PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP & YOI Norwich in January 2012

Report by the Prisons and Probation Ombudsman for England and Wales

December 2012

This is the report of the investigation into the death of a man, who was found hanging in his cell at HMP Norwich in January 2012. He was a 29 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A clinical review was conducted by a clinical reviewer on behalf of the local PCT. Norwich prison cooperated fully with the investigation.

The man had been in prison on several previous occasions. He was released on licence from an earlier prison sentence on 10 October 2011, but his licence was revoked on 21 December 2012 and he was recalled to prison. He had also been arrested, but not charged, in connection with other serious offences. On 23 December he was remanded into custody at Norwich, where he died several days later.

Assessing the risk a prisoner poses to himself is not an exact science and involves balancing the prisoner's demeanour and behaviour against known risk factors. However, it is a concern that staff seem to have relied too much on subjective assessments of the man's personal presentation. An ACCT document was opened and closed on the day of his arrival. On the evidence available, greater weight should have been given to his known static risk factors, including his documented history of self-harm, his treatment for depression and the fact that he was a recalled prisoner facing further charges. In addition, he was a heavy user of alcohol in the community. Prison Service guidance emphasises that withdrawal from alcohol is a particularly risky time, yet he received no assessment or treatment.

We cannot know whether a longer period of monitoring under suicide and self-harm monitoring procedures would have protected the man. During his short time in prison, he portrayed himself as confident and untroubled. He sought no support from staff and revealed nothing to suggest his intentions. Nevertheless, the investigation has identified a number of areas for improvement in ACCT arrangements, family contact, alcohol detoxification procedures, and support for recalled prisoners, which need to be addressed.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2012**

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SUMMARY

1. The man was released from prison on licence on 10 October 2011, after serving six years of a 12 year sentence for robbery. On 21 December 2011, he was recalled to prison for breach of his licence conditions. He was suspected of being involved in other serious offences for which he had been arrested but not charged. As a consequence of his recall, he was arrested on 22 December. While in police custody, it was flagged that he had attempted to kill himself on 19 December 2011 by attaching a hose to his car exhaust. In prison, he said that he had made this up to try and get out of police custody.

2. On 23 December 2011, the prisoner escort service company Serco, took the man to court. Serco staff completed a Suicide/Self-Harm Warning Form indicating that he had recently tried to self harm "by exhaust fumes" and he was to be checked regularly. It also noted he had health problems which were listed as "leg pain" and "depression".

3. After his court appearance, the man was taken to HMP Norwich. He had been at Norwich previously in 2005 and, by all accounts, seemed undaunted at his return. When he arrived at Norwich that morning, he went through the routine reception screening process. Suicide and self-harm monitoring was started because of the information about his risk from Serco, although he denied feeling suicidal or having any intentions to harm himself. Following assessment and review, prison staff judged that he posed a low risk of harming himself and the monitoring ended later that day. He continued to be prescribed medication for his leg pain and depression, but otherwise the prison doctor had no concerns about his physical or mental health.

4. The man went through the usual induction process in the prison delivered in both group and one to one sessions. Prison staff had no concerns that he appeared to be at risk. He continued to deny having any suicidal feelings when he was interviewed on 29 December, as part of a routine follow-up review of the decision to end the suicide and self-harm monitoring.

5. When the man was discovered hanging in his cell in January 2012, staff acted promptly and professionally. However, it was clear he had been dead for some time and resuscitation was not appropriate.

6. The report makes seven recommendations as a result of the investigation. These cover the need for a multi disciplinary approach for suicide and self harm monitoring, assessments for alcohol problems, healthcare record keeping, support for recalled prisoners, access to PIN telephones and first aid training.

THE INVESTIGATION PROCESS

7. The PPO's office was informed of the man's death in January 2012 and the investigation was allocated to an investigator, who visited Norwich on 6 January 2012. He met relevant staff and visited the wing and the cell where the man died. He was provided with copies of the prison and health records and other documentation relating to his time in custody. Notices were issued to staff and prisoners at Norwich informing them of the investigation and inviting them to contact the investigator. He interviewed two prisoners as a result.

8. A review of the clinical care the man received at Norwich was undertaken on behalf of the local PCT by a clinical reviewer, an independent consultant.

9. The investigator and clinical reviewer carried out joint interviews with prison and healthcare staff in February and March 2012. The Governor was provided with verbal and written feedback following the interviews.

10. HM Coroner for Norwich was informed of the investigation. A copy of this report will be sent to him to assist his enquiries into the man's death.

11. One of the Ombudsman's family liaison officers (FLO) contacted the man's family shortly after his death. She explained the investigation process and gave them the opportunity to raise any concerns or questions they wished to be addressed as part the investigation. They raised the following concerns:

    - He had been very depressed and suicidal before his arrest and had been under the care of a doctor and psychiatrist. His family informed the police and the prison of this, and he was watched while in the police station.
    - When he was transferred to the prison, he was told by the prison doctor he was OK and the doctor immediately stopped all his medication.
    - His mother spoke to a prison officer on 30 December as he contacted her for the telephone number of his solicitor. She said she took this opportunity to pass on her concerns about his state of mind.
    - The family said that other prisoners who were friends of his were concerned about him, and mentioned this to them as well as staff.
    - The family believed there was a delay in getting money and letters to him. They sent a letter, with money in on 23 December that was not received. His family felt the delays in contact could have affected him, particularly the time it took to arrange a visit.

