PRISONS AND PROBATION OMBUDSMAN for England and Wales
Independent Investigations

Investigation into the death of a man in August 2011 at Norfolk and Norwich University Hospital while in the custody of HMP Norwich

Report by the Prisons and Probation Ombudsman for England and Wales

May 2013

This is the report of an investigation into the death of a man. The man was found hanging and unconscious in his cell at HMP Norwich in August 2011 and subsequently died in hospital a few days later. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was appointed to review the clinical care the man received while in the custody of Norwich. Staff at Norwich co-operated fully with the investigation. I am sorry that this report is late.

The man had long standing mental health problems and that his condition was recognised soon after arriving at the prison. Extensive continuing mental health support was put in place. The clinical reviewer raised a number of concerns over the organisation of the man's care, however overall he felt that the man received a level of care that he could have expected in the community.

The man was identified as being at risk of suicide or self-harm on arrival at Norwich and appropriate support and safeguards were put in place for a time. This investigation has identified a concern that although he later gave clear indications of vulnerability, those warning signs were not acted on and suicide and self-harm monitoring was not reinstated. Sadly, it is impossible to know whether any further monitoring would have changed the outcome for him.

The 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 **May 2013**

SUMMARY

1. In March 2007, the man was sentenced to three concurrent sentences of imprisonment, the longest being for five years. In November 2010, he was released on licence. On 8 February 2011 he was arrested on suspicion of aggravated burglary and appeared at court on 10 February. A court custody officer was concerned about the man's safety and noted that he showed signs of a mental disorder and had a history of self-harm. She therefore opened a suicide and self-harm warning form. The man was remanded into custody the same day.

2. The man arrived at HMP Norwich around 2.00pm on 10 February, and was seen and assessed as part of the reception process. The information from the court custody officer was noted, as was his history of post traumatic stress disorder, anxiety and previous self-harm. As a result the prison suicide and self-harm monitoring process (ACCT) was put in place.

3. The man was seen by a doctor the same day and his prescription confirmed with his community GP. His medical record shows that he received a number of medications for mental health problems.

4. In the following days and weeks, the man was monitored frequently under the ACCT process and there were regular review meetings.

5. On 15 February, the man was further assessed by a nurse and referred to the Mental Health In-Reach Team (MHIT). An appointment was arranged for 22 February, on a day that he was not able to attend as he had a hearing at Ipswich Crown Court.

6. On 3 March, there was a final ACCT case review meeting, when it was decided that the man's risk of self-harm was sufficiently lowered so that the ACCT plan could be closed.

7. The man saw a consultant psychiatrist on 8 March, when his medication was reviewed and a referral made for an appointment with a psychologist. He also saw a mental health support worker regularly and during these meetings frequently asked about his medication, said he was stressed about his court case and had increased anxiety and sometimes said he had thoughts of self-harm.

8. On 30 March, the man had his first appointment with the psychologist who agreed a further eight sessions aimed at providing support. His medical record does not make clear in what time frame these sessions were intended to be delivered.

9. During April, the man continued to see the mental health support worker regularly. In May, he had a further three appointments with the psychologist.

Throughout May and June, he frequently asked whether his medication could be increased as he was feeling anxious and some adjustments were made.

10. On 20 June, the man saw a psychiatrist who reviewed and reduced his medication with a view to introducing a new anti-psychotic drug. However this change was not made until 29 June, when a locum GP noticed that the changes in the original medication had not been made. Throughout the rest of June and July, the man was seen regularly seen by the mental health support worker and on 18 July, by the psychiatrist.

11. On 29 July the man told a MHIT nurse that he was anxious and stressed about his forthcoming court appearance. He again asked for additional medication. The nurse offered to meet him daily so that he could "ventilate any fears and anxiety", but there is no record that this happened.

12. On 2 August, the man had an appointment with the psychologist. A further appointment for 16 August, had to be cancelled as the psychologist was not available.

13. The man attended Ipswich Crown Court on 17 August, and pleaded guilty. He was remanded back to prison custody pending sentence. When he got back to the prison he asked to see a nurse and who said he was overwhelmed and in need of support. The nurse did not consider he was suicidal at that time.

14. On 18 August the man saw his mental health support worker. He again asked for medication to help with his anxiety, but the support worker said he appeared less anxious.

15. At 5.45am in August, officers carrying out a roll check found the man suspended from the window bars in his cell. Healthcare staff attended quickly and began resuscitation. An ambulance was called and paramedics attended and began further resuscitation treatment. The man responded and was put on a ventilator and taken to hospital.

16. The man remained unconscious and in intensive care in hospital. At 9.32pm a few days later, the man died. His family were with him.

17. We make 13 recommendations covering more efficient management of mental health care, medicines prescribing policy, appropriate use of the ACCT process, effective management of healthcare appointments, maintenance of emergency equipment, and accurate record keeping.

THE INVESTIGATION PROCESS

18. This office was informed of the man's death the day he died. Notices to staff and prisoners were issued inviting anyone with any information to contact the investigator. Two prisoners asked to speak to the investigator, one of whom wished to remain anonymous. The investigator took over the investigation on 19 September.

19. A clinical reviewer was appointed to carry out a review of the clinical care the man received in prison.

20. The prison provided the investigator with the man's prison and medical records. On 31 October and 2 November, the investigator visited Norwich and interviewed a number of prison staff. The investigator and the clinical reviewer also interviewed a number of healthcare staff. Afterwards, the investigator and the clinical reviewer provided feedback to the Governor.

21. On 29 November, the investigator attended a Clinical Review Panel Meeting at the office of NHS Norfolk and Waveney convened to discuss the findings of the clinical reviewer with the medical team before a draft clinical review was issued.

