

**Investigation into the circumstances surrounding the death of
a man in July 2005 at HMP Norwich**

Prisons and Probation Ombudsman for England and Wales

March 2006

The man was aged 43 when he died in July 2005, apparently by his own hand, in his cell at HMP Norwich. This is a report into the circumstances surrounding his death.

The man had been diagnosed with a terminal illness, and was experiencing a great deal of pain and discomfort that appears to have been too much for him to tolerate. My investigator and I offer our sincere condolences to his family and friends on their loss.

A member of my team carried out the investigation. I wish to thank the Governor of Norwich for making the necessary facilities available to my investigator, and for the help and support of the Liaison Officers. Additionally, I wish to thank the Area Manager and Governor for their close working relationship with my investigator. This was a model of good practice between the Prison Service and my independent office.

In the course of the investigation, I asked for a clinical review of the care and treatment received by the man to be carried out. I am extremely grateful to Norwich Primary Care Trust (NPCT), for their assistance and report. The report makes four recommendations - which will be monitored via the Norwich Prison and NPCT Healthcare structure - and identifies two areas of good practice.

I am satisfied that the man was given every care following the diagnosis of his condition and that appropriate support and treatment was available to make his remaining time as comfortable as possible. I do not believe there were any grounds for suspecting that he might take his own life.

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Prisons and Probation Ombudsman

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Summary

1. The man died in July 2005, having been found hanging in his cell at HMP Norwich.
2. Whilst at HMP Highpoint, the man had been diagnosed as having a terminal illness. During a period of treatment at Addenbrooke's Hospital, the medical team and the man agreed that, in the event of cardio pulmonary arrest, he should not be resuscitated. A "do not resuscitate" (DNR) order was placed in his medical notes.
3. On 29 March 2005, the man was transferred from Highpoint to Norwich prison. He was initially located in the prison hospital and later transferred to the elderly prisoner unit, which is a specialised facility offering full time medical care to its residents. Although he was not elderly, the Governor and Head of Healthcare decided that he should live in an environment that was quieter and offered him the medical care that he needed. The decision taken at Addenbrooke's Hospital was re-examined by the prison doctor, Healthcare Manager, Area Manager and Governor. They, in agreement with the man, decided that the DNR decision was correct and would be the policy for the management of his condition.
4. On 28 July, between 5:00pm and 5:15pm, a nurse commenced an observation patrol of the unit. She said that the man was in his cell, sitting on his chair and had looked up at her when she looked through the cell door observation hatch. As his actions were not out of the ordinary, she continued with her patrol duties.
5. At 5:50pm, a Healthcare Officer (HCO) was unlocking patients to allow them to collect their evening meal. When he arrived at the man's cell he was unable to see him. He confirmed with another nurse that the man was meant to be in the cell, and decided to open the door and check on his whereabouts. As he attempted to open the door, he found that a locker and table that had been placed behind the door, blocking access into the cell. He and the nurse pushed the door open and saw the man suspended at the neck by a ligature made from the edge of a bed sheet, which had been secured to the in cell television wall bracket.
6. Once the ligature had been removed, the HCO checked for signs of life, but could not detect any. Even though the decision had been taken that the man should not be resuscitated, he began to carry out cardio pulmonary resuscitation (CPR). The nurse left to summon assistance from unit staff and the emergency services.
7. At 6:10pm, paramedics arrived and after completing their own tests, stopped any further attempt at resuscitation. The man was pronounced dead at 6:15pm.

8. The clinical reviewer examined the DNR decision and concluded that nursing staff were aware of it. However, as the man had been found hanging and this was not within the boundaries of the DNR policy, they ignored it and made every attempt to resuscitate him. The report shows that nursing staff took the correct decision in attempting to resuscitate the man and that their actions were in keeping with the policy.