12. The family received a copy of the draft report as part of the consultation period. The family raised concerns about the alleged shouting heard by another prisoner the night the man died. The investigation was unable to find out any more information on this matter. The family also would like to point out that both the man's mother and wife contacted the prison on more than one occasion to highlight their concerns with prison staff about his mental health.

HMP Norwich

13. HMP & YOI Norwich is a multi-functional prison, predominantly serving the courts of Norfolk and Suffolk. The prison accepts adult and young adult men under 21, both convicted and on remand. It holds up to 767prisoners. The prison's health services are commissioned by the NHS and since October 2010 have been provided by a healthcare provider and their subcontractors. There is a healthcare centre which provides 24-hour nursing cover. A mental health in-reach service operates between 9.00am and 5.00pm on weekdays.

Her Majesty's Chief Inspectorate of Prisons (HMIP)

14. HMIP carried out an unannounced inspection of Norwich in February 2010. The Inspectorate noted that

> "There had been an understandable and appropriate focus on safer custody, after a number of self-inflicted deaths, and suicide prevention procedures were largely sound and supportive. However, the large number of men subject to those procedures risked insufficient attention being given to those really at risk, and the virtually unused day care centre was a lost opportunity to provide better support for them."

15. Norwich was inspected again in January 2012. The Chief Inspector said

> "The number of incidents of self-harm was high but we were concerned that support for those in crisis and day to day care was limited. Too many prisoners in self-harm crisis found themselves segregated or in special accommodation. Many of our previous recommendations concerning the issue of self-harm had not been implemented".
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16. Commenting on the integrated drug treatment system, the Chief Inspector said

> "Clinical and psychosocial services delivered a good standard of care and were appreciated by prisoners but, until recently, had lacked integration and joint working … The drug strategy was being updated in a combined drug and alcohol strategy, but the annual developmental objectives or action plan was yet to be completed."

Suicide and self harm monitoring/ Assessment, Care in Custody and Teamwork (ACCT)

17. The Assessment, Care in Custody and Teamwork (ACCT) system is a Prison Service-wide process for supporting and monitoring prisoners thought to be at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. As part of the process, a CAREMAP (plan of care, support and intervention) is put in place.

There should be regular multi-disciplinary review meetings involving the prisoner.

Previous self inflicted deaths at HMP and YOI Norwich

18. In the twelve months before the man's death, there was one self inflicted death at the prison. There are no similarities with the issues identified in that report and those made as a result of this investigation.

KEY EVENTS

19. The man was born in October 1982 in Kings Lynn. He lived at a traveller's site in Cambridgeshire. He was married and had two children.

20. He started a 12 year sentence for robbery on 3 October 2005 at HMP Norwich. As part of his sentence progression, he later moved to HMP Peterborough and on 14 May 2008 to HMP North Sea Camp, an open prison. He was released on licence on 10 October 2011, after serving six years of his sentence

21. On 20 December 2011, the man was arrested on suspicion of a murder committed in 2010 (while he was at North Sea Camp). He was not charged at this stage. The next day, 21 December 2011, the National Offender Management Service (NOMS) revoked his licence and he was recalled to prison because of alleged poor behaviour and suspicion of involvement in other further offences. He had been arrested on suspicion of robbery and theft as well as suspicion of murder.

22. The police arrested the man for the breach of his licence on 22 December and took him to a Police Station. During his risk assessment in police custody, his medication was noted amongst his property. This included fluoxetine[1] 20mg, pregabalin[2] 300mg, and lorazepam[3] 1mg, all to be taken daily. He said he was taking the medication due to an old leg injury from a road traffic collision. He also suffered from depression. He said he could neither read nor write. However, he told the police that he felt fine and had never tried to harm himself. He said that he had not consumed any alcohol in the previous 24 hours and was not dependant on alcohol or drugs. He was referred to a police medical officer for authorisation of his medication.

23. During his police risk assessment, it was noted that it had been flagged on the Police National Computer that the man had a previous indicator of self harm. The date when this incident was supposed to have occurred was not noted. He said he had made it up because he had wanted to get out of the police station at the time. He was subsequently considered to be low risk of harming himself and subject to normal observations in police custody.

24. The following morning (23 December) he was escorted to Magistrates Court. The Person Escort Record (PER) which was initially completed by the police and accompanied him to court, noted that a risk of self harm had been identified. It was recorded that on 19 December 2011, he had attempted suicide, "in car – hose to exhaust". Serco staff completed a Suicide/Self-Harm Warning Form indicating that he had recently tried (within the last month) to self harm "by exhaust fumes". He was to be checked regularly. It also recorded his health problems, which included leg pain and depression.

[1] Fluoxetine is frequently used to treat major depression, obsessive compulsive disorder, panic disorders.
[2] Pregabalin is used to relieve neuropathic pain (pain from damaged nerves) that can occur in your arms, hands, fingers, legs, feet, or toes.
[3] Lorazepam is a benzodiazepam used to treat anxiety disorders.

25. On the history and detention events record (part of the PER) completed by Serco escorting staff it was recorded that at 8.23am,

> "D/P (detained prisoner) states that he has no intention of self harming- the incident on 19-12-11 was a misunderstanding on his part over his partner".

26. The man arrived at court at 9.09am and after a short hearing was transferred to HMP Norwich. His medication was held by escort staff and handed to staff at Norwich.

HMP Norwich Reception

27. He arrived at Norwich at 10.25am on 23 December and went through the routine prison reception screening process. He was interviewed by staff who recorded a number of basic details, checked his property, issued him with prison clothing and confirmed his understanding of the prison rules and procedures. A risk assessment initiated by a reception officer and completed by a nurse indicated that he was suitable to share a cell with another prisoner.

