in the reception area. A Listener is a prisoner who volunteers to be trained by the Samaritans to carry out a similar role within the prison.)

17. The investigator interviewed the prisoner at Wayland. He said that he was in the reception area when the man came in and that it was obvious he was withdrawing from drugs and in a bad way. The prisoner said he spoke with the man briefly and then talked to him in his capacity as a Listener. (He was unable to talk about that latter conversation. The Listeners operate under the same rules of confidentiality as the Samaritans.) Crucially, the prisoner told my investigator that he had overheard the man say to the reception staff that he would hang himself if he did not get more medication.

18. The allegation is obviously very serious and, if true, means that the staff did not open an ACCT document as they almost certainly should have done, nor did anything else in respect of the man's threat to commit suicide at that time.

19. At 2.35pm, the man was seen in reception by a nurse. She completed a first reception health screen. Norwich uses a computerised system which all of the healthcare staff are trained to use. The man told the nurse that for a year he had injected £40 worth of heroin each day and had last done so the day before. He also admitted to using crack cocaine occasionally. The nurse recorded that the man was concerned about withdrawing from heroin and that he was a "bit down" and looked pale. She referred him to see the doctor regarding drug detoxification. The man told the nurse that he did not drink and had not

previously tried to harm himself either in or out of prison. The nurse tested the man's urine which was positive for opiates (heroin) and cocaine.

20. About fifteen minutes later, the man saw a doctor and told him he used four bags of heroin and £20 worth of crack cocaine a day. The man complained of having stomach cramps and feeling shaky. The doctor recorded that the man had rhythmic heart sounds, no tremors or sweating, a pulse of 74 beats per minute and that his pupils were a bit dilated, equal but slow to react to light. The doctor decided to put the man onto a ten day lofexidine detoxification programme, with ibuprofen, buscopan, loperamide and zopiclone. The man was given his medication by the nurse at 3.17pm. She gave him some medication to take immediately and extra medication for the rest of the day.

21. The man was then taken to the First Night Centre (E wing) and an officer conducted what is known as the first night interview. The man told the officer that before he had been arrested he was living with friends in Hastings, and intended to return there upon his release. The officer went through the questions on the questionnaire with the man. The man said that he had expected to be in custody that day and had no concerns about that (in fact, his mother told my investigator that in the past the man had liked being in prison). When asked by the officer about self-harm and depression, the man said that he had never committed any act of self-harm and did not feel at risk of self-harm or suicide at that time. He also said he had never suffered from or been treated for depression.

22. The man was locked into cell E2-02. An officer who was on duty that afternoon on E wing later wrote that she had had the opportunity to talk with and observe the man. She said that she spoke with the man when he was in his cell. He asked her when he would have canteen. (Canteen refers to the system used in prisons which allows prisoners to place an order for tobacco, sweets, various food items and toiletries.) The officer replied that he would be able to order from the canteen on Monday. The officer also saw the man later as he was collecting his tea meal. She said that he did not show any signs of distress, although she asked him if he was not very hungry as he had very little food on his plate. The man just shook his head.

23. The officer that saw him for his initial induction had cause to speak to the man about his use of the cell bell. The man had pressed it four or five times in the space of an hour during the afternoon. Each time the officer responded and the man said he wanted to speak with the nurse about his medication. The officer contacted healthcare when the man first pressed his bell, and was told that a nurse would come over to see the man when duties in reception were complete. The officer passed that information to the man.

24. At 6.35pm, a nurse went to the man's cell with the officer that saw him for his initial induction and a senior officer. The nurse is an agency nurse who has worked at Norwich on a regular basis since 2005. He recorded that the man was alert, oriented, had no tremors and normal speech. The man's blood pressure was 115/80, his oxygen saturation was 98 per cent and his pulse rate was 84 (ten higher than when checked earlier by the doctor). The readings are normal, although the pulse is slightly higher than average.

25. The nurse discussed the medication prescribed to the man who said, “They might be alright now, but not later on.” The man told the nurse that he had not taken all of the medication he had been given, yet he was insistent that it was not enough and asked for the nurse to give him Subutex or methadone (both are synthetic opiate substitutes used to detoxify from heroin). The nurse told the man that he was unable to give him any more medication until Monday, and that he should allow what he had been given a chance to work. The man was adamant that the medication was not working and on two occasions said, “If I don’t get Subutex or methadone I will hang myself.” In his interview with my investigator, the officer that conducted the man’s initial induction said that when the man said that he was lying back on his bed, relaxed and apparently not agitated in any way. When the officer was asked about the level of concern he had about the man as he left his cell, he told my investigator:

> “It’s unfair to categorise it but the comment was made by him and you could say flippantly, in his body language, how he was lying on the bed, so on a scale from 1 to 10, I would say 4 to 5.”