HMP Norwich

9. HMP Norwich is located within the city boundaries and holds convicted and remand prisoners, including adults and young offenders. It is designated as a local prison and serves the courts of East Anglia. The certified normal accommodation is 591 and the prison has an operational capacity (maximum crowded capacity) of 823.
10. A car park and road divides the prison. One section of the prison accommodates young offenders and the Healthcare Centre, which also includes an elderly prisoner unit. The remainder of the population is accommodated in the main prison complex. In December 2004 a new governor was appointed to the prison.
11. In March 2005, Her Majesty's Chief Inspector of Prisons (HMCIP) carried out a full announced inspection of the prison. In the introduction to her subsequent report, she said that there were unacceptable deficits in safety and recommendations from seven recent deaths in custody had not been implemented. She also identified that the management of prisoners who were at risk of self-harm was poor. Additionally, HMCIP said that key functions within the prison were inadequate and had been poorly managed. Support plans for prisoners at risk were poor, access to the Samaritans restricted, and prisoners' cell alarm bells regularly muted. However, the report also said that, since the appointment of the new Governor, performance improvement was under way.
12. All prisons undergo an audit by the Prison Service Standards Audit Unit (SAU). The SAU examines the establishment's compliance when measured against national standards and awards overall scores for, Standards, General Standards (Critical Baselines) and Security. Following an audit, the Governor is issued with an action plan which identifies areas where improvement is required in order to bring the performance level up to the required standard. The Governor is required to comment against each area identified and explain how and when the action will be completed.
13. In October 2004, the prison was audited and it was identified that six critical baselines, which included suicide and self-harm, were non-compliant. On 19 May, an internal re-assessment of the six baselines identified that they were still not being met.
14. The executive summary noted the score for the subjects under the safety banner is the lowest at 76 per cent and attention was needed in the areas of Segregation, Use of Force and Suicide and Self-Harm.
15. Each prison has an Independent Monitoring Board (IMB) and their role is to monitor the prison and to report any concerns that they have regarding the prison, or how prisoners are treated. They feedback in the first instance to the Governor, but also have a direct link to Home Office Ministers. Board members are able to visit any area of the prison at any

time and have access to any prisoner they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chair of the Board produces an annual report for the Home Secretary.

16. The IMB's Annual Report 1 March 2004 to 28 February 2005 raised a number of concerns, one of which related directly to an area that my investigation would consider. Their recommendation was that suicide prevention should have a higher profile and that lessons must be learnt from the past.
17. The IMB included the following comment in their report: "... *we also feel that the inquests are taking far too long to get to court, so the urgency to implement change is lost.*"
18. The Governor has a Service Level Agreement, which he has agreed with the Area Manager, and which sets out the priorities for the prison. Priority two of the agreement refers to suicide prevention and is the second of the concerns raised by the IMB.
19. In common with other jails, Norwich has a number of prisoners who have been trained by the Samaritans in how to help and support any prisoner feeling vulnerable or considering suicide or self-harm. They are known as Listeners and their work is carried out on a confidential basis, overseen by a member of the Samaritans team. The Governor has recently appointed a Principal Officer as the manager with responsibility for the Listener scheme. His role is to raise the profile of the Listener scheme, which sadly had been neglected.
20. The Prison Service has an established suicide and self-harm prevention policy, and training is prioritised locally by the Governor. Training includes the use of the Self-Harm at Risk Form, which is normally referred to as F2052SH. The F2052SH document is a form that can be opened by any member of staff who has concern about the safety of a prisoner. Prison staff are required to report on the prisoner's mood and behaviour at least daily. The level of observation is decided on a case by case basis determined by the level of risk of suicide or self harm. Once the document has been opened, the prisoner is invited to meet a multi disciplinary team, who assess the reasons behind the raised concern and jointly agree an action plan with the prisoner. The team has a wide range of support interventions available and design a plan to fit the individual needs. The plan is reviewed regularly and only closed when the team agrees that the risk of self-harm has been reduced.
21. Since taking over, the Governor has raised the profile of suicide prevention and on a daily basis, either he, or the Deputy Governor reviews all F2052SH documents that are open and quality check the entries and decisions made.