28. The officer said at interview that licence recall prisoners were treated the same as other prisoners. Staff would generally try and provide them with the information about why they had been recalled but it would depend on what information the prisoner arrived with. The information would normally be very limited and so staff would reassure the prisoner that usually within five to seven working days, they would get a "recall pack" from National Offender Management Service Headquarters, setting out their position.

29. The officer recalled reviewing the suicide warning form completed by Serco and as a result he opened an Assessment Care in Custody and Teamwork (ACCT) document. The man said he had no suicide or self harm thoughts and felt there was no need for the ACCT to be opened. The officer's impression was that he was in quite good spirits. The officer said that the other reception officer working with him had known him from a previous time he had spent in prison. The officer recalled he had been a hard worker and they discussed trying to get him a job on the wing when he was settled. It was noted that he had arrived with £20 cash in his possession.

30. The ACCT "Concern and Keep Safe Form" was completed by the officer at 11.10am in reception. It noted that Serco had raised concern about the man's self harming but that he had emphasised to the officer that he was not suicidal.

31. A nurse completed an initial health screen shortly afterwards. She said the comment he had made about suicide had been said to his wife as a figure of speech and his wife subsequently contacted the police about it. He denied having any thoughts of self harm and said he felt good and was happy. He conversed well throughout his assessment and maintained good eye contact with the nurse. In spite of this, the nurse told the investigator that she still had concerns about him. However, she did not pass on her concerns to anyone else and these were not documented.

32. The nurse noted that the man had previous damage to his right lower leg following an accident. He disclosed that he could not read or write and normally drank about one litre of brandy a day. He last had a drink on 21 December 2011 and had last taken drugs (Subutex[4]) two weeks before. This information was contrary to what he had said at the police station. She took urine samples for drug tests which returned positive results for cannabinoid, cocaine, buprenorphine (Subutex) and benzodiazepine. He told the nurse he was prescribed medication of fluoxetine 20mg, pregabalin 300mg, and lorazepam 1mg and had last taken them while in police custody the previous day. In referring him to the "GP for IDTS" she recorded that he appeared "snuffly and yawning". She made the IDTS (Integrated Drug Treatment System) referral because of his history of alcohol misuse.

33. Following this, the officer, a SO and the man, discussed and agreed the ACCT immediate action plan (timed at 12.00pm). The plan identified four areas/actions which could assist in keeping him safe. These were (1) sharing a cell if required, (2) monitoring by staff through ACCT (consisting of hourly observations recorded and quality conversations to be recorded three times a day. All recorded until assessment of him), (3) access to the telephone, including to the Samaritans and (4) access to Listeners, and the Listeners scheme was explained.

34. The man said he was not pleased about being recalled to prison and his main concern was about receiving visits from his family. The officer therefore spent some time with him discussing the visit process, after which he appeared content. Despite the circumstances of his recall, he noted that he seemed in quite a good mood. He said that he had never attempted to harm himself. He said his wife had had cancer and he had previously stated that, if she died, he "would take his life by killing himself in his car by exhaust fumes". However his wife was now clear and he loved his family too much to do this. There is nothing to suggest that prison staff ever confirmed this account with his family.

35. The officer said he had opened the ACCT purely based on the information which had been received from Serco, as opposed to how the man appeared. The SO agreed with the officer's assessment and said that he was not anxious, depressed or upset, and was familiar with Norwich. She was aware he had said he could not read or write and explained why the ACCT was opened, read to him the agreement about sharing information contained in the ACCT and explained the services of the Samaritans and Listeners.

36. The man later moved to A wing where he continued his prison induction. This included a first night interview and an explanation of the rules of the prison. He was given a telephone PIN card (credited to the value of £2) so that he could make a telephone call as soon as his account was set up. Staff raised no concerns about him. An officer later wrote in the P-NOMIS electronic records that he had settled well. He subsequently made four telephone calls to his wife from 23 – 25 December, using all his £2 credit.

[4] Subutex is an opioid drug that is similar to heroin.

37. As part of the ACCT process, an ACCT assessment took place shortly after 2.00pm conducted by the Safer Custody Manager. At interview she said that when she arrived at the man's cell he was in a deep sleep. She took him into an interview room on the wing landing and explained the ACCT process to him and why his particular ACCT had been opened. He said that the notification that he had tried to take his life was a "big mistake" and he did not want to be on an ACCT. He talked about the incident which led to the suggestion being made and said he loved his wife and children a lot and would never harm himself. He had also spent time previously in prison and was used to it.

38. Although at the beginning of their 45 minute interview, the man had yawned a lot, by the end of the meeting, she said he was quite upbeat and positive and that he was laughing and joking. He told her that he drank a lot but did not take drugs and therefore did not want to be on his current wing, which was for those going through drug detoxification. He wanted to be on B or C wing where he had friends. He raised no issues about his licence recall. She said she was aware that it was noted that he could not read or write, but he told her that he had learnt to read and write a little during his previous prison sentence. He signed the ACCT document to confirm his understanding of how it worked. She also noted that he drank one litre of brandy a day and was currently taking anti-depressants.

39. After the ACCT assessment, an ACCT review (Action Following ACCT Assessment) was carried out at 3.04pm. This was conducted by a SO and the Safer Custody Manager, with the man present. The review noted that:

> "He attended his review. He stated he has no thoughts of self-harm or suicide. He stated he had said something to his wife which had followed him to prison. He has loads of family support and his kids are his world so he wants to do his recall and get out. No concerns by the review team ACCT to be closed."

