PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in May 2011 at HMP Norwich

Report by the Prisons and Probation Ombudsman for England and Wales

February 2013

This is the report of an investigation into the death of a man. He was found dead in his cell in HMP Norwich on a morning in May 2011. The post mortem concluded that he died of a subarachnoid haemorrhage (brain haemorrhage). He was 34 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. NHS Norfolk commissioned a clinical reviewer to undertake a review of the man's clinical care while he was in custody. Staff at HMP Norwich fully co-operated with the investigation. I apologise for the long delay in issuing this report.

The man was remanded into the custody of HMP Chelmsford in January 2011 from where he moved to HMP Peterborough. He received treatment for substance misuse and depression. He then moved to HMP Norwich in February. His prescription chart was not sent with him to Norwich, which resulted in some delay in him receiving his medication. A mental health referral was also not followed up. There were some suggestions that he traded his medication at Norwich, but there was no evidence to support this.

While the investigation has identified some areas for improvement, none of these matters would have helped prevent the man's death. I agree with the clinical reviewer that the man's treatment was largely comparable to that which he could have expected in the community and that his death could not have been predicted or prevented. I am pleased to see that the National Offender Management Service has accepted three recommendations. They offered an explanation as to why they did not accept a fourth.

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 **February 2013**

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SUMMARY

1. The man was first remanded to HMP Chelmsford on 11 January 2011. The reception healthscreen noted that he had mental health issues, which included auditory hallucinations, depression and post-traumatic stress disorder. He also had a history of substance misuse, and was prescribed Subutex to help treat this. An initial mental health nursing assessment carried out two weeks later indicated that he would be referred to a psychiatrist.

2. On 2 February, the man transferred to HMP Peterborough. He was again prescribed Subutex, a mental health referral was made and a few days later a prison doctor prescribed anti-depressants. He was later found to be concealing his Subutex, so the prescription was stopped. The man declined the alternative treatment offered.

3. The man was transferred from Peterborough to HMP Norwich on 25 February. In an apparent oversight, his drug administration charts were not sent with him.

4. During the reception healthscreen, the man told the nurse that when he came into prison, he had been placed on special measures to support those thought to be at risk of harming themselves. He disclosed his history of mental health issues and that he had been prescribed anti-depressants while at Peterborough. The nurse referred him for a mental health assessment. On 7 March, he was assessed by a doctor. He was prescribed anti-inflammatory medication and anti-depressants. The doctor did not pursue the previous referral to a psychiatrist.

5. On a day in May, prisoners who knew the man noticed nothing unusual in his demeanour or physical appearance. Following exercise and dinner, prisoners were locked in their cells at 5.00pm. At approximately 6.00am the following morning, the prison officer conducting the morning roll check could not gain a response from him. The officer raised the alarm and despite resuscitation attempts, the man was pronounced dead a short time later.

6. Staff contacted the man's family and informed them of his death. Prisoners on his wing were notified, and a memorial service was held to allow them to pay their respects. Staff were offered the support of the prison's care team, but some of the staff involved did not feel that they had been supported as much as they would have liked.

7. The post mortem concluded that the man died of natural causes – a brain haemorrhage following a burst aneurysm which caused bleeding in his brain. The man's death could not have been foreseen, and the general standard of health care he received was broadly comparable to that which he would have expected in the community. We make four recommendations about transfer of health records, mental health assessment, and consultation with families after a death.

THE INVESTIGATION PROCESS

8. This office was informed of the man's death on 7 May 2011 and the investigator spoke to the duty governor that day. He visited HMP Norwich on 10 May and obtained the man's prison record and prison medical records. The investigator met the Governor, and spoke to staff and prisoners who knew the man.

9. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact the investigator. No further information was received.

10. NHS Norfolk commissioned a clinical review of the man's care and treatment while is custody, which was carried out by a clinical reviewer. The investigator discussed the report with the clinical reviewer and they conducted joint interviews with staff.

11. The investigator formally interviewed five members of staff, one member of the Independent Monitoring Board and three prisoners. Four of these interviews were conducted jointly with the clinical reviewer. Four interviews were recorded and transcripts produced. Notes were produced of the other interviews. The investigator provided feedback to the Governor of Norwich during the investigation. He also spoke to the Head of Healthcare at HMP Peterborough about the transfer of medical records.