22. On 24 February 2012, the investigator and an Assistant Ombudsman, re-interviewed a doctor at Norwich who had raised some additional matters which she had felt unable to share at the first interview.

23. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of this investigation and to invite them to ask any questions or raise any issues that they wanted the investigator to consider. His family raised the following matters:

    - Why was the man not being monitored for self-harm, as he had been when he first arrived at the prison?
    - Why had it taken over 80 minutes for him to be transferred to hospital and what time had he been found?
    - Was the man seeing a psychiatrist or anyone from the mental health team?
    - What medication had the man been prescribed? .

24. In addition the man's family raised the following issues:

    - They had wanted to speak to the man's friends at the prison, but had been told that this was not possible unless the prisoners came forward of their own accord. His family wanted to know how prisoners would know to come forward.

- His family said they had been told by a prison chaplain that the man was close to a particular prisoner and asked if our investigator could speak to the prisoner. The investigator contacted the chaplain but he had no recollection of the conversation or the prisoner referred to so we were unable to identify the prisoner.

- They understood that prison officers had made "inappropriate comments" to a doctor at the hospital. The man's family were concerned that his custodial history, medical history and life had been discussed inappropriately. We have not been able to find any evidence of this.

- Although they had been offered a visit to the prison to see the man's cell, his family felt that they were rushed into making a decision to view it.

- His family were concerned that the man's letters were read by prison staff before they were posted. In some circumstances, for security reasons, prisoners' mail is monitored but we have established that the man's post was not read.

25. We hope that this report addresses some of these issues and helps the man's family gain a better understanding of the circumstances surrounding his death. We are sorry that this report is late, due to work pressures within the Ombudsman's office.

26. The man's family received a copy of the draft report as part of the consultation period. Comprehensive and substantial written representations were provided by the man's sister in response to the findings of the investigation. The man's sister remained unhappy with a significant number of issues identified in the report. Although the comments provided have led to no changes to the investigation report, the Assistant Ombudsman has sought to address, clarify and provide further information where appropriate to the points raised. This was provided by way of separate correspondence to the man's sister.

27. The service also received a copy of the draft report as part of the consultation period. No factual inaccuracies were raised, and the service responses to the recommendations are included on page 29 of this report.

HMP NORWICH

28. 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 767 prisoners. The prison's health services are commissioned by NHS Norfolk and 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

Her Majesty's Inspectorate of Prisons (HMIP)

29. Norwich was last inspected in January 2012. The inspection report notes that the prison was better than it had been historically, but was in need of a period of management stability and focus. Inspectors found that the suicide prevention policy was well promoted with good analysis of data. They found that a high number of prisoners were monitored as at risk of suicide and self-harm and there was a high incidence of self-harm. However, inspectors noted that the quality of monitoring documents varied and most were poor and did not evidence consistently good standards of day to day care.

30. In relation to healthcare, Inspectors found that service delivery arrangements were complex but some aspects to healthcare had improved since the previous inspection in 2010. The general environment in the main healthcare unit remained poor but other clinical facilities such as a day centre were of a high standard if underused. Mental health services were regarded as much improved but primary mental health services were insufficiently developed. Over one third of uniformed officers had received training in mental health awareness. Secondary mental health services had good links with the primary service and patient care was informed by a consultant forensic psychiatrist and clinical psychologist and delivered by suitably experienced nurses.

Independent Monitoring Board (IMB)

31. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In their latest published annual report, covering the period March 2011 – February 2012, the Board repeated their previous view that healthcare provision continued to be deficient but acknowledged that there had been improvements in some areas. They referred in particular to problems with pharmacy and dispensing arrangements.

32. In relation to safer custody the IMB expressed major concerns that healthcare seemed unwilling to share important information that might help keep prisoners safe. The Board noted that, although still relatively high, the number of open ACCTs (suicide and self-harm monitoring documents) had reduced from the previous year, but the number of incidents of self-harm had increased. The Board found the quality of some ACCTS unsatisfactory. While the IMB acknowledged that some mental health awareness sessions

has been held they were concerned that not all staff dealing with prisoners had been trained.

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

33. Assessment, Care in Custody and Teamwork (ACCT) 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 Norwich

34. There were no self-inflicted deaths at HMP Norwich in the two years before the man's death. However, there has been one self-inflicted death since which raises similar issues in relation to appropriate assessment of known risk factors in relation to suicide and self-harm monitoring.

KEY EVENTS

35. The man was born in Beirut, Lebanon. He said his childhood was not easy one and included abuse by some members of his family and witnessing disturbing scenes during the Lebanese war. It is not clear when it was he first came to the UK, but he received his first conviction (for shoplifting) in this country in 1979. The man was convicted and imprisoned for further offences on a number of occasions.

36. There are a number of reports in the man's prison record noting that he had said he suffered depression following sexual abuse and imprisonment by relatives during his childhood and that he had mental health problems and suffered from post traumatic stress disorder. It was also noted that he had attempted to kill himself previously, including by overdosing when he had been admitted as a mental health in patient. He had once cut one of his wrists so severely that he needed plastic surgery to repair tendons.

37. On 30 March 2007, the man was found guilty at St Albans Crown Court of three offences. He was given concurrent sentences of imprisonment, the longest of which was for five years. In November 2010, the man was released on licence, but subject to recall to prison to serve the remainder of his sentence if he breached his licence conditions. In February 2011, the man was arrested on suspicion of an aggravated burglary which had taken place the previous month. He appeared at West Suffolk Magistrates Court on 10 February and his licence was revoked. He returned to prison to continue his original sentence and to wait for a hearing in relation to the new offence.