40. The SO told the investigator that he remembered the man from his previous time in custody at Norwich which helped with talking to him. He said he was in good spirits, talked about his family fondly and was looking forward hopefully to being released soon. He expressed his wish to move to B or C wing again, saying he did not want to be on a wing with "druggies". On closing the ACCT, neither the Safer Custody Officer nor the SO had any concerns about him.

41. The man was examined by locum general practitioner and substance misuse doctor at 4.54pm. The doctor told the investigator that he noted the medication the man was currently taking as pregabalin 300 mg twice a day, fluoxetine 20 mg daily and lorazepam 1 mg. He explained that lorazepam is not normally used in prisons. The man said that he had been prescribed this medication by his GP two weeks before to calm him down. The doctor agreed that diazepam 5mg would be prescribed (for seven days) as its replacement, as it was more suitable for longer term use in prison. All his medication was to be administered by healthcare staff as they were not held in possession by

prisoners. He told the investigator that prisoners on long term medication would be reviewed every three months.

42. The man told the doctor that he used a variety of drugs but was not dependant on them. He did not appear to be suffering from any drug withdrawal symptoms. His mood was described as stable. The doctor asked him a number of screening questions to ascertain whether he was experiencing withdrawal symptoms and he scored low. He was referred for an alcohol detoxification assessment, but the low score meant he would not have been categorised as urgent.

43. The man also denied having any thoughts of self harm when questioned about the opening of the ACCT. Although he was taking an anti-depressant, he did not, in the doctor's opinion, appear clinically depressed and so he felt no need for a referral to a mental health nurse. He did not mention, and the doctor did not note, that he had ever been referred to a psychiatrist.

44. He was checked throughout his first night in custody and the nurse on duty reported no problems. No information was noted about his alcohol withdrawal. On 24 December, he made an application to have £10 telephone credit added to his PIN account. This would be taken from money he arrived with. The officer who assisted him with this request did not document any concerns. The request was e-mailed through to the PIN telephone clerk the next day. The PIN telephone clerk told the investigator that the office was closed until 28 December.

45. The Safer Custody Manager told the investigator that because of the Christmas holidays the visits hall was closed between 25 -27 December. No visits were booked by the man's family before or after this period.

46. Healthcare staff had faxed the man's community doctor shortly after his arrival at Norwich to obtain his medical history. A response to this was received on 28 December. It confirmed his leg injury, the medication he was prescribed and that he suffered from depression.

47. On 28 December, the man's PIN telephone account was activated and £10 was added. The PIN clerk told the investigator that the temporary PIN number that he had used when he first arrived at Norwich would be deactivated and he would be issued with a new number. Because of the large volume of requests received by prisoners requesting changes to PIN accounts, prisoners are not informed when changes are made or new ones added. He therefore might not have known his account had been activated. There is a reliance on officers to contact the PIN clerk to get new PIN numbers for prisoners. The PIN clerk confirmed that the only number that he had requested to be added was his wife's.

48. On the evening of 28 December, following the everyday routine check of cells on A wing, an officer spoke with him. He complained that he wanted to be moved off A wing as there are "too many drugs" on the wing. A Security Information Report (SIR) was submitted by the officer about this.

49. On 29 December, an officer conducted an ACCT Post Closure Interview with the man. He told the investigator that he interviewed him in the A2 landing office. They talked about how he was feeling. His demeanour raised no concern, he said he was okay, had no thoughts of self harm and wanted to attend the gym. He also hoped for a move to either B or C wing. He was talkative and said he had support from his family.

50. Later that day, the man was moved to a single cell on C wing, (C2-19) a standard residential wing. He was due to have a secondary healthcare screen, but this did not happen. It was noted that he declined to attend the screening. No further detail about this was entered on his medical record. Although it had been six days since his arrival at Norwich, it was also noted in his medical record that he was still awaiting an assessment from the IDTS team.

51. One of Norwich's Licence Recall clerks confirmed with the investigator that when she receives a Licence Recall Appeal pack (a document that provides details of why the prisoner was recalled to prison) from the Ministry of Justice Public Protection Casework Unit, a copy is sent to the Senior Officer of the wing where the prisoner is located. This is so that staff can disclose the whole appeal pack, including the reasons for recall, to the prisoner. Having checked her records, she said that the appeal pack was sent in the internal mail on 30 December 2011. This would have been addressed to the Senior Officer who would then pass the pack to the prisoner or to an officer to pass to the prisoner. The paperwork was signed as being received on the wing that day, however the signature was illegible.

52. The investigator made enquiries on A wing and confirmed that when recall paperwork arrives on the wing any member of staff signs for its receipt. The mail is then put in the tray for the landing and the landing officer gives out the recall packs with other mail for prisoners. There is no evidence trail and no staff had any recollection of giving the man his licence recall pack or discussing it with him. There is also no documented information of whether he had any specific concerns about his recall.

53. An officer who worked on C wing during the man's short stay on the wing, said he had no particular concerns about him. The officer did however contact the man's mother on his behalf to get his solicitor's telephone number. The investigator was told that setting up telephone numbers for new prisoners on their PIN[5] account would normally take about a week before they could make telephone calls. Although the PIN phone clerk said the man's account had been activated, neither the man nor the officer appeared to be aware of this. The man said he had not been able to make any telephone calls, including to his family. The officer said he had a brief conversation with the man's mother and obtained the solicitor's telephone number. He also found the solicitor's address in a directory and wrote it down for him. He was aware the man was

[5] Pinphones are used in prison and provide individual electronic prisoner telephone accounts. Each prisoner is given a unique PIN number which they key in before making a call and they are only able to dial authorised numbers. They may complete a form to select telephone numbers for their family, friends and legal contacts, which has to be agreed by the prison.

illiterate but said prisoners often asked another prisoner or staff to write letters for them. When the PPO FLO spoke to the man's family, they confirmed that a telephone call had been made by a prison officer on the Friday before New Year's Day, 30 December. The man's mother said she also raised concerns about her son with the officer but the officer said she did not mention any concerns about his state of mind.