26. The nurse and the officers returned to the wing office and the nurse opened an Assessment, Care in Custody and Teamwork (ACCT) document at 6.45pm. The plan encourages staff to work together with the prisoner to provide individual care to prisoners in distress, to help defuse a potentially suicidal crisis, or to help individuals with long-term needs (such as those with a pattern of repetitive self-injury) to better manage and reduce their distress.

27. The nurse explained to my investigator why he decided to open the ACCT document:

> “The thing that worried me about him was I say it wasn’t what I took to be his physical symptoms but the fact as he said at least twice something along the lines of if I don’t get more drugs or whatever I’m going to hang myself. Now the fact is on a day to day basis here a lot of prisoners say things like that. Then I thought to myself, I don’t know the man, I don’t know that he won’t hang himself, I knew he was quite young so I was thinking he might not be thinking things entirely rationally”.

28. At 6.58pm, the senior officer completed the ACCT immediate action plan. He wrote that the man was happy to stay in a single cell, and had been told about the Samaritans phone, the Listener scheme, and that an appointment was to be made for him to see the doctor on Monday morning. The senior officer decided that under the circumstances the man should be checked hourly. The senior officer, the nurse and another nurse (who had seen another prisoner on the wing) then left E wing.

29. The officer decided to return to the man’s cell after the other officers had left to “have a chat” and see how he was. He opened the cell door observation flap and looked into the cell. He then saw that the man was hanging from the bars at the cell window by a torn strip of green prison bed sheet. The officer radioed a ‘code blue’ message to alert the control room and other staff that he required assistance with a prisoner who had a breathing problem (the message is timed at 7.02pm). At the same time, he opened the cell door and called to the man

but did not get a response. The officer then closed the cell door and ran back downstairs "to aid staff to get in so we could lift the man and cut him down".

30. The officer returned to the man's cell almost immediately with the senior officer, the nurse (who had previously assessed him for his ACCT) and one of the officers that was on duty when he arrived in reception. The nurse described how long, in his opinion, the man had been hanging:

> "I would have guessed from the colour, I had seen him not too long before, which looked quite reasonable from what I recall when I saw him, so I would have guessed in retrospect that given how cold he was and widely dilated his pupils were, that he'd possibly hung himself the minute we had left the cell and gone down stairs, certainly more than a few minutes but exactly how long I don't know. But I didn't think he had just done it you know, I think he had been in there a while in that state a while."

31. The officer who carried out the man's initial induction and the other staff supported the man's body while the senior officer cut through the bed sheet ligature with a special knife issued to staff for that purpose. The man was placed onto the floor of the cell and the nurse who assessed him for the ACCT and the other staff began Cardio Pulmonary Resuscitation (CPR). An officer requested an ambulance. It was called by the control room staff at 7.04pm. The second nurse that was there when they where assessing the man for ACCT arrived with oxygen and assisted with the CPR. The officer that carried out the man's initial induction had left the cell by that time.

32. A paramedic arrived at the man's cell at 7.10pm and later noted on his report sheet that the nursing staff were carrying out good quality CPR. The paramedic took control of the CPR, although he was assisted by the prison staff. An ambulance crew arrived between five and eight minutes later and its crew assisted the paramedic. Four doses of adrenaline along with saline and atropine were administered to the man by the paramedics along with the CPR. However, at 7.32pm the man was pronounced dead. It was noted on the paramedic's report sheet that there had been no change in the man's condition.

33. The extra medication that the nurse that carried out his first health screening had given the man at 3.17pm was found in his cell after his death.

34. The governing governor arrived at the prison shortly before 8.30pm. At 8.50pm, the governing governor wrote on his incident log that he had considered holding a 'hot debrief' but that he did not think it suitable at that stage as the staff were very distressed. At 9.00pm, the governing governor contacted a prison local to the family to request that staff from there inform the man's family of his death (The local prison is much nearer to the man's mother's home and the decision to use staff from there would have speeded up the notification.) The man's mother was told of his death at five past midnight. The man had told the reception staff that his mother was to be his next of kin.