38. A court custody officer raised a suicide and self-harm warning form as the man had made statements of intent to harm himself, and she described his behaviour as "bizarre with signs of mental disorder". She noted that the man had a history of self-harm by hanging, strangulation, overdose and cutting. The court officer wrote that the man "…suffers from post traumatic stress disorder, personality disorder and is impulsive and resourceful when it comes to self-harming. Seems fine in self but very unpredictable". She placed the man on an intermittent watch while he was held in the court cells.

39. When the man arrived at Norwich, Nurse A carried out a routine reception health screen and identified that the man had a history of post traumatic stress disorder, anxiety disorder and previous self-harm. The nurse noted that the man had been prescribed diazepam (for the short term relief of symptoms related to anxiety disorders), dihydrocodeine (for pain relief), olanzapine (an antipsychotic drug used in the treatment of schizophrenia and bipolar disorder) and zopliclone (used in the treatment of insomnia).

40. The man was then seen by a locum prison doctor, Dr A, who confirmed with Signed transcript - the man's own doctor that the medication noted during the health screening process was correct.

41. The reception officer at the prison opened an Assessment Care in Custody and Teamwork (ACCT) plan. Officer A wrote "Information received from G4S. The man has tried to commit suicide in the past. Last time was at Christmas by overdosing on alcohol and drugs. Stated to me that he could not rule out further attempts of S/H [Self-harm] or suicide". The officer completed a routine Cell Sharing Risk Assessment and decided that the man should not share a cell "because of past events when he was young. Cannot share with anyone".

42. Shortly afterwards Senior Officer (SO) A assessed the man and produced an "Immediate Action Plan". That plan indicated that the level of observation was four times per hour and the man was told how he could contact the Samaritans and Listeners (prisoners selected and trained by the Samaritans to provide confidential emotional support to other prisoners in distress).

43. On 11 February, the man was seen during a normal surgery by locum doctor, Dr B, who discussed the man's mental health issues with him. The doctor suggested the man would benefit from a mental health review, but it is not clear from the records whether the man was referred for a mental health review at that time.

44. Later that day, the man was interviewed by Officer B, one of the prison ACCT assessors who noted that the man had been experiencing a high level of emotional problems and he considered him at risk of self-harm or suicide. The officer summarised the man's situation as:

> "Brought up in Lebanon during troubles, post traumatic stress due to his upbringing, suffers from depression, treated by medication, appears noise sensitive, very edgy, shaky at times, struggled to speak, dropped cup when making tea, eye contact, thought mirror in cell was a camera, hears voices some family in London, some abroad".

45. The officer noted that the man had said he felt like hanging himself, but could not go through with it. He went on to tell the officer that he was unable to control his emotions and that he had cut, overdosed and attempted hanging previously. The officer also noted that the man felt depressed, enclosed and that he cried himself to sleep at night. The officer added that the man said he would remain "awake for days" if he did not take his medication and that he could not think of the past without becoming emotional. The man had said he "wants to end it" and that he could not control his emotions and felt isolated from his family.

46. Officer B and the man had discussed what would help, and the officer noted that as there were possible mental health issues, a quiet location would be preferred. The man told the officer he felt supported by staff and "feels better when settled".

47. After completing the assessment, a first case review was held at 4.00pm on 11 February. The case manager, Senior Officer (SO) B, Officer B, Safer Custody Nurse, B and the man attended. The SO recorded a summary of the

meeting in the ACCT plan and noted that the man was “still quite downbeat. He is not currently suicidal but does feel low”. The man discussed his case and said that he hoped to be found not guilty. He was going to apply for counselling to help him with the flashbacks he was having about Lebanon. As part of the assessment a CAREMAP was completed with two actions: that the man would be referred for a mental health assessment, and that he would be encouraged to continue with his job as a wing cleaner in order to keep his mind active. It was decided that the ACCT plan should remain open but with reduced observations, to give the man time to settle down. The man’s level of risk to himself was assessed as low. The levels of observations were reduced to two each hour. A further review was arranged for 17 February and a referral was made for a mental health assessment.

48. On 14 February, Safer Custody Nurse B spoke to the man in his cell because the man was “feeling low” and that he had had thoughts of “ending it all”. The nurse agreed to undertake a mental health assessment the following day.

49. On 15 February, Nurse B saw the man and noted that he “continues to hallucinate and feels depressed” and made a referral to the Mental Health In-reach Team (MHIT), a secondary mental health care service for prisoners with serious and enduring mental health problems. The clinical reviewer said although there was a note on the man’s computerised medical notes to say a referral had been made to the MHIT, no recognised assessment tool was used and there was no formal record of the referral. An appointment was made for the man to be assessed by a member of the MHIT on 17 February.

50. On 17 February a second ACCT case review was held. Present at that meeting were the man, the case manager SO C and Safer Custody Nurse B. Following the review, the SO noted that the man was quite open and had good eye contact. The man said that he had “good days and bad days” but tried to cope each day. The man was anxious about what his solicitor might tell him about his case, but admitted to some paranoia. It was noted that the man was due to be seen by the mental health team and the man was hoping they could help him lead a normal life “without getting too paranoid”. It was agreed to keep the ACCT plan open and the man was still assessed as low with the level of observations unchanged. The CAREMAP was updated and a further case review meeting was arranged for 24 February.

51. The planned appointment with the MHIT did not take place as the man’s name was not added to the appointment list. Instead, a nurse from the MHIT went to see the man in his cell and arranged an appointment for 22 February. That appointment did not take place because the man was required for a hearing at Ipswich Crown Court that day.