54. Another prisoner on the wing, Prisoner A, told the investigator that he had known the man for a number of years. His cell was about three cells away from the man's. The day after the man arrived on C wing, (30 December), the prisoner said he had a general chat with him in his cell. The man had expressed his unhappiness at being back in prison and was upset at this. However, the prisoner had no concerns that he would self harm. No concerns were noted about him on New Year's Eve.

55. C wing Landing Officer A said that he introduced himself to the man when he first arrived on the wing. The man remembered the officer from his previous time at Norwich. After this, he had no worries about the man's mood or that he would self-harm. He described him as "positive, fine". However, he said he was worried about his children and would miss them.

56. Prisoners are locked into their cells on the weekend between 5.00pm and 5.30pm for the night. Officer A concluded his duty for the day at about 5.30pm and said that he had had no concerns about the man during the day.

57. Officer B arrived for his evening/night duty on B and C wing at 8.00pm. There were no reported problems on the wing when he arrived. This was his last of seven consecutive night shifts. He had no recollection of coming into contact with the man before this night.

58. The officer said he carried out a roll check (a security check that prisoners are properly accounted for in their cells). He said he did not recall what the man was doing when he checked his cell but he had no concerns. He said that, if there had been anything unusual to note, he would have been suspicious and taken some follow up action. He said that there were no issues during the night on the wing. He carried out his usual patrols of the wing every 30 minutes throughout the night and there were no unusual occurrences around the man's cell.

59. Prisoner B told the investigator that he was in the cell next door to the man and had met him when he first arrived on the wing. He had seen him regularly while socialising on the wing and in the exercise yard and had no reason to be concerned about him. He said he wrote two letters on his behalf, one on 1 January 2012 and the other a day or so before. The man passed paper through a gap for a pipe in the wall and then said what he wanted him to write.

60. In the letters, one to his mother and the other to his wife, he apologised for his past actions. The prisoner said he did not find the man's apologetic nature disconcerting and believed he was the type of person who would apologise over and over again. He had heard him talking in a similar manner in general

conversation. He described his mood "as good as it can be really in jail. Obviously he was happy sometimes but you're not really going to be too happy". He said he wrote the last letter around 8.00pm and passed it through to him.

61. Around midnight, Prisoner B said he heard noises, which he described as sounding like trainers screeching on the floor, coming from the man's cell. He knocked on the cell wall and asked him what he was doing. He replied that he was shadow boxing. He had no reason to be concerned and went to sleep.

62. The next morning, Officer B began his roll check of C wing at 5.30am. An Operation Support Grade (OSG) began the roll checks of B wing around the same time. The officer said he arrived at the man's cell at about 5.45am. He opened the cell observation panel and could see a silhouette of a person standing at the window at the back of the cell. He said it looked like he was looking out of the window. The curtain was slightly ajar. His feet were on the floor and his head was leaning towards the window.

63. He looked again and was concerned. He called to him but received no response and so tapped on the cell door. There was still no response. He turned the cell night light on and saw he was facing the door with his head back. He was hanging from torn bed sheets around his neck attached to the window hinge. He radioed a Code Blue[6] emergency call (recorded on Control Room Log as occurring at 5.55am) through his radio and called the OSG to the wing.

64. The officer broke his sealed key pouch[7] and went straight into the cell and the OSG arrived at the cell within a minute. He told the investigator that when he entered the cell, the officer was supporting the weight of the man's body. The OSG used his cut down knife[8] to cut the bed sheet. As the man was laid on the cell floor, the officer said his body was stiff and his limbs did not move. There was also a lot of liquid coming from his mouth and eyes. Neither the officer nor the OSG had current first aid training, but they believed he was dead.

65. At this point a nurse arrived. The OSG left the cell so there would be more space. He was met on the landing by a SO (Night Officer In Charge), who had already requested an ambulance (at 6.00am), and instructed the OSG to open the prison vehicle gates in preparation for its arrival.

66. At interview, the nurse said she responded to the emergency call immediately. She was between B and C wing and arrived at the cell within minutes. She brought with her the emergency resuscitation bag, which included a defibrillator[9]. The man was lying on the floor with his head towards the cell

[6] Emergency codes are used to summon staff to deal with a particular situation. A Code Red indicates a blood related injury and a Code Blue is used to indicate a life threatening incident or if a prisoner is unconscious.

[7] During night state, officer grade staff carry a sealed key pack which can be broken to gain entry to cell in emergencies.

[8] Cut down tools are knives that are specifically designed for safely cutting ligatures and are carried by all officers and healthcare staff who are in contact with prisoners.

[9] A defibrillator is a life-saving machine that gives the heart an electric shock in some cases of cardiac arrest.

door. She described him as looking “very waxy, very grey, eyes were fixed and opaque”. A clear and dark mark was on his neck. She used the defibrillator machine which indicated to ‘take no action’. She said that the build up of fluid meant that he had probably been dead for some time and therefore cardiopulmonary resuscitation (CPR) would be futile.

67. The ambulance paramedics arrived at the cell at 6.06am. The nurse updated them on the man’s condition. The paramedics assessed him and declared his death at 6.12am. The nurse attended the healthcare centre and updated his medical records.