35. There was some confusion regarding further contact between the prison and the man's mother. At 2.46am on Sunday 21 December, the governor was told via email by a member of staff from the prison near the man's family that she

expected the man's mother would make contact later that morning. The man's mother believed that she was told that someone from the prison would be contacting her. Norwich's safer custody manager was the only available trained family liaison officer, but she was not informed of the man's death until the next morning (Monday, 22 December). She contacted the man's mother at 12.30pm after first speaking with the Coroner so as to be able to give the best information to the man's family. The man's mother has told us that the prison had since paid for the funeral expenses and that the safer custody manager had kept them informed in the weeks following the man's death.

36. My office received a letter in January 2009 from a prisoner who arrived on E wing five days before the man. He wrote in praise of the staff on the wing, ending his letter:

> "Although obviously my experience has no direct link to the man's unfortunate death I felt that my personal experience of reception onto E wing should be considered to show the high standard of care delivered by the staff. I will always be thankful to them."

ISSUES

Clinical review

37. The review by the clinical reviewer on behalf of the Norwich PCT highlights a number of areas where improvements to policies and procedures relating to healthcare and substance misuse treatment at Norwich could be made. However, with the exception of the issue regarding methadone maintenance which is now in hand (as the extract from the Chief Inspector's report and the response, cited above, shows), none of the changes would have been likely to have made a difference to the man's care given the very short time he was at the prison. I commend the clinical reviewer's review to the governor.

Detoxification

38. The man declared in reception that he was a heroin user and was prescribed a ten day lofexidine detoxification programme. The clinical review panel's comments on lofexidine are as follows:

> "HMP/YOI Norwich currently offers an interim substance misuse service. A full integrated drug treatment service is due to be implemented later this year. Lofexidine is currently the only medication offered for the management of opiate withdrawal and this is prescribed with a combination of other medications to control some of the effects of opiate withdrawal which include stomach cramps and diarrhoea. Lofexidine can cause significant drops in blood pressure and patients require close monitoring when starting on the drug and for that reason it should not be given 'in possession' to prisoners which means they can take it any time. the man was given the supper dose of this drug 'in possession'.
>
> The man was appropriately referred to a doctor following his first reception at the prison and prescribed a detoxification regime in line with the local guidelines. The prescribing doctor was a locum who had worked at the prison several times but did not have a qualification in substance misuse. The doctor was familiar with the policies and management of substance misuse at HMP/YOI Norwich. The man was described as being happy to undertake the prescribed detoxification."

39. The nurse that was the reception nurse on 20 December, was not aware of the correct prescribing procedures for detoxification medication in force at that time. She wrongly believed that the man was allowed to have his later lofexidine tablets in his possession and that she was not required to take his blood pressure.

40. My investigator has spoken with the clinical reviewer. She said that, like many of the other issues in her report, there might be other cases when the lack of close monitoring and having the medication in possession might have caused

problems. However, in the man's case there was not enough time for either the medication to have had a significant effect or his blood pressure to drop.

41. The clinical reviewer describes the procedures at Norwich for keeping healthcare staff up to date:

> "The method of circulation of new policies, procedures and guidelines to the healthcare team at HMP Norwich is by email. There does not appear to be a process for staff to acknowledge receipt and understanding of new policies or that staff are given the opportunity to discuss them. Nor does there appear to be any form of management assurance that dissemination has occurred and information has been understood.
>
> Some of the policies used in relation to substance misuse have been in draft or pilot form for several months. It is difficult to understand what status these policies have in relation to practice. Norfolk Community Health Care have recently participated in the development of a policy to Develop and Manage Procedural Documents (V1.2 March 2009). The process for ratification of such documents prior to this time is unclear. It is not clear what information staff are given on induction about provider organisational processes.
>
> The healthcare services at HMP Norwich rely on agency nursing staff to maintain adequate levels of staffing. Agency staff employed at HMP/YOI Norwich do not have access to the email system within the prison and it is difficult to understand how this group of staff receive information and how this is monitored.
>
> Although informed that staff meetings did occur there was no evidence to suggest that this was the case. Minutes were not available. Information from members of the healthcare team about staff meetings was inconsistent. It is not clear how communication in general occurs across the healthcare team."