Conduct of the Investigation

22. The investigation opened at the prison on 2 July. My investigator met the Governor, Liaison Officer, a member of the PCT, Prison Healthcare Manager, and received a briefing about the circumstances of the mans death. He then visited the cell where the man had been found.
23. A number of prison documents were made available by the Governor which the investigator read. The prison records and reports identified which members of staff the investigator would seek to interview and, in the majority of cases; the interviews were carried out using recording equipment.
24. A clinical review was commissioned from Norwich PCT and they were asked to review the care and treatment received by the man during his period in custody.
25. Throughout the investigation, the Governor made himself available on a daily basis to receive any feedback that my investigator had to share with him. Following the meetings, the Governor addressed any findings that he was able to deal with immediately. Additionally, the Area Manager made time available to meet with my investigator and discuss his findings and likely recommendations. I am very grateful to them both.
26. I have as part of my office team, staff who are employed as Family Liaison Officers (FLOs). Their role is to contact the family and, should they wish to speak to the FLO, invite any comments that they have in relation to the care and treatment of the person who has died.
27. On 26 August, the FLO contacted the mans brother. He told her that his main concern was the delay in informing the family of the mans death. The concern he raised will be addressed later in report.

Significant events prior to 28 July 2005

HMP Highpoint

28. On 24 January 2005, the man complained to medical staff of headaches and dizziness.
29. Five days later, on 29 January 2005, he lacerated his left wrist with a razor blade and told staff that he had done it in order to relieve his headache pain. Although the man told staff that he did not have any suicidal intent, he was correctly monitored under the F2052SH procedure.
30. Following the opening of the F2052SH, a case review was carried out and on 19 February a decision was taken to close the document. My investigator reviewed this decision. In light of the fact that monitoring followed an isolated event, he concluded that the document was closed appropriately.
31. The Clinical Review shows that between 31 January and 3 February, the man saw a doctor on four further occasions due to headache, dizziness and nausea. On 3 February, he was referred and admitted to the West Suffolk Hospital for further investigation. After being given an intravenous injection during a CT scan, he had a seizure and became unresponsive.
32. On 11 February, following a deterioration in his condition, he was transferred to the Neuro Clinical Care Unit at Addenbrooke's Hospital, where he was diagnosed and treated for Glioblastoma Multiforme WHO grade IV of posterior fossa, which is a terminal cancer. The man underwent a variety of treatments and investigations which are well documented in the Clinical Review. Additionally, and with the agreement of the man, a decision was taken that in the event of cardio pulmonary arrest he should not be resuscitated and a "do not resuscitate" (DNR) order was placed in his medical record. He was admitted into intensive care, where his condition was stabilised. The scan showed a large cerebella mass and gross hydrocephalus. This is a brain tumour, surrounded by liquid that is unable to drain away due to its size.
33. On 28 February, the man was granted temporary release from prison on compassionate grounds to enable him to receive medical treatment at Addenbrooke's Hospital. Following treatment, he returned to the prison.

Addenbrooke's Hospital

34. On 22 March, an entry was made in the clinical notes confirming that radiotherapy would be completed on 24 March and that the tumour would grow again and produce similar symptoms in one to two months. It goes on to say that the survival rate was 120 days.
35. Following the diagnosis, the Healthcare Manager at Highpoint contacted the Healthcare Manager at Norwich to discuss transferring the man to

Norwich, which could offer 24 hour medical cover, should his condition deteriorate. The Healthcare Manager at Norwich agreed to the transfer.