52. The following week, on 24 February, a third ACCT case review was held. This time it was chaired by SO D and the man and Nurse B also attended. The case review summary written by SO D noted “the man is waiting to see mental health. He presents as somewhat unpredictable. ACCT to remain open on hourly observations”. The document shows that the level of

observations were reviewed and reduced to hourly, his risk was still assessed as low, with a further case review meeting arranged for 3 March.

53. The next day, 25 February, the man asked Nurse Prescriber A for an increase in his medication and something to help him sleep. The nurse told the man that she could not make any changes and that she would be guided by the mental health team.

54. On 1 March, at a healthcare multi-disciplinary team meeting Nurse C reminded the MHIT that the man was still awaiting assessment by a member of the team. Following this a support worker from the MHIT later spoke to the man to reassure him.

55. On 3 March, a fourth ACCT case review meeting took place. The Case Manager, SO B, SO E, Safer Custody Nurse C and the man were present. SO E summarised the meeting and wrote in the ACCT plan:

> "The man [the man] attended his review and was very positive. He has been helping with the cleaning on A4 landing and is hopeful of getting the job. He is on medication to control his anxiety and the activity is helping him. He is hopeful an appointment with his psychiatrist will result in a slight alteration to the level of his medication. States has no other issues, has no thoughts of suicide or self-harm and would talk to staff if this changes in the future".

56. The CAREMAP goals were marked as achieved and the ACCT document was then closed with a post closure meeting arranged for 10 March. Although the goal to make a referral for a mental health assessment had been completed, at that stage the man had not had the actual assessment.

57. Five days later, on 8 March, the man saw a consultant psychiatrist, Dr A. The doctor noted that the man had a long standing medical history of borderline personality disorder, post traumatic stress and severe anxiety. The doctor also noted that the man said he was "feeling wound up" and that he could impulsively self-harm as he told the doctor he had no future. It was agreed between the doctor and the man that his Community Mental Health Service should be contacted to clarify what the doctor had been told and to build on the information. The doctor reviewed the man's medication and increased his olanzapine prescription, and prescribed zopiclone for 14 days. He also referred the man for an appointment with a psychologist.

58. On 10 March, an ACCT post-closure review was held and attended by SO F, Officer C and the man. No one from healthcare was present. The ACCT plan shows that the SO noted that the man's outlook was far more positive. The SO also noted that the man was employed and working as a cleaner and that he had been mixing with other prisoners. The meeting agreed that the ACCT plan should remain closed. There was no reference to the man's mental health assessment.

59. Between 9 and 15 March, the man was seen by a mental health support worker three times. The man's main concern was that he might not be able to cope with a long prison sentence. He had seen two doctors during that time and had been prescribed diazepam and dihydrocodeine. Dr C had reviewed the man's medication and on 15 March, issued a further seven days' prescription for zopiclone.

60. On 22 March, the man spoke to a MHIT support worker A. The man asked about his psychologist appointment and additional zopiclone medication. The records do not show what was done other than to say appropriate responses had been given. On 28 March, the man had a doctor's appointment but did not attend. His medical record does not indicate why.

61. On 30 March, and in response to the earlier request by Dr C, the man had his first appointment with a psychologist, Dr D, the consultant psychologist for the mental health in-reach team at Norwich. The doctor noted the historical information about the man's emotional difficulties and experiences and she offered advice on coping strategies. The doctor and the man agreed a further eight sessions aimed at providing support. No time frame for the sessions was specified in the man's medical record.

62. During April 2011, the man met the MHIT support worker five times. He frequently asked the MHIT support worker for changes to his medication and was told that he would need to ask the doctor. The man said that he had become stressed about his impending court appearance and he had been experiencing increased anxiety and problems sleeping. The MHIT support worker told the investigator that the man had thoughts of self-harm but had not elaborated on them. On 12 April, Dr C prescribed a one week course of zopiclone for sleeping difficulties. Later that month Dr E prescribed further dihydocodeine and olanzapine and on 26 April, Dr F prescribed diazepam.

63. In May the man had a further three appointments with Dr D. The clinical reviewer notes that the doctor focussed on the agreed plan and made her own handwritten notes, but she had not entered the information onto the man's computerised medical record.

64. On 10 May, the man's medication was reviewed by Dr F, a locum general practitioner. The doctor decided to "wean" the man off the dihydrocodeine and diazepam, but he does not appear to have discussed this plan with any of the other doctors involved in the man's care who had prescribed the medication.

65. On 11 May, the MHIT support worker saw the man and noted he had "low mood thoughts to self-harm, increased stress re pending court case…" However, on 25 May the MHIT support worker noted that the man had been in "good spirits, no thoughts of self-harm". Two days later, 27 May, the man told the MHIT support worker that he was feeling anxious and asked for his medication to be reviewed again. The MHIT support worker told him that he would discuss the request with the MHIT.

66. During May, the man also had some dental treatment including a tooth extraction.

67. On 1 June, the man had an appointment with Nurse D, of the MHIT. The nurse described the man as “agitated” and ”concerned that his medication had been adjusted”. The nurse discussed with the man ways that he could manage emotional stress, along with the support of the psychologist. The nurse noted that the man was unsure when he would be seeing the psychologist again. On 6 June, the man asked the MHIT support worker when his next appointment with the psychologist was due, but the MHIT support worker did not know. His record shows that the next scheduled appointment with the psychologist was for 2 August.