The Governor together with Norwich PCT should introduce a robust system to ensure that all staff are aware of new or changes in policy, protocol or guidance which impacts on clinical care.

The prison accepted this recommendation at draft report stage and said:

"A system has been developed to cover all Healthcare Staff. Head of Healthcare will ensure that all staff sign to accept receipt of changes in protocol and guidance. Governor's Notice to Staff and Intranet."

42. The clinical reviewer also expresses concern that some healthcare staff had not fully completed the substance misuse training:

> "Training in substance misuse has been commissioned for the healthcare team by NHS Norfolk as part of the interim substance misuse service provided by the local community drugs service provider TADS. The Royal

College of General Practitioners Substance Misuse Level 1 certificate is recognised as the training of choice for use within prison healthcare in the national guidance. The course requires participant attendance at a face to face event and then completion of two e-learning modules. Some staff have not completed the e-learning modules, therefore are not fully trained. A list of staff that have attained the certificate was not available nor was there a training plan that identified the process by which all healthcare staff would undertake and complete training prior to the comprehensive introduction of IDTS later this year."

The Governor together with Norwich PCT should establish a robust system in order to ensure that all healthcare staff undertake substance misuse training and complete the entire syllabus.

The prison accepted this recommendation at draft report stage and commented:

"Ongoing training provided [as part of the implementation of the IDTS] and opiate withdrawal competences completed."

The man

43. When the man arrived at Norwich he was seen in the reception area by a number of staff and by the reception orderly, (a prisoner who later contacted my investigator regarding the death of the man) and another prisoner at the prison. The prisoner was interviewed by the investigator and claimed that the man had spoken to him during his time in the reception area both as an orderly and as a Listener. He said that the man was obviously withdrawing badly and had told the reception staff that he would hang himself if he did not get his medication.

44. The staff denied that the man said anything like that to them. They maintained that, if he had said any such thing, they would have opened an ACCT. It is also clear that they felt the man was only presenting with mild withdrawal symptoms. One of the two officers that was in the reception when the man arrived revealed in her interview that the man had been removed from his orderly post, a trusted position, for attempting to smuggle items into reception. I also note that the reception area was not busy on Saturday 23 December, and there would have been no reason for the staff not to have opened an ACCT if the man had made the threat at that time. It may be that the prisoner's comments were based on the man's later remarks whilst on E wing.

ACCT training

45. The nurse who was involved in assess him for his ACCT has worked at Norwich on a regular basis since 2005. He is employed by an agency which supplies services to the prison via the PCT. Despite having an important clinical role within the prison, the nurse had not received any training in ACCT documentation and protocols. That is not to imply that his decision to open the ACCT nor his completion of the initial sections were in any way incorrect. The nurse told my investigator that he "[hadn't] had any ACCT training, I've picked up how it works".

46. Prison Service Order (PSO) 2700 states in section 1.2.1,

> "All staff in contact with prisoners must be trained to at least ACCT Foundation level, be aware of the signs of risk summarised in the ACCT Staff Pocket Guide and when caring for at-risk prisoners follow the ACCT procedures set out in Annex 8G."

The Governor must comply with PSO 2700 section 1.2.1 to ensure that all staff in contact with prisoners receive ACCT training to the required standard.

The prison accepted this recommendation at draft report stage and commented:

"Foundation Training in Place monthly for all new members of staff. Refresher Training provided to all current Staff – January 2009. Monthly ACCT Foundation Training on-going."

Discovery of the man

47. The nurse and senior officer opened the ACCT document in the wing office and, even though the frequency of observations had been set at once an hour, The officer that saw him for his induction process carried out the man's initial induction decided to return to the man's cell "for a chat" as the other members of staff left to go to another wing. Upon looking process the man's cell through the observation hatch glass, he saw that he was hanging. The officer correctly radioed for assistance using the code blue call sign. He then opened the cell and tried to get a response from the man. When the man did not respond, the officer re-locked the cell and ran back downstairs "to aid staff to get in …" I am afraid the reasoning behind that action is unclear as all of the staff at that time would have had keys. My investigator asked the officer if there was a particular reason that he did not try to cut the man down and he replied:

> "Because the man may have been unconscious, that's why I didn't get a response, if I had cut him down myself that may have caused me an injury, and if I had cut him down myself, again, and dropped him it may have caused him an injury if he was unconscious, that's why I waited for the staff to get to the unit to aid me to cut the man down."