HMP Norwich

36. On 29 March, the man was transferred to Norwich. He was admitted to the Healthcare Inpatient Unit where the Healthcare Manager reviewed the records and discharge summary. She wrote in his medical record that, even though a decision had been taken at Addenbrooke's that the man was not for resuscitation, until such time as a local decision has been made and documented, resuscitation must be attempted.
37. Two days later, the man was referred to the Macmillan team which would provide palliative care.
38. A doctor reviewed the case notes on 4 April, and sought the advice of the Neuro Oncology Team regarding the mans condition. In agreement with the man, the doctor and the medical staff agreed that the decision taken at Addenbrooke's Hospital for the man not to be resuscitated in the event of cardio pulmonary arrest was correct. His medical notes were updated to reflect the decision.
39. On 26 April, the Staff Nurse discussed the diagnosis and prognosis with the man and explained that the Palliative Care Team would be visiting him the following day. The nurse also agreed to move the man into the elderly prisoners unit, as he was becoming increasingly upset by the noise from the patients in the unit where he was located.
40. A consultant in palliative care wrote to the prison on 4 May explaining that the prognosis for the mans condition was poor, and asking for compassionate licence to be considered. My report comments on this later.
41. An urgent referral for a repeat CT head scan was made on 26 May, as the man had developed recurrent symptoms suggestive of raised intra cranial pressure. The mans tumour was not allowing fluid to drain away from the area, which in turn caused headache due to the pressure. The mans condition was noted as having improved, but that his mood had changed and that he was becoming hostile and experiencing difficulty in retaining information.
42. On 16 June, the man attended Norfolk and Norwich University Hospital, but the results were not with his medical records.
43. Throughout July, the medical records indicate that the man was experiencing worsening symptoms which resulted in his medication being changed. The man was not happy that one of his drugs was being increased, as the side effects made him feel sick. He decided to remain on the lower level of 4mg and said that he would discuss it with the consultant at his next appointment due on 29 July.

44. On 25 July, the man complained of having dizzy spells, difficulty seeing and numbness in his mouth. Nursing staff explained that the symptoms were as a result of his tumour, but the man believed that it was as a result of his medication.

Events of 28 July

45. On 28 July, the man had spoken to nursing staff and collected his meals as normal, giving them no cause for concern. He received his morning medication and carried on with his usual daily routines, which consisted of resting in his cell and the occasional walk in the unit corridor.
46. Between 5:00pm and 5:15pm, a nurse carried out an observation round of the unit. This meant that she would check on certain designated patients and, although the man was not one of the patients she specifically needed to check, she looked into his cell. She saw that he was sitting on his chair and said that he looked up to acknowledge her. She closed the observation flap and continued with her duties. She was the last person to see the man alive.
47. At 5:50pm, a Healthcare Officer was unlocking patients to allow them to collect their evening meal. When he arrived at the mans cell, he was unable to see him through the observation panel situated in the cell door. He confirmed with a nurse that the man was meant to be in the cell and called out his name, but did not receive a response and decided to open the door and check on his whereabouts. As he attempted to open the door he found that a locker and table had been placed behind the door, preventing access into the cell. He and the nurse pushed the door open and saw the man suspended at the neck by a ligature made from the edge of a bed sheet, which had been secured to the in cell television wall bracket.
48. My investigator examined the room and the view through the observation panel. He found the level of observation to be good, but that there is a blind spot on the left hand side of the door which is where the TV wall bracket is located. He discussed the possibility of re-locating the wall bracket to the opposite end of the room, but this suggestion was not possible as it would mean the bed would need to be moved. Moving the bed would restrict the staff view of patients.
49. The HCO lifted the man to release the pressure on his neck, whilst the nurse removed the ligature from around his neck. They laid the man onto the floor and began to check for signs of life, but could not detect any. The HCO commenced Cardio Pulmonary Resuscitation (CPR) at a rate of 15 compressions to two breaths. The nurse left to obtain the assistance of other nursing staff and collect the emergency bag, which contained an Ambu bag and oxygen. Ambu bags have a facial mask, which is placed over the patient's mouth, and a bag which is then squeezed, supplying air into the patient.
50. A Principal Officer was in the unit at the time assistance was requested. He responded and assisted with resuscitation and continued with cardiac massage while the HCO carried out the breathing procedure. The nurse

returned and an airway was inserted into the mans mouth, with the Ambu bag being used to supply oxygen via the airway.