68. On 20 June, the man had an appointment with a psychiatrist, Dr G, who noted that the man had a history of long standing personality problems. The doctor said there was no evidence of psychosis or major depression. The man’s medication was reviewed during that meeting and his olanzapine was reduced from 20mg to 10mg with the aim of replacing it with quetiapine (another anti-psychotic medication). However, the reduction was not made until 29 June when a locum general practitioner, Dr B, reviewed the man’s medication and realised the change had not been made.

69. On 8 July, the man saw the MHIT support worker and discussed his medication and his anxieties about his pending court appearance, which was scheduled for 24 August. On 14 July, he saw the MHIT support worker again and talked about his increased anxiety and stress due to the court case. The MHIT support worker had noted that the man had no immediate thoughts of self-harm and that he was uncertain when his next appointment with Dr D was due to take place.

70. On 18 July, Dr G saw the man for a further review of his medication and issued the first prescription for quetiapine. On 25 and 29 July, the man declined to take his medication. He told MHIT support worker he found it difficult to manage his anxiety, especially at night. He asked for additional medication and the MHIT support worker advised him to speak to the doctor about this. There is no indication he did.

71. On 29 July, the man met saw Nurse D from the MHIT. The man again referred to anxiety and increasing stress and that asked for more medication. The nurse noted in his medical record that he had a long history of preoccupation with his medication. She offered to see the man each day so that he could “ventilate any fears and anxiety due to the pending court case” but there is no record that he took up this offer.

72. On 2 August, the man attended his appointment with the consultant psychologist, Dr D. At that meeting a further appointment was agreed for 16 August, but unfortunately the doctor was ill that day and unable to attend the prison.

73. In the meantime, it was noted that the man had not collected his quetiapine medication for three days. On 4 August, the MHIT support worker arranged for the man to collect and take the medication. He noted in the man's medical record that he appeared in a "good mood" and was managing stress, although he added that the man had not been sleeping well. Once again the man asked for additional medication and was advised to speak to a doctor. He did the same again when he saw the MHIT support worker on 16 August. Later on 16 August, the man saw Dr F who prescribed quetiapine again.

74. On 17 August, the man appeared at Ipswich Crown Court where he pleaded guilty. He was remanded back into prison custody, pending sentence.

75. One of the man's friends told the investigator that he had known the man for about five months. He described him as polite and well liked. He said that the man had told him that he suffered from depression and had attempted suicide before. The man told his friend that he was anxious about his sentence and would commit suicide if he received an indeterminate sentence because he believed he would never be released. However the man's friend did not think the man was serious about this. The man's friend said that when the man returned from court he became more isolated and remained in his cell more than usual. The man's friend said that the man spent a lot of time writing to one of his sisters and was sleeping a lot.

76. When he returned to the prison on 17 August, the man asked to speak to a mental health support worker. Nurse E saw him and described him as being overwhelmed and wanting support, but said that the man had said he was not suicidal at that time. For that reason an ACCT document was not opened.

77. The next day, Thursday 18 August, the MHIT support worker saw the man and noted he appeared less anxious, although he asked for medication to help with his anxiety. He was expecting to receive an eight year prison sentence. There is no further recorded interaction between the man and prison or healthcare staff.

23 August

78. At about 5.45am on 23 August, OSG A began the C wing roll check. When he arrived at the man's cell he thought he saw him standing by the window. At interview he said something did not appear to be correct and so he looked again and knocked on the door to try and gain a response. The OSG said he could see that the man's head was at an "odd angle". He then noticed something around the man's neck which appeared to be attached to the window frame. He radioed a code blue call for urgent assistance. (Code blue means there is a prisoner with breathing difficulties and the code system is used to alert healthcare staff to bring the appropriate medical equipment to the emergency).

79. As usual with prison staff on night duty, OSG A had a cell key sealed in a pouch for use in an emergency. He broke the seal, but was unable to get the key out. He explained to the investigator that the key was attached to a split

ring and the only way to get the key out was to unwind it from the split ring which he said took between one and two minutes.

80. Officer D told the investigator that at about 5.45am he was carrying out the morning roll check on B wing when he heard the emergency radio message and went immediately to C wing to assist. The officer said that when he arrived at the cell, which he estimated took him just a few seconds, he saw OSG A at the man's cell door. The officer looked into the cell through the observation panel and although not immediately certain, he believed the man was suspended from the window by something. He said the man was upright, but that his head was at an angle which led him to think he was hanging. The officer said he took the sealed pouch from the OSG, but like the OSG found it difficult to remove the key, which he said had been incorrectly inserted. The officer said there was a delay of between five and ten seconds before he could remove the key and he then opened the door and entered the cell, followed by the OSG.

81. Officer D and the OSG found the man was suspended by a bed sheet tied to the window bars. The officer supported the man while the OSG cut the sheet. They then placed the man on the floor.

82. At that point, the first nurse on the scene arrived. (It has not been possible to interview the nurse as he has since moved to Australia.) Officer D said the first nurse on the scene was unable to detect any signs of life so they both began cardiopulmonary resuscitation (CPR - a mixture of rescue breaths and chest compressions to manually preserve blood flow and oxygen around the body). The nurse attempted to use an ambu-bag (a device which pushes air into the patient) but it was broken and unusable and so returned to mouth to mouth resuscitation.

83. During the CPR procedure, the first nurse on the scene left the cell briefly to collect a defibrillator (a device that detects electrical activity in the heart and gives automated instructions to the user whether to apply a shock or not). The defibrillator advised not to shock but to continue with CPR.

84. An ambulance had been requested at 5.50am and arrangements were made to allow the vehicle immediate access into the prison. An emergency responder vehicle arrived first followed quickly by an ambulance with two paramedics. Ambulance staff reached the man's cell at about 5.56am.