12. One of this office's family liaison officers contacted the man's mother to explain the investigation process and offer the opportunity for her to raise any issues or concerns. His mother asked if the investigation could consider whether the remembrance cards she provided had been given to her son's fellow prisoners, what medication he was on, and how often he was checked during the night. The man's family received a copy of the draft report as part of the consultation period. Having considered the investigation findings they requested further clarification on a number of points, via their legal representative. The investigator reviewed the findings of the investigation and has, where appropriate, amended the report to reflect their comments. It was felt, however, that some of the issues raised would be more appropriately addressed outside of this report in separate correspondence to the man's family and legal representative.

13. The investigator wrote to HM Coroner to inform him of the investigation and to obtain a copy of the post mortem report. This report will be sent to the Coroner to assist his enquiries.

14. Investigations about the medical issues in this report caused a delay, further exacerbated by workload pressures in this office. We apologise for any added distress the late issue of this draft report has caused the man's family.

HMP NORWICH

15. 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 remanded. It holds up to 767 prisoners. The prison's health services are commissioned by NHS Norfolk and, since October 2010, have been provided by Serco Health 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.

Suicide and self-harm monitoring

16. Assessment, Care in Custody and Teamwork (ACCT) procedures are used by the Prison Service to monitor and support prisoners assessed as at risk of suicide or self-harm. Once placed on ACCT, the prisoner is observed according to the perceived level of risk. Each prisoner should be assessed within 24 hours of the ACCT being opened, and then reviewed at intervals decided on a case by case basis.

Night state

17. When prisoners are locked in their cells in the evening, the prison is in what is known as night state. Staffing levels are reduced, with patrols on each wing. The Night Orderly Officer is in charge of the operation of the prison, and is the only one with keys to access all areas. Staff carry cell keys in sealed pouches, which they can use to open cells in an emergency.

Previous deaths at Norwich

18. Before this man, 39 prisoners had died in Norwich since the Ombudsman became responsible for investigating deaths in custody in 2004. There have been a further seven deaths there since. 32 of these deaths have been due to natural causes. The prison contains a unit which is used to house elderly prisoners and, as a consequence, has a high number of deaths due to natural causes.

19. A number of previous reports from this office have contained recommendations about the healthcare provision in the prison. These recommendations include issues around the reception process, and about mental health services including triggers for assessments. Additionally, following a death in 2009, this office recommended that the Governor ensured that debrief sessions included all necessary staff. We make a similar recommendation about the latter in this report.

Her Majesty's Inspectorate of Prisons (HMIP)

20. The last inspection report published on Norwich by HMIP followed an unannounced inspection in February 2010, when health services were being re-tendered. By the time the man arrived at Norwich, Serco Health had been commissioned to provide healthcare services. In 2010, the inspection found, in relation to healthcare, that:

> "Provision had been informed by a recent health needs assessment, and patient primary health care had improved. Clinical governance was in place with clear lines of accountability. Reception health screening was reasonable and all new arrivals had a follow-up secondary healthscreen. Prisoners could wait up to 10 days to see the doctor or nurse practitioner, and triage protocols were limited. Waiting lists were not validated, and many prisoners failed to attend appointments. Prisoners had reasonable access to the pharmacist. …..The mental health service was poor for prisoners with mild to moderate mental health issues but was adequate for those with serious and enduring conditions."

21. Inspectors found that treatment for those dependent on drugs was flexible, and access to treatment for new arrivals was effective, with at least symptomatic relief available very quickly. The random mandatory drug testing rate was currently just under 11% which was not regarded as excessively high, but arrangements to drug test prisoners who were suspected of using drugs were weak. A high proportion of security information reports involved drugs, including the misuse of prescribed medication.

Independent Monitoring Board (IMB)

22. Each prison has an Independent Monitoring Board, made up of unpaid volunteers from the local community responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The last report published by the IMB for Norwich covered the period March 2009 to February 2010. At the time the IMB listed a number of deficiencies about healthcare provision but hoped for improvements under a new contract. The IMB also noted there had been issues with diversion of medication which led to other problems such as bullying and intimidation.

23. The investigator spoke to a member of Norwich's IMB. The IMB has previously raised some concerns about the operation of the Integrated Drug Treatment System (IDTS – a Prison Service scheme which aims to increase the quality of substance misuse treatment available to prisoners) on A wing. The Board was concerned that medication prescribed to help prisoners detoxify from drug use was being traded between prisoners. The IMB had also raised concerns about free movement of prisoners on A wing, which contains first night, induction

and drug treatment landings which the IMB believed exacerbated the problem.