51. The Clinical Review has identified that a defibrillator was available to the healthcare staff attending the man, but that they were not trained in its use. A recommendation has been made in the Clinical Review to address this as soon as possible.
52. The Healthcare Manager, who had left work for the day, was contacted by mobile telephone on her way home and asked to return to the prison. At 6:05pm, she arrived and assisted with the resuscitation attempts. These continued until the arrival of the paramedics at 6:10pm.
53. Paramedics were briefed about the mans medical condition and the circumstances in which he had been found. They carried out their own examination and, after confirming that the cardiac monitors did not show any sign of life, decided to stop any further attempts to resuscitate the man and pronounced him dead at 6:15pm.

Events following the mans death

54. Following the mans death, a Prison Service Operational Manager attempted to contact the mans family using the information contained in his prison record. As the address identified was some considerable distance from Norwich, he telephoned a prison close to the Slough area but could not obtain a response. He telephoned another prison local to Slough and spoke to the duty governor to ask him to break the news to the family. The person he spoke to said that he was unwilling to assist due to the distance and lack of knowledge of the Slough area. I understand that The Governor has discussed their response separately with the Governor of the establishment concerned.
55. The police were then asked to visit the family home to break the news. At first, the police declined and said that it was the responsibility of the Prison Service to notify the family. However, following the intervention of a Sergeant at Norwich Police Control Room, Thames Valley Police agreed to inform the family. Unfortunately, when they arrived they found that the address given to them was wrong, as the person named had moved house and the information in the prison record was out of date.
56. My investigator concluded that the Operational Manager had gone to extraordinary lengths to ensure that the mans family were made aware of his death. Despite failing to obtain the support of a colleague and the initial reluctance of the police, he persisted until the police eventually agreed to help. It is regrettable that the address given to the Thames Valley Police was in fact incorrect. The managers actions are commendable.
57. However, it was not until the following day, once the prison records could be accessed fully, that a telephone number was obtained from the prison telephone system and the mans brother was informed of his death. Unfortunately, the delay meant that the family were not informed until lunchtime of the mans death the previous evening. This is very regrettable and, while I have explained the reasons, there are lessons to be learned.
58. The mans brother said that the prison had returned all his property to them and that the Governor had offered to assist with the cost of the funeral. He confirmed that the mans family was aware that he had a brain tumour and that the illness was terminal. He said that he had spoken to the man about ten days prior to his death and, although the man said that he was not feeling well, he confirmed that he was not in pain. The man said nothing to suggest to his brother that he was planning to take his own life. He said that he did not know what eventually caused him to end his life, but thought that either the pain became too much for him or that he had given up on life.
59. On 7 September, The Coroner, wrote to my investigator enclosing a copy of a letter that had been written by the man which had been forwarded to

him by the prison. The mans letter was not written in English and the author of the letter from the prison suggested that it could have been a suicide note. My investigator had the letter translated and confirmed that it was a religious greeting, written in Punjabi, and dated in line with the Hindu calendar.

Area Manager's Review

60. Since September 2001, there have been 17 deaths at HMP Norwich plus two men who died shortly after being released. Of the deaths in custody, ten appear to be self-inflicted, with five of the prisoners being monitored under the F2052SH procedure.
61. Prior to April 2004, the Prison Service investigated the circumstances of all deaths in custody and produced a report containing the investigation findings and necessary recommendations. (Since that date, my office has taken over responsibility for investigating all deaths in prison custody.)
62. Following the mans death, the Area Manager commissioned a team of his own staff to review prisoner care arrangements at the establishment. Although his report does not form any part of my own, I support and welcome his review.