85. The paramedics used a defibrillator which did not advise shocking the man. The ambulance crew could not detect any heart beat, but inserted an airway and provided the man with oxygen after which a pulse was felt. The paramedics administered sodium chloride to try and raise the man's blood pressure. The man responded and paramedics attached him to a ventilator. Attempts to stabilise the man took some time and he was eventually taken to Norfolk and Norwich University Hospital, arriving at about 7.00am. The man was accompanied by two prison officers and no security restraints were used.

86. On arrival at hospital a number of tests were carried out including blood tests and a Computerised Tomography (CT) scan (a scan which shows a detailed image of the inside of the body). The scan of the man's head and neck showed "global brain oedema (an excess accumulation of water in the spaces of the brain) that was consistent with hypoxic brain injury (reduced oxygen to tissues)". Following the tests the man was taken to the Intensive Therapy Unit where he remained unconscious for the next four days. On 28 August, the man's condition deteriorated significantly and he died at 9.32pm. His family were with him.

Events following the man's death

87. After the man's death all prisoners at Norwich being monitored as at risk of suicide or self-harm had their ACCT plan reviewed to check they had not been adversely affected Prisoners were informed of the man's death through Governor's notices on the wings. The chaplaincy team were also present and offered support.

88. After a death in custody there is a Prison Service requirement to hold a 'hot debrief' to 'acknowledge what happened, acknowledge the role of the staff involved, normalise the situation and ensure that immediate needs of the staff have been met'. (PSI 64/2011). Individual members of staff were contacted by members of the care team and offered support. Each were seen individually by an operational manager over a three day period but there was no group meeting of all those involved in the incident.

89. After the man's death three undated letters addressed to specific members of the man's family were found in his cell. There was also an undated letter to his family in which he asked them not to be upset and said he was "going on a journey that carries no pain" and "…at last I'm at peace now…".

Support for the man's family

90. When the man was admitted to hospital, the prison Safer Custody Manager, contacted his next of kin, his nephew and his sister who lives in France. The prison Safer Custody Manager, one of the prison's trained Family Liaison Officers (FLO) was appointed to support his family. Her log shows that she had a great deal of contact with the man's nephew and his sister. As well as comprehensive records of contact, the log shows that the prison Safer Custody Manager arranged for transport to the hospital from the airport and provided accommodation for the man's family. The prison appropriately contributed toward the cost of the man's funeral.

91. The man's family were offered the opportunity to see his cell. The offer was not taken up immediately. The prison log shows that the man's sister made a number of requests to be allowed to see the cell, but was unable to give a clear indication when she would be able to attend. The operational manager told his family that the cell still contained medical equipment used in the resuscitation which she could remove it they preferred. On 14 September,

after asking for the medical equipment to be removed, the man’s sister visited the cell, left flowers and was able to take a book which the man had been reading.

ISSUES

Clinical care

92. Before issuing his clinical review the clinical reviewer's findings were discussed at a Clinical Review Panel Meeting. He has produced a comprehensive report which those responsible for providing and delivering heathcare services will need to consider carefully. He makes 20 recommendations, five of which are repeated from previous clinical review reports relating to deaths at Norwich. We do not repeat all of the clinical reviewer's recommendations in this report, but we have reframed and included those most pertinent to the man's death.

93. In his report, the clinical reviewer said that overall he considered the healthcare the man received at the prison was equivalent to what he could have expected in the community. He emphasised that the man had regular contact with a number of clinical staff from primary and secondary health services, although he considered that some aspects of his care could have been better organised and coordinated.

94. The clinical reviewer said when the man arrived at the prison a full health screening had taken place. The man's health needs were identified and appropriate and timely responses made. He added that the man's mental health, risk of self-harm and suicide had been identified during the screening and that some action had been taken for further assessment.

The man's mental health

95. The clinical reviewer was concerned that a referral for a mental health assessment on 11 February was not formalised and was not appropriately recorded on the man's computerised medical record. He said that a mental health template was not completed and there was insufficient coverage of the man's level of risk.

96. The clinical reviewer goes on to say that the lack of rigorous referral system meant the service was not delivered in an efficient and seamless way. Initially the man was not added to the MHIT appointment list; although when this was noticed a MHIT nurse went to see him and arranged an appointment shortly after.

97. Following an assessment by a consultant psychiatrist further plans were made for the man and included a referral to a clinical psychologist in the MHIT. The clinical reviewer said it had been indicated to him that a referral to psychological services was made during discussions at a weekly healthcare multi-disciplinary meeting (MDT) held weekly. He could find just one reference to the man in the minutes of the meeting of 1 March 2011, and this referred to him not having received an appointment. Nothing about the

referral was recorded in the man's clinical record which was indicative of an informal process for referrals to psychological services.

The Head of Healthcare should ensure there is an effective method of referrals to all secondary health services, which are clearly recorded in a prisoner's computerised medical record. This should include appropriate use of relevant clinical templates.

98. The clinical reviewer was also concerned that there did not appear to be a comprehensive and accurate system to record which patients were on the caseload of secondary mental health services. There was also a lack of detailed risk assessments and use of the Care Programme Approach (CPA) to identify individual patient's needs.[1]. Such systems are an important part of ensuring an appropriate and continuing level of care

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99. When the man was eventually referred to the MHIT, the clinical reviewer said it was not clear who was the allocated caseworker responsible for the man's ongoing assessment of risk, his reviews and his care plan. He said this had been rectified when a new member of staff joined the team as his caseworker in April, but even then it had not been clearly documented.

The Head of Healthcare should ensure that a comprehensive and robust recording system of patients in secondary mental health services is implemented, to include detailed risk assessments and appropriate use of CPA.