24. The member of Norwich's IMB confirmed that the man had not come to the attention of the IMB apart from when he spent two days in the segregation unit in late March. (A segregation unit is a separate section in the prison in which prisoners are held separately from other prisoners for reasons of safety, good order and discipline, or to serve punishments for breaches of Prison Rules.) An IMB member visited the unit on both days and their notes indicated no concerns.

25. The IMB had been satisfied with the follow up to the man's death. The Board had been informed and a member had attended the prison.

KEY EVENTS

26. The man was remanded to HMP Chelmsford on 11 January 2011. He was 33 years old at the time. The reception healthscreen noted that he had mental health issues, which included auditory hallucinations (hearing things), depression and post-traumatic stress disorder (PTSD, an anxiety disorder which develops after exposure to psychological trauma). He told staff that he had broken up with his partner of two years, that day. He tested positive for buprenorphine (used to treat heroin misuse) and cocaine. He was prescribed Subutex (a trade name of buprenorphine used to treat opiate addiction) and confirmation was requested from the man's GP that he had been prescribed this in the community. The man requested a single cell due to feelings of paranoia.

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27. As a result of concerns raised during his reception screening, the man was initially supported through the Prison Service suicide and self harm monitoring (ACCT) from 11 until 18 January. At the review meeting on 18 January, he said he was more settled and no longer had any thoughts of self harm and the ACCT plan was closed.

28. An entry in his medical record the following day shows that the man suffered from acute bronchitis (inflammation of the airways to the lungs). His case was discussed at the healthcare daily meeting and a non-urgent mental health assessment was requested. His prescription of Subutex was confirmed by his community doctor.

29. On 26 January, an initial mental health nursing assessment was carried out. The man was put on the list to see a psychiatrist. He was also continuing to engage with the Counselling, Assessment, Referral and Throughcare Service (CARATS, which helps prisoners with drug misuse problems). The nurse noted that a review would be held in four weeks. A further record on the same day notes that the man also had asthma, obsessive compulsive disorder (OCD, an anxiety disorder), and clinical depression.

30. On 2 February, the man was transferred to HMP Peterborough. The reception healthscreen noted his prescription of Subutex and that a mental health referral was necessary. He was assessed by a prison doctor on 11 February and prescribed seroxat (an anti-depressant).

31. The same day, the man was caught hiding his Subutex. This prescription was therefore stopped. He was offered methadone as an alternative treatment, which he declined. In response, he threatened to "flood the prison with drugs". The following day, he was assessed by a substance misuse nurse. He requested that he again be prescribed Subutex but this was refused.

32. Two weeks later, on 25 February 2011, the man was transferred from Peterborough to HMP Norwich. His drug prescription chart was not

sent with him. A nurse carried out a routine initial health screen. The man told the nurse that he was being prescribed naproxen (a painkiller and anti-inflammatory) and seroxat. He also had cream for a rash on his face and told her that he had salbutamol and beclomethasone inhalers for asthma, although these had not been prescribed to him at Peterborough.

33. The man told the nurse that he had harmed himself by making cuts to his arm when he was 12 years old, although he could not remember why. He said that, on coming into prison, he had been placed on special measures to support those thought to be at risk of self-harm, but the nurse had no current concerns.

34. The man also told the nurse that following a road traffic accident, he had suffered a neck injury. He said that he used alcohol only occasionally, but recounted a history of drug misuse, including ecstasy, crack cocaine, methadone, cannabis and heroin. He said that he had stopped injecting drugs in January 2010.

35. The nurse referred the man for a mental health assessment. He told the nurse that he had started to be prescribed seroxat a month previously, because of mental health issues, and he would like to continue with the prescription. He said that he was concerned because he suffered from OCD and PTSD.

36. A locum prison doctor saw the man on 26 February. He noted that the man continued to suffer neck pain further to his road accident, and this had worsened after a fight the previous summer. The pain was worse during rest, and he noted that the man might require surgery. The doctor also obtained the man's consent to request his previous medical records. He was prescribed diclofenic (an anti-inflammatory).