68. Officer B said the cell was tidy. He had left a letter, either on the bed or the cupboard, addressed to a family member.

69. The SO contacted the governor to activate the prison’s death in custody contingency plan. This involved contacting various agencies including the police, coroner and the Governor in charge. He held a hot de-brief meeting around 9.30am for staff involved. The Care and Support team and chaplaincy were deployed to support staff. Staff told the investigator that they had welcomed the de-brief meeting as finding the man in the condition he was had been upsetting. All prisoners on an open ACCT were reviewed during the day.

Contact with the man’s family

70. The Governor spoke to the police when they arrived at the prison. The police were concerned about the safety of prison staff visiting the traveller site where the man’s family lived. As he had a number of family friends on the wing and wanting to ensure his family were notified as quickly as possible before his family learn of his death by other means, the police agreed to visit the site to break the news. This was done shortly after 11.00am.

71. A prison’s family liaison officer was appointed. He spoke to the man’s mother by telephone about midday. He told her about the process following a death in prison custody and support offered to the family. He told her that two un-posted letters were found in her son’s cell, but the police had taken them as evidence.

72. On 3 January, the family visited the prison to lay a floral tribute to him. Details about financial assistance towards the cost of the funeral and the role of the Coroner were explained. The funeral took place on 12 January. The following day, his family visited the prison to view his cell. His personal possessions, including a copy of the two letters found in his cell, were returned to his family.

73. A critical debrief took place on 15 February. Staff were provided with a further opportunity receive support following the death.

Post mortem report

74. Following a post mortem, the cause of the man’s death was noted as,

(1a) Asphyxiation due to (or as a consequence of)
(1b) Hanging.

The man's post

75. When the PPO FLO spoke to the man's family, they believed that as he had not received the New Year's card they had sent him and that this would have had a negative impact on him. The prison gave the investigator a copy of a New Year's card his family had sent him. The envelope was date stamped by the Post Office on 24 December. Because of the public holidays it would not have been delivered to the prison until 28 December at the earliest. The Safer Custody Manager confirmed that a postal order that was inside was taken out and entered in the prisoner cash book on the 29 December. The card would then have been put in the prison internal mail to be delivered to the wing. The prison does not believe that the man had received the card before his death as it was not in his possessions in his cell. It was discovered among his prison records which were collated after his death.

ISSUES

Clinical care

76. The clinical review conducted by a clinical reviewer. It includes 19 recommendations, most of which relate to healthcare systems and policies at Norwich. The most pertinent recommendations relating to the man's death are discussed below.

Reception screening

77. The nurse who saw the man in reception made a comprehensive assessment of his condition including taking account of the time of his recall, (Christmas) his potential length of sentence and the self harm warning on the Person Escort Record. At the time, he denied any thoughts of self harm. After his death and at interview, the nurse said she felt there were some underlying concerns. She did not however share her anxieties with any of the reception officers or those who carried out the ACCT assessment. Neither did she record her concerns in the clinical record system.

78. We cannot know whether, had the nurse's concerns been documented, it would have made a difference, but it his important that such matters are recorded and shared to help with risk assessments. We make the following recommendation about sharing information:

The Head of Healthcare should ensure that the healthcare staff document all concerns about prisoners received in reception and share this information with relevant staff.

Referral to Integrated Drug Treatment System

79. The man reported that he drank a litre of brandy a day, equivalent to 40 units of alcohol. As a result he was assessed as requiring alcohol detoxification through the IDTS. Although he was seen the doctor on arrival an alcohol assessment was not carried out. He went to A wing, which acts as the first night centre and also the IDTS wing. However, there is no record of him having an assessment or receiving treatment for alcohol withdrawal at any time during his stay at the prison. This is contrary to the IDTS clinical protocol which clearly states this should happen if an addiction is identified. There is no evidence that this referral was followed up, or that anyone identified it had not been done.

80. This is a serious concern. Alcohol withdrawal symptoms usually occur within five to 10 hours after the last drink, but can also occur days later. Symptoms are known to get worse in 48 - 72 hours, and may persist for weeks. Amongst the common symptoms an individual may experience when withdrawing from alcohol are anxiety or nervousness, depression, not thinking clearly, fatigue and mood swings.

81. The man went from a very high daily alcohol intake to total abstinence as a result of his imprisonment. He was referred for alcohol detoxification

assessment but this did not take place. This was an opportunity for IDTS staff to obtain more detailed information about his alcohol intake and assess whether he was experiencing any of the common symptoms of alcohol withdrawal. One of these symptoms is constantly yawning, which he clearly displayed during his ACCT assessment. Had he received an IDTS assessment and treatment, it should have provided him with some physical and mental support which might have improved his outlook on life. We therefore make the following recommendation:

The Head of Healthcare should ensure that all prisoners referred for an alcohol detoxification assessment receive prompt and supportive treatment, backed up by regular monitoring, in line with IDTS policies and procedures.

Drug administration

82. The prison doctor who assessed the man in reception noted in the clinical record that he discussed treatments with him. He decided that diazepam 5mg for seven days would be more appropriate for him to use in prison than lorazepam and more suitable for longer term use. This medication was administered by healthcare staff at night since it is not held in possession by prisoners. The doctor raised no concerns about the dosage of any of his medications. While there was a change of drug from lorazepam to diazepam, the clinical reviewer was satisfied that this was an appropriate substitute. His family were concerned that all his medication was stopped when he transferred to prison, but other than the change from lorazepam to diazepam, all his existing medication continued to be prescribed. Lorasepam is, in any event, recommended only for short term use.