100. The clinical reviewer commented that most interactions the man had with the MHIT were through regular meetings with a mental health support worker at the request of different practitioners. With the man's complex needs, long history of mental health difficulties and attempted suicides there needed to be clearer lines of responsibility aimed at providing a consistent approach to his care. In addition to the lack of a clear lead practitioner to co-ordinate the man's care, there was no regular formal supervision for the support worker (although there appears to have been informal support). The clinical reviewer noted that from the records and interviews carried out it would appear that the MHIT support worker had a good close working relationship with the man.

The Head of Healthcare should ensure that a policy is agreed and followed, to provide appropriate recorded clinical supervision for all healthcare staff, including support workers.

101. There were occasions when the man did not attend healthcare appointments and the records do not always make clear why this was the case. The clinical psychologist indicated in interview that this was a general problem with healthcare appointments at Norwich, partly to do with a lack of cohesion

[1] The Care Programme Approach (CPA) is a way of identifying the care needs of people with a mental illness. It provides an organised way of assessing all a persons' needs if they have a mental illness, and developing a single care plan which will ensure those needs are met.

between healthcare and prison staff, but also with healthcare. On one occasion the man had an appointment arranged on a day when he was required to be in court. Such clashes ought to be able to be avoided by more effective liaison between the prison and healthcare staff and use of the information systems available.

The Governor and Head of Healthcare should ensure that there is effective liaison and sharing of information between prison and healthcare staff to allow appropriate scheduling of appointments and activities, so that prisoners do not miss healthcare appointments and to allow continuity of care.

The man's medication

102. During his initial healthscreen the man's medications were checked with his community GP. Although it is not clearly recorded whether these were then prescribed for him in prison, it is apparent from later entries in his record that the man was prescribed a number of medications for the treatment of anxiety and pain. A nurse prescriber issued him with his medication daily to reduce the risk of him harming himself through overdose.

103. The man frequently requested changes to his medication. The clinical reviewer said that although the man's requests were managed in a clear way, when changes were made there were occasions when prescribing clinicians had delayed responding to the amended prescription for no clear reason. When the man did not comply with his medication regime, this was usually dealt with by his mental health support worker.

The Head of Healthcare should ensure that there is a prescribing policy that sets out clear lines of accountability and responsibility and those changes in medication and compliance are appropriately recorded in a prisoner's computerised medical record.

Suicide and self-harm procedures

104. An ACCT plan for the man was opened 11 February and closed 10 March. The plan is well documented, including an updated CAREMAP and shows appropriate referrals and support. However, we are surprised that his level of risk to himself was consistently assessed as low, given his history of serious self-harm and suicide attempts, his complex and troubled background, his depression, post traumatic stress and declared paranoia and anxiousness about his court appearance. We do not consider this was an accurate reflection of his risk. An initial CAREMAP objective of making a referral for a mental health assessment was achieved. We believe this objective should have been updated at subsequent reviews and the ACCT should not have been closed until the mental health assessment had been completed, which would have given further information about his risk.

105. The ACCT review on 3 March did not include anyone from the MHIT, who were involved with the man at the time and it is not clear that the MHIT was invited. The man considers that this was an example of poor communication between prison staff and healthcare. We are concerned that there appeared to be too little transfer of information and integrated working to support prisoners at risk. In such cases relevant healthcare staff who understand the needs of the prisoner should always be involved in ACCT reviews. This is an expectation in Prison Service guidance about ACCT reviews.

The Governor should ensure that all relevant staff, including representatives from healthcare attend ACCT reviews, in order to take into account all aspects of a prisoner's care and management when taking decisions about risk.

The Governor should ensure that staff consider all known risks and triggers when assessing the risk a prisoner poses to himself as part of the ACCT process.

106. In the months following the closure of the ACCT plan, the man gave clear indications that he was not coping well. He regularly told his MHIT support worker that he was anxious and stressed; particularly about his forthcoming court appearance and that he had thoughts of self-harm.

107. The clinical reviewer found that the man's clinical notes contained much information of his mental health history, previous suicide attempts and the suicide of his mother when he was a child. These should have been seen as key risks in relation to his potential self-harm, but they do not appear to have been considered. Other matters such as the stress of the man's court appearance should have been considered as key risk factors. Again this appears indicative of poor communication about safer custody concerns between healthcare and prison staff. There were a number of occasions in the months following the closure of the ACCT when consideration should have been given to placing him on a further ACCT. He was regularly seen by members of the MHIT but it was not clear to us that all healthcare staff understood the circumstances in which an ACCT should be opened.

The Governor and Head of Healthcare should ensure that all healthcare staff are trained in ACCT procedures and fully understand their responsibilities to open an ACCT when a prisoner is regarded as at risk of suicide or self-harm.

The Governor and Head of Healthcare should ensure there is an agreed procedure for appropriate sharing of information about risk between all staff groups in health services and others in the prison, with the informed consent of the individual when necessary.

Emergency Response

108. The clinical reviewer commented that the man received emergency treatment in a quick and efficient way from both the staff on duty and the emergency services.

109. However, when the man had initially been discovered hanging, the OSG and officer on duty had difficulty removing the key from the sealed pouch. The cell key had been wrongly attached to the ring and could not easily be removed, thus impeding the OSG's and the officer's attempt to get into the man's cell immediately. This led to an initial delay, but it is not possible to say whether this impacted on the outcome.

110. When the investigator raised the issue of the sealed cell key pouch with the Governor all sealed pouches were checked the same day. Nevertheless, it is a matter of concern that this had not been done earlier as we understand that the staff involved had identified it as a problem after the man's death.