37. On 28 February, the man spoke to a healthcare assistant about some health problems. He told the healthcare assistant that he was asthmatic, suffered from OCD, PTSD, and clinical depression. The healthcare assistant made a note that the man had a recent history of drug abuse, depression and/or mental health issues within the past month. He was judged to present a moderate risk of self-medicating (using whatever he could obtain to make himself feel better). The form indicated no recent problems with the man managing his own medication and no current concern about him holding his medication in-possession (as opposed to needing to collect it from healthcare each time he needed it).

38. The man was assessed by a doctor on 7 March. He told the doctor that he had previously been on various types of opioid painkillers (containing opiates, strong painkillers). He said that he was now suffering from severe pain and the non-steroid and anti-inflammatory drugs he had been prescribed were not alleviating this. He told the doctor that in the past tramadol (an opioid painkiller) had helped,

although he was aware of its addictive nature. He said that he had previously been prescribed seroxat, which had helped with his OCD and depression, and he would like to be prescribed it again. The doctor prescribed him tramadol and a month's supply of paroxetine (another anti-depressant). The doctor did not follow up the man's referral for a mental health assessment.

39. On 16 March, the man accidentally shut his hand in a door during the lunch period. He was assessed by a nurse. She gave him ibuprofen, and advised him to see the doctor the following morning, but he did not.

40. The man was taken to the segregation unit on 22 March, having been accused of trying to incite other prisoners to destroy property. He was seen there by a nurse on 22 March. No problems were reported. The man went from the segregation unit back to his wing on 24 March.

41. On 28 March, the man was again prescribed tramadol by a locum doctor. He was prescribed two 20mg tablets a day. To be taken under supervision. The following day, the locum doctor additionally prescribed a daily dosage of 20mg of paroxetine.

42. The man stepped on a razor and hurt the sole of his foot on 1 April. He saw a nurse, and the cut was dressed. Nursing staff redressed the foot the next day. While waiting to see the doctor on 4 April, the man decided that he did not need to do so. He left the clinic without keeping the appointment.

43. On 2 May, the man was re-prescribed tramadol for a further month by a locum doctor.

44. The man had met a fellow prisoner at Norwich whom he had known since childhood, but had not seen for some years. The fellow prisoner told the investigator that he thought the man had looked well and seemed to be in a similar physical shape to how he remembered him. The man told his fellow prisoner that he had been having relationship problems. It seemed to the fellow prisoner that the man's partner had ended their relationship, which the man found difficult to accept. His partner had not visited or written to him since he arrived in Norwich. The man told his fellow prisoner that he did not telephone her, as they would only argue, but he had written to her. The fellow prisoner thought the man was quite depressed about the situation.

45. His fellow prisoner said that the man had told him that when he was in HMP Peterborough, he had not been given his prescription of Subutex. He had therefore bought Subutex from other prisoners, and continued to do so on arrival at Norwich. He said that he believed the man had had a problem with his medication up to two or three days before he died. He said he had not received any medication for three or four days. However, the records do not show this to be the case.

Events the day before the man's death and the day of the man's death

46. The investigator interviewed a friend of the man in the prison. He last saw the man in the exercise yard some time between 3.00pm and 4.00pm the day before he died. As far as he could tell, the man seemed to be fine, both physically and in mood. After the exercise period, prisoners went back to their cells. They were unlocked again at approximately 4.45pm to collect their meals, which they took back to their cells. From 5.00pm the prisoners were locked in their cells until the following morning.

47. A prisoner who lived in the cell next door to the man also saw him in the exercise yard during Friday afternoon, when he seemed to him to be cheerful and physically well. A fellow prisoner at Norwich last saw him just before they were locked up at approximately 5.00pm. He also said the man seemed to be perfectly well.

48. Two officers were on duty overnight on the man's landing. They started work at around 8.30pm and completed the evening roll count to check that all prisoners were present in their cells. After that, prisoners are not routinely checked again during the night unless they are on special monitoring measures or have any medical needs. Staff patrol the landings at intervals during the night but do not check on individual prisoners unless there is some specific reason. If prisoners require staff assistance, there are emergency call bells in the cells. According to the electronic records, the man pressed his cell bell at 7.12pm. Staff answered the call after 15 seconds. The investigator was unable to confirm why the man did so. After this, he did not use his cell bell during the night.