Although others may have made different decisions, I judge that the officer's actions were not inconsistent with the instructions in PSO 2700, Annex 13B, Action upon entering a cell following an incident of self-harm. However, the investigator also asked the officer whether it had occurred to him to try and support the man's body to relieve the pressure on his neck. He replied:

> "It did, however it's a 50/50 decisions isn't it, that person may have took me hostage, if it wasn't a genuine attempt and put my own safety at risk."

48. I do not wish to be unfairly critical of the officer's actions. Those of us who have never been called upon to respond to an apparent suicide should be slow to criticise those who have been placed in that daunting and unenviable

position. Nevertheless, Annex 13 C of PSO 2700 requires staff to, "Support the body. Consider utilising other methods of support e.g. furniture." In retrospect, the officer's actions were excessively risk-averse, especially when someone is found hanging and seconds can count in minimising the loss of oxygen to the brain. While judgements on such matters may differ, my own view is that the officer's actions are to be regretted but were not so egregious that I should make other than a general recommendation to the Governor:

The Governor should remind all staff of the actions they are expected to take if they find a prisoner hanging, as set out in PSO 2700.

This recommendation was accepted by the prison at draft report stage. They commented:

"Governors Notice to Staff Issued and discussed at Full Staff Meeting. Weekly Bulletin to all staff and POA Meeting where it was discussed with the Union."

Lack of a hot debrief

49. The governing governor, was contacted shortly after the man was found in his cell and he went into the prison to take command of the situation. He decided not to hold a hot debrief at that time as he thought the staff were very distressed. PSO 2710 Follow-up to deaths in custody, section 5.3 says:

> *"There must always be a hot debrief immediately after the incident and provision for this should be made in local contingency plans. A senior member of staff must act as debriefer and a duty care team member must also attend."*

The fact that the paragraph is in italics makes the requirement for a hot debrief mandatory.

50. Later, the same section describes the purpose of the hot debrief as follows:

> "The purpose is not to analyse or re-live the incident. Nor is it an opportunity to apportion blame or pre-judge investigation findings. The hot debrief should focus on reassurance, information sharing, normalisation and how staff can support each other".

51. The governing governor made his decision not to hold a hot debrief based on the situation as he found it and with the welfare of his staff in mind. The duty chaplain and members of the prison care team were available for staff to speak to individually on the night if they so wished. The next day the staff were contacted and offered the services of occupational health through the PCT. In these circumstances, I do not believe it is necessary for me to make any further comment other than to say that even mandatory instructions should sometimes be tempered by good sense. This is what I think happened here.

Family Liaison

52. The sad news of the man's death was broken to his mother and her partner in the early hours of Sunday morning (21 December 2008) by staff from a prison local to them. The governing governor was informed of that fact by email, and that it was expected that the man's mother would contact Norwich later that morning. Staff at Norwich respected what they believed to be the wishes of the man's mother and did not initiate contact. Unfortunately, his mother herself believed that she would be contacted by the prison. That misunderstanding meant that the man's mother and partner waited in vain for further information for the whole of Sunday.

53. The governing governor discovered that, because of staff leave, the safer custody manager, was the only trained family liaison officer available, but she was not told of the man's death until the Monday morning. This was a breakdown in communication which caused the man's mother some distress and anxiety.

The Governor should ensure that following a death in custody the appointed Family Liaison Officer is notified as soon as practicable.

The prison accepted this recommendation at draft report stage and commented:

"Contingency Plan shows that the FLO will be notified immediately and will be deployed under the direction of the Governor."

RECOMMENDATIONS

1. The Governor together with Norwich PCT should introduce a robust system to ensure that all staff are aware of new or changes in policy, protocol or guidance which impacts on clinical care.

2. The Governor together with Norwich PCT should establish a robust system in order to ensure that all healthcare staff undertake substance misuse training and complete the entire syllabus.

3. The Governor must comply with PSO 2700 section 1.2.1 to ensure that all staff in contact with prisoners receive ACCT training to the required standard.

4. The Governor should remind all staff of the actions they are expected to take if they find a prisoner hanging, as set out in PSO 2700.

5. The Governor should ensure that following a death in custody the appointed Family Liaison Officer is notified as soon as practicable.