Key Findings

(i) Compassionate Release

63. Under certain circumstances the Governor can release prisoners on compassionate licence, but this is only done following a risk assessment. The risk assessment process considers the nature of the offence, custodial history, and level of compliance with the sentence plan. Any decision taken is based on the likelihood of failure to comply with the conditions of the licence and the likely risk to the public.
64. The Governor informed my investigator that he had considered compassionate licence as an option for the man. However, he said that the documentation process to consider the licence had not been started. He said that, in his opinion, it was preferable for the man to be with people that he knew, rather than in unfamiliar surroundings in an external hospital setting. I am satisfied that the decision taken to allow the man to remain in the elderly prisoner unit rather than in an external hospital was compassionate and correct. Nevertheless, if the Governor is to allow terminally ill patients to remain in the unit, then a protocol needs to be developed that allows the relatives of a terminally ill patient to be at the bedside as with normal NHS practice. The Clinical Review makes a recommendation on this matter which the Prison Service may wish to consider and offer guidance nationally.

(ii) Emergency Equipment

65. The emergency bag did not contain a defibrillator, although one was available within the Healthcare Unit. Nursing staff attending to the man were not trained in its use and it is therefore not possible to say with any certainty what the outcome might have been had they been able to use the equipment. The Clinical Review has identified this and makes a recommendation to address this, which I support.

The Governor in partnership with Norwich PCT should implement the recommendations made in the Clinical Review.

(iii) Contacting the family

66. One of the contributory factors in the delay in informing the man's family of his death was that the next of kin information contained within his prison record was out of date. Sadly, this is not the first occasion where my office has found similar problems. My investigator discussed with the Governor ways of keeping next of kin details up to date, and suggested it could be carried out at the time of lifer reviews and sentence plans were completed. The Governor was receptive to this idea and said that he would be looking to introduce it locally into the prison routine. I welcome his approach and ask the Prison Service as a whole to examine ways of updating prisoner records and to issue guidance.

The Prison Service should examine ways to update prisoner next of kin details and issue guidance.

The Operational Manager should be commended for his efforts to inform Gurmail's family of his death.

(iv) Caring for the man

69. I have been impressed by the decisions taken with respect to the mans care in custody once his terminal illness had been diagnosed. I do not believe that he gave staff at Norwich any grounds for believing that he might take his own life.

Recommendations

For the Prison Service

1. The Prison Service should examine ways to update prisoner next of kin details and issue guidance.

For the prison

1. The Governor in partnership with Norwich PCT should implement the recommendations made in the Clinical Review.
2. The Prison Service Operational Manager, should be commended for his efforts to inform the mans family of his death.

Clinical Review Recommendations

1. A Healthcare reception screening form is completed for all transfers in to Norwich Prison including direct transfers into the Healthcare Inpatients Unit.
2. A policy is developed to facilitate visits within the Healthcare Older Person's Lifer Unit as appropriate.
3. Healthcare Norwich Prison fully adopts the NPCT Resuscitation Policy.
4. Healthcare Staff receive defibrillator training as soon as possible.

Good Practice

1. Effective partnership working between the Healthcare Staff, Norwich Prison, Palliative Care Services at Priscilla Bacon Lodge and Oncology Department at Norfolk and Norwich University Hospital.
2. Negotiation of the implementation of HMP Norwich Cardio-Pulmonary Resuscitation Decisions Protocol with the Prison Service.

Annexes

1. Clinical Review
2. Transcript, Healthcare Manager
3. Transcript, Health Care Officer
4. Transcript, Staff Nurse
5. Transcript, Nurse
6. Cardio Pulmonary Resuscitation Policy
7. Letter from Norwich Prison to Coroner, 1 September
8. Letter written by the man, 28/07/2549 (Hindu Calendar)
9. Release on Temporary Licence Form, 28 February 2005