49. In the early hours of the following morning, the prisoner occupying the cell next door to the man said he heard the toilet in the man's cell flush. This woke him, so he got out of bed. He said that this was approximately 4.30am, but he did not have a watch in his cell, so this was only a rough estimate based on the sunlight.

50. At around 5.55am that morning, an officer was completing the morning roll check. When he got to the man's cell, he slid open the observation panel and saw that he was wrapped in his bedding and lying on the floor. The officer said it looked as if the man was asleep on the floor, which he told the investigator was not that unusual for prisoners.

51. However, the officer was concerned as he could not see the man moving or hear him breathing. The officer shouted through the observation panel, but he did not respond. He went to the nearby wing office, told his colleague, and telephoned the SO, who was the night orderly officer (in charge of the security of the prison and responding to any emergencies). He told the SO that he was going to break the

sealed key pouch, that every officer carries in case of emergencies, and enter the man's cell.

52. The two officers on duty overnight (one male, one female), then immediately went to the man's cell, unlocked it and entered. The male officer found the man cold to the touch and immediately radioed for the night orderly officer and a nurse to come to the cell. He also asked for an ambulance. He uncovered the man from his bedding and put him on his back. He was in the process of getting a mouthshield out for mouth-to-mouth resuscitation, when a nurse arrived with an Ambu bag (used to artificially encourage breathing during resuscitation). The nurse began to perform cardiopulmonary resuscitation (CPR – a mixture of chest compressions and rescue breaths to try and maintain a flow of oxygen around the body). The female officer had gone to get the emergency bag from the wing office.

53. The night orderly officer and a further nurse then arrived and this nurse took over CPR. A defibrillator (a machine that detects whether there is any heart activity that might respond to electrical stimulation) was attached to the man, but it could detect no rhythm. The nurse was unable to open the man's mouth to insert an airway so she inserted a nasal airway. The nurse told the investigator that she believed the man was dead, but that resuscitation had to be continued until paramedics arrived who could certify his death.

54. The female officer on duty overnight brought paramedics to the man's cell as soon as they arrived at the prison. The paramedics assessed the man, asked the nurse to stop CPR and, at 6.06am, confirmed that the man had died.

Informing the man's family

55. The man's partner was listed as his next of kin. The prison's safer custody manager went to break the news of her partner's death to her on 7 May. She gave the safer custody manager contact details for the man's mother and the safer custody manager visited her to inform her of her son's death.

Debrief and staff support

56. It is a Prison Service requirement that, following the death of a prisoner, a debrief is held as soon as possible with staff involved in his or her care. This is known as a 'hot debrief' and aims to ensure that staff have an opportunity to discuss any issues arising, and for support to be provided.

57. The Governor told the investigator that he held a hot debrief with the two officers who had found the man, the nurses who had administered first aid, and the healthcare manager. He told the investigator that no

problems were reported which had hampered the staff response to the emergency.

58. However, all four staff that the investigator interviewed about the emergency response said they did not remember a debrief after the man's death. They said they had been offered the support of the care team and the Governor has asked them individually about their welfare, but they said they had not been given the opportunity to discuss the man's death as a group. However, the Governor produced a note which indicates that the two officers and both nurses attended the hot debrief. The prison officers said they had been contacted at home to check on their wellbeing.

59. The night orderly officer/SO said he spoke to both officers to check on their welfare, but in turn, he had been deeply affected by the events. Both the SO and one of the nurses felt that, after they had left the prison that day, they had not been treated sensitively. The night orderly officer said he raised these issues with a governor and believed the procedures had now improved.

Support for prisoners

60. Between 8.00am and 8.30am on the morning the man died, when they were still locked in their cells, the man's friend's neighbour called him to the door of his cell and told him the man had died. The man's friend confirmed this with an officer. Friends of the fellow prisoner on A6 landing told him that prisoners on A6 later received letters from the Governor telling them that the man had died, but those on A3 landing, where the man lived, did not. The man's friend said that other than the officer confirming it when he had asked, no-one officially told him what had happened. However, he said that staff were subsequently supportive. The chaplaincy held a memorial service for the man on the wing that afternoon and he was mentioned in prayers during the church service the following morning.

61. Another of the man's friends found out that he had died at about 9.00am, when a cleaner came to his cell door and told him. He did not receive any official notification, but he said staff spoke to him about it and offered him the opportunity to talk to them. He was also aware of the availability of Listeners (prisoners trained by the Samaritans) and the Samaritans themselves. He said that he had not been offered any support other than the opportunity to move cells.