83. The drug administration chart for the man showed that he received diazepam each night from the 23 December through to the 28 December. There is no signature for the seventh dose and it has not been possible to discover if or why the dose was missed. It was not noted if diazepam was to be re-prescribed again after the weekly dose had expired.

84. There is no evidence to suggest that one day's abstinence from his medication had an impact on the man's mood, but this was does not support good practice of clear and accurate records reporting the relevant clinical findings and decisions made. We therefore make the following recommendation:

The Head of Healthcare should ensure that accurate and clear records are made of all prescribed and administered medications to ensure accurate monitoring of a prisoner's healthcare is maintained.

Assessment Care in Custody and Teamwork (ACCT)

85. The man had a number of risk factors. Firstly, he was subject to licence recall. Prison Service Order 2700 (now replaced but in force at the time of his death) highlights that there is an increased risk of suicide and self-harm among prisoners recalled from licences being served in the community. It states "*all*

local prisons must put in place a strategy to respond to the needs of this group of prisoners".

86. Staff in reception appeared aware that being recalled heightens risk, but it does not seem that the prison had a clear strategy to respond to the needs of recalled prisoners. After his reception screening, there is nothing to demonstrate that any support was offered to the man in relation to his recall to prison.

87. Secondly, the man had an alcohol problem. PSO 2700 states "there is a significant relationship between drug and/or alcohol withdrawal and suicide, the risk of which may be significantly reduced if people are assessed on reception and provided with effective needs based treatment commenced on the day of reception." Although he was seen by a doctor, he did not receive an IDTS assessment for his alcohol use or begin an alcohol detoxification programme as indicated.

88. The man was also suffering depression and receiving medication for this. It was Christmas time and it was said he was missing his children. Police had documented that he had made threats to self harm, and SERCO referred to it being a recent self harm attempt using car exhaust fumes. He told police and prison staff this was a misunderstanding. It is not clear whether he had made a recent attempt on his life, or had threatened to. There is no evidence that the prison staff sought to clarify this, either with the police or with his family.

89. The ACCT was opened by prison reception staff at 11.10am based on information in the Person Escort Record (PER). It was closed later that day at 3.04pm following the "Action Following Assessment" review interview. Although he was assessed by up to four members of staff during the ACCT process, there was no healthcare input. The nurse who undertook the man's reception screening on 23 December 2011 said at interview with the investigator that she had anxieties about his mental state but did not share them with staff or include them in the clinical record, despite noting him suffering from depression and a large daily alcohol intake.

90. Those carrying out the ACCT assessment and review, were aware of the man's alcohol intake and that he was taking anti-depressants. The ACCT was closed before he was seen by the prison doctor, who subsequently changed one of his medications as well as referred him for an alcohol detoxification assessment. Had the doctor's opinion been sought and if it had, whether his input would have delayed the closing of the ACCT however, is unknown. Nonetheless, a lack of general staff awareness and information resulted in the ACCT being closed without all the essential information being used to make the decision. Too much reliance was placed on his personal presentation at an early stage rather than taking into account the static risk factors.

91. The ACCT procedures require a multidisciplinary approach if vulnerable prisoners are to be supported successfully. The clinical review noted that the HMP/YOI Norwich Safer Custody Policy Agreement (2012) does not appear to have any strategic healthcare input. This policy promotes a multidisciplinary

approach to keeping prisoners at risk safe but this did not appear to be the case in practice.

92. The role of Safer Custody Nurse was introduced last year at HMP Norwich whose function appears to have been specifically related to assisting in managing the ACCT caseload across the prison. At the time of the clinical review, the role was in the process of being replaced by a wing based mental health nurse scheme. Some of the staff the investigator and clinical reviewer spoke to were unsure of the purpose of this new role.

93. ACCT procedures are not a fail-safe and, while their purpose is to safeguard prisoners, this is not always possible. It is important therefore that whatever concerns staff have about a prisoner are shared. Staff also need to be aware of the factors that can contribute to increasing a prisoner's risk of self harm. Had these been fully taken into account it is likely that the man's ACCT plan would have referred to the need to ensure his depression and alcohol withdrawal issues had been appropriately addressed and that the circumstances of the previous self-harm incident identified by the police was properly established.

The Governor should ensure there is a multidisciplinary approach to the management of prisoners subject to ACCT procedures and that staff fully take into account all indicators of risk when assessing the risk of self-harm.

Recall to prison

94. The man was recalled to prison due to alleged poor behaviour and failing to comply with the licence conditions. He was also potentially facing further serious charges. A possible outcome of this was that he would have to spend a further lengthy time in prison.

95. After the man's death, a prisoner informed staff that he might have been worried about being charged with murder. Prison information confirmed that the victim of a crime previously committed by him had died and the police were investigating this. He was aware of this development as this was one of the reasons why he was arrested before his recall. However, he did not raise any concern about this in any of his risk assessments.

96. There is no evidence that staff discussed his licence recall pack with him before his death. None of the staff were able to tell the investigator that they had spoken to the man about it and in the short time he was at Norwich he does not appear to have been allocated a personal officer. Recalled prisoners are known to have heightened risk of suicide and self-harm and the fact that it was the Christmas period is likely to have increased his anxiety, yet there is no evidence to suggest a member of prison staff had considered his recall and whether it increased his anxiety and risk. This should have included knowing what support mechanisms were available to him and knowing about the contents of the recall pack. This would be in line with guidance provided on

licence recall prisoners in Prison Service Order 2700. The following recommendation is therefore made:

The Governor should establish a system to ensure that prisoners recalled from release on licence have any immediate risks identified and are appropriately supported and informed of recall procedures.