62. All prisoners who were subject to monitoring as at risk of self-harm had their care reviewed following the man's death. At the regular staff meeting on the morning of 9 May, staff were reminded of the need to be vigilant about prisoners who might have been affected. Listeners were available to provide support.

Drugs and Toxicology

63. After the man's death, rumours circulated that he had been buying drugs from other prisoners. There was also a suggestion that he had had a dispute with a prisoner on B wing. A prisoner told a member of staff that he had been buying tramadol from him. The prisoner also said that the man had illicitly been buying Subutex (buprenorphine) on the wing.

64. As for all deaths in custody, Norfolk Police attended the prison. They found a capsule wrapped in clingfilm, and two tablets in a medicine cup in the man's cell. The drugs were analysed, and were found to be tramadol (in the clingfilm) and ibuprofen.

65. A forensic toxicology report was completed on 29 June 2011. In the man's system were traces of tramadol and paroxetine, both of which he had been prescribed in prison. The levels were low and consistent with therapeutic use. They did not indicate an overdose. There was no indication of buprenorphine (Subutex) as had been suggested, and no indication the man had not been taking his prescribed medication.

Post Mortem

66. A post mortem report found that the man's death was due to a subarachnoid haemorrhage – a brain haemorrhage. He had an aneurysm (a bulge in a blood vessel caused by a weakness in the vessel wall) in his brain, which burst. The doctor could find no trauma or drug use which might have contributed to this, and concluded that it was likely that the aneurysm had been present since birth. The doctor concluded that the man had died of natural causes.

Funeral

67. The man's funeral was held at a crematorium on 26 May. In line with Prison Service policy the prison made a financial contribution. Prison staff attended, with the man's family's permission.

ISSUES

68. As the man died of natural causes, this report should be read in close conjunction with the clinical review, which includes nine recommendations about wider healthcare matters rather than matters directly related to this man's death. The clinical review will be shared with the Governor at Norwich as well as NHS Norfolk and the Director of Serco (the healthcare provider at Norwich). While there is no indication that the man's death could have been foreseen or prevented, the investigation identified some areas for improvement in practice which are discussed below.

Clinical Care

Prescription charts

69. When the man was transferred from Peterborough to Norwich, his drug chart was not sent with him, which appears to have led to delay with some of his medication. The investigator has discussed this with the Head of Healthcare at Peterborough. She believes that this was an individual error and, since that time, procedures have been amended to improve continuity of care for transferring prisoners. There is no indication that healthcare staff at Norwich attempted to rectify the error and obtain the information from Peterborough.

The Head of Healthcare at HMP Peterborough should ensure that all clinical records are sent with a transferring prisoner, including drug administration charts to allow appropriate continuity of treatment.

The Head of Healthcare at HMP Norwich should ensure that missing clinical records, such as drug administration charts, are requested immediately from sending prisons.

Mental health care

70. As the clinical reviewer notes, the man had an apparent long history of mental health issues including depression, OCD and PTSD. He was prescribed anti-depressants (seroxat) while at Peterborough and subsequently another anti-depressant (paroxetine) around two weeks after his arrival at Norwich. When he was assessed in reception at Norwich on 25 February, he was referred for a mental health assessment. There is no evidence that this took place and it was not followed up by the doctor when he prescribed the man anti-depressants on 7 March. Nor was the referral to the psychiatrist that had been made in Chelmsford pursued.

71. Although this does not appear to be a factor which contributed to the man's death, it is important that mental health assessments take place when a need is identified. The clinical reviewer notes that some

healthcare staff had found the introduction of a process for making referrals to the mental health team had increased the delays in referrals being assessed. The clinical reviewer comments that the mental health pathway from referral in reception is not clear. Nor is it clear how mental health priorities are determined. We agree and make the following recommendation.

The Head of Healthcare at HMP Norwich should ensure that the referral process and priorities for mental health assessments are clear and fully understood by healthcare staff, and that referrals are appropriately monitored.

Use of illicit drugs and diverted medication.

72. The man told his fellow prisoner and friend that when he was in HMP Peterborough he had not been given his prescription of Subutex. He had therefore bought "bits" of Subutex from other prisoners, and continued to do so on arrival at Norwich. After his death another prisoner said that the man had been trading drugs on the wing. The only drugs found in the man's cell following his death were a tramadol tablet and two capsules of ibuprofen.

73. Staff in Norwich were aware that there were rumours of drug misuse on the wing at the time. There were, though, no security reports that implicated the man. As far as the man's friend and fellow prisoner knew, he had stopped buying drugs shortly after he moved to Norwich and his prescription was sorted out. None of the tablets found in his cell were illicit drugs. The toxicology report show that the only drugs in his system were those he had been prescribed and were within therapeutic levels. This investigation found no evidence to show that, at the time of his death, he was taking any drugs other than those prescribed to him.

Debrief and Staff Support

74. The Governor told the investigator that a hot debrief took place after the man's death. The staff involved, however, said that the overall response after he had died was not as sensitive as they would have liked.

75. The requirement for a debrief is set out in PSI 64/2011 (which replaced PSO 2700) and clearly states:

> "… a 'Hot Debrief' must be held immediately after the all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including Healthcare staff, should be invited".

The evidence of most of the staff involved showed that they did not recall a hot debrief. However, the Governor provided the investigator with a note of the debrief, which included the names of those present, arrangements for support, and arrangements to offer support to those unable to attend. Although it will be of some concern to the Governor to hear that some staff did not feel well supported, we are satisfied that the requirement to provide immediate support was met.

Informing prisoners of the man's death

76. Prisoners who spoke to the investigator said they learned of the man's death in different ways. Although, as with the staff, there was some difference of perception it appears that adequate support was put in place. A memorial service was held on the wing on the same day as the man's death.

Family Support

77. The man's mother wanted to know whether the remembrance cards she provided to the prison had been given to her son's fellow prisoners. The investigator was told that there were not enough cards for all prisoners who knew him, so a card was put in the display cabinet on the man's wing. Unfortunately, this meant that prisoners were unable to see the man's mother's address, which was printed on the cards. We consider it would have been courteous and helpful, for the prison's family liaison officer to have discussed this with the man's mother and explained the situation.

The Governor should ensure that families are involved and consulted about arrangements to commemorate the death of a prisoner.

CONCLUSION

78. The man was only 34 years old when he died from a subarachnoid haemorrhage, as a result of an aneurysm which was likely to have been present since birth. During the few months that he was in prison, the man was treated for depression, substance misuse and other relatively minor physical issues and injuries.

79. Some aspects of the man's medical care, such as the transfer of his clinical records and the handling of a mental health referral could have been better, but neither of these contributed to his death. .

RECOMMENDATIONS

1. The Head of Healthcare at HMP Peterborough should ensure that all clinical records are sent with a transferring prisoner, including drug administration charts to allow appropriate continuity of treatment.

   The National Offender Management Service (NOMS) accepted this recommendation. They commented:

   > "We now have designated Reception Nurses for Male & Female prisons, and part of their procedure is to ensure that patient's records being transferred include prescription charts, both IDTS and general charts. Any nurse rotating into the Reception role gets a handover period to ensure that familiarisation with correct reception Nurse duties is full and comprehensive. SystmOne records are subject to electronic transfer, so that they may be accessed at the receiving prison."

2. The Head of Healthcare at HMP Norwich should ensure that missing clinical records such as drug administration charts are requested immediately from sending prisons.

   NOMS accepted this recommendation. Their comments noted:

   > "This will be part of the Reception/A wing protocol and will be managed by the new lead for that area of the prison."

3. The Head of Healthcare at HMP Norwich should ensure that the referral process and priorities for mental health assessments are clear and fully understood by healthcare staff, and that referrals are appropriately monitored.

   NOMS accepted this recommendation. They commented:

   > "The mental health team has since changed its referral and management system. RMN's now case manage and there is a new clinical lead in post. RMN's are now in Reception to ensure that the capture of information and the screening process for prisoners with mental issues is addressed."

4. The Governor should ensure that families are involved and consulted about arrangements to commemorate the death of a prisoner.

   This recommendation was not accepted. NOMS said that some copies of the Order of Service were given to the family liaison officer at the funeral with a request that they be given to the man's friends on the wing. It was noted, however, that the documents contained the family's address so for security reasons they were not distributed. To comply with as much of the request as possible, relevant parts of the Order of Service were displayed in locked glass cabinets on wing landings. Cards for the family were facilitated through the prison chaplaincy.