Use of PIN telephone

97. The investigation found that because of the extended Christmas holiday period the man was unable to use his PIN phone account and keep in touch with his family. Although we were told that his PIN account was activated on 28 December, neither he nor an officer on his wing were aware of this on 30 December, when the officer made a phone call on his behalf. When his account was activated there appeared to be no way of informing him of this. The Christmas and New Year period can be an extremely vulnerable time for prisoners, yet there were no arrangements to ensure that those who arrived just before Christmas were not prevented further from being able to contact their family over the holiday period, such as by increasing the amount provided on the temporary PIN phone account or extending its period. In his case he had his own funds which could have been added. We make the following recommendation:

The Governor should ensure that newly arrived prisoners have appropriate access to telephones, particularly over extended public holiday periods.

Emergency response

98. Leading up to and including on the eve of the man's death, he gave staff no obvious indications that he intended to harm himself. The prisoner in the cell next door to him who was the last person to have any contact with him, was not aware that he had planned to take his life. When he was found hanging in his cell, the response by prison and healthcare staff was immediate and professional. The code system was well used to alert staff to the nature of the emergency.

99. It is apparent that when he was found, he had been dead for some time, rigor mortis had already begun and so any attempt to resuscitate him would have been inappropriate.

100. The nurse who responded to the emergency call had undertaken mandatory training for cardio pulmonary resuscitation (CPR) and use of the automated external defibrillator within the last twelve months. However, the first two members of staff who discovered the man (who arrived before the nurse) had not received any recent first aid or resuscitation training.

101. Previous investigations from deaths in custody have shown that it is essential that an adequate number of uniformed prison officer staff, who are usually the first responders to medical emergencies, have up to date first aid training which

enables them to start CPR. Although this was not appropriate in this particular case, prisons need to ensure they have sufficient first aid trained staff on duty at all times. We make the following recommendation:

The Governor should ensure that there are sufficient numbers of staff on duty at all times who are up to date in their training for first aid or basic life support so that there is a swift and appropriate response to emergencies.

CONCLUSION

102. The man was recalled to prison on 22 December 2011, after serving six years of a twelve year sentence. He was also facing further serious charges. He was being treated for depression and there was a warning from the police and the escort staff about a previous incident of self-harm. This concern was not sufficiently acted upon, with greater reliance placed on his own account. The suicide and self harm procedures were subsequently opened and closed on the day of his arrival. He was heavily dependent on alcohol yet was not properly assessed for an alcohol detoxification. A few days after arrival at the prison, he was found hanging from his cell window. He could not be resuscitated as it was evident he had been dead for some time.

103. He apparently gave staff and fellow prisoners no reason to worry about him. However, he exhibited a number of risk factors which should have caused prison staff more concern. There was also no proper follow up of his assessment for alcohol detoxification.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that the healthcare staff document all concerns about prisoners received in reception and share this information with relevant staff.

   The National Offender Management Service accepted this recommendation, writing:

   "Staff follow a SystmOne template which ensures they document any concerns. Staff in reception also use the templates on SystmOne to refer prisoners to relevant areas, and this is included in the Reception Audit – next audit due by end of August 2012."

2. The Head of Healthcare should ensure that all prisoners referred for an alcohol detoxification assessment receive prompt and supportive treatment, backed up by regular monitoring, in line with IDTS policies and procedures.

   The National Offender Management Service accepted this recommendation, writing:

   "This is in place at HMP Norwich. This was not relevant to the man as he did not require a detox as confirmed by the doctor when he assessed him."

3. The Head of Healthcare should ensure that accurate and clear records are made of all prescribed and administered medications to ensure accurate monitoring of a prisoner's healthcare are maintained.

   The National Offender Management Service accepted this recommendation, writing:

   All staff have been re-issued guidance on record keeping, and SystmOne does not allow for a prescription to be written without this being recorded onto the system. Record keeping audit is due to be undertaken by the end of October 2012.

4. The Governor should ensure there is a multidisciplinary approach to the management of prisoners subject to ACCT procedures and that staff fully take into account all indicators of risk when assessing the risk of self-harm.

   The National Offender Management Service accepted this recommendation, writing:

   ACCT Awareness Training is regularly delivered to staff at HMP Norwich to ensure they are up to date on procedures and best practise. Comprehensive information gathering takes place around the ACCT process and this is drawn together for Assessments and reviews. Where input of staff from another agency or department is identified as relevant to managing the risks or issues, they are always included in the process going forward.

5. The Governor should establish a system to ensure that prisoners recalled from release on licence have any immediate risks identified and are appropriately supported and informed of recall procedures.

   The National Offender Management Service accepted this recommendation, writing:

   Information for Licence Recall prisoners will be placed in Reception outlining the support that they will receive across the prison.

   An improved call up book will document the issuing officer, and prompt the issuing officer to question the prisoner's ability to read and comprehend the recall pack presented to him.

6. The Governor should ensure that newly arrived prisoners have appropriate access to telephones, particularly over extended public holiday periods.

   The National Offender Management Service accepted this recommendation, writing:

   Phone calls are always available through Wing Managers/Duty Governor. Systems will be put in place to allow extra phone calls over week-end/Bank Holiday periods for new receptions.

7. The Governor should ensure that there are sufficient numbers of staff on duty at all times who are up to date in their training for first aid or basic life support so that there is a swift and appropriate response to emergencies.

   The National Offender Management Service accepted this recommendation, writing:

   A training programme will be implemented.