111. We were concerned to find that the ambu-bag, used to try and deliver air to the man was faulty and therefore unusable. The clinical reviewer has indicated that the lack of a working ambu-bag did not impede the resuscitation attempt but it is important that emergency equipment should be kept in working order.

The Governor and Head of Healthcare should implement regular auditable checks of all emergency equipment to ensure it is in good working order at all times.

Debrief and support for staff

112. After the man's death the operational manager spoke to the staff involved individually rather than as a group. This was apparently because she had spoken to them when they were on night duty and difficult to get together. The record shows that the night manager on duty that night told her of the problems the staff had experienced getting into the cell, faulty medical equipment and he suggested that all night staff should carry a sealed cell key. However, the operational manager did not see him to get this information until 30 August, a week after the emergency incident and two days after the man's death.

113. One of the purposes of a hot debrief is to acknowledge what happened and the role of the staff involved and to "normalise the situation and ensure that immediate needs of the staff have been met". A hot debrief should be carried out in the immediate aftermath of a potentially traumatic incident, before the staff go home. We consider one should have been held immediately after the emergency incident in which the man was found hanging. A senior member of staff should act as the debriefer and a member of the care team should attend. All staff directly involved in the incident, including healthcare staff, should be invited.

The Governor should ensure that a hot debrief is always carried out in line with national policy, after any potentially traumatic event.

Support for the man's family

114. The man's family were critical of the family liaison provided by Norwich. However, we found that they were quickly informed of his admittance to hospital and regularly contacted by the family liaison officer. The comprehensive log provided to the investigator shows considerable contact and support for the man's family, including the arrangement of transport and accommodation.

115. It appears that the family were offered the opportunity to see the man's cell and eventually attended left flowers and took a book that he had been reading. There does seem to have some difficulty arranging a time suitable for all, but we have not found that the man's family were rushed into a decision to view his cell.

116. We understand that when a family member dies in custody and in tragic circumstances the loss is very difficult to accept. However, we are satisfied from the evidence we have seen that the family liaison officers at Norwich did their best to support the man's family.

Record keeping

117. In his review, the clinical reviewer said the man's electronic medical notes (SystmOne) show references made by other practitioners to the man seeing a consultant clinical psychologist for psychological therapy. However the notes were incomplete as they did not record when he had seen the consultant apart from the initial appointment.

118. At interview the consultant said that there had been problems accessing the computerised record and she had kept handwritten notes of her meetings with the man. We accept that notes of the detail of individual sessions may be kept separately, but there should always be a formal record of appointments, actions and decisions made that is accessible to other clinicians to ensure effective continuity of care.

The Head of Healthcare should ensure that all clinicians have access to the computerised medical record system (SystmOne) and ensure that all interactions and interventions with prisoners are recorded.

Staff culture at HMP Norwich

119. The consultant psychologist raised a number of issues with the investigator and an assistant ombudsman during a further interview. Most of the matters were about the general culture in Norwich prison and some of the difficulties healthcare staff experienced rather than matters which directly impacted on the man's care. Where they did, the issues the psychologist raised are

referred to elsewhere in this report such as missed appointments, poor communication between different staff groups including within healthcare and inadequate access to SystmOne. A number of more wider-ranging issues about the culture at Norwich and the healthcare department were raised when the investigator contacted the Governor the next day and followed up in writing on 27 February. While the issues raised were not necessarily directly related to the man's death they did not reflect a healthy culture or environment which would ensure prisoners' needs were met. It is beyond the scope and remit of this investigation to consider those wider concerns in more detail but nevertheless they should not go unexamined.

The Governor should examine the issues raised by the consultant psychologist and discuss with the healthcare commissioner, healthcare provider and his managers at Norwich to ensure any necessary action is taken.

CONCLUSION

120. The man had been at HMP Norwich for just over seven months when he was found hanging from the window bars of his cell. His ongoing mental health issues had been identified and he received extensive input from both primary and secondary mental health services.

121. The clinical reviewer raises some concerns about the efficiency of the mental health services at Norwich, including appropriate use of the Care Programme Approach, which should have provided a more organised means of managing the man's mental health.

122. It was clear early on that the man presented a significant risk of self-harm, and this was recognised at his reception health screen. A suicide and self-harm monitoring plan (ACCT) was appropriately put in place. This was subsequently closed as it was decided that the man was no longer at risk of harming himself. We are concerned that the man remained vulnerable and gave clear indications of this in his meetings with healthcare staff, yet a further ACCT was not put in place to support him. Information healthcare staff had about his risk what not shared with other prison staff.

123. There was a slight delay in getting access to the cell but the emergency response was mostly well carried out, so that paramedics were able to obtain a pulse when they arrived. Sadly, the man did not recover in hospital.

124. A hot debrief immediately after the man's emergency incident was not held for staff and we raise this as a concern.

125. A family liaison officer contacted the man's family as soon as he was taken to hospital and we are satisfied that the contact and support his family received was the best that could have been provided in the circumstances.

RECOMMENDATIONS *(service response in italics below)*

1. The Head of Healthcare should ensure there is an effective method of referrals to all secondary health services, which are clearly recorded in a prisoner's computerised medical record. This should include appropriate use of relevant clinical templates.
   Accepted: *An electronic read code system is being developed through System 1 which will enable an immediate referral to secondary services – this will form part of the clinical pathway within electronic case notes.*

2. The Head of Healthcare should ensure that a comprehensive and robust recording system of patients in secondary mental health services is implemented, to include detailed risk assessments and appropriate use of CPA.
   Accepted: *Secondary services have a referral/CPA register which captures all useful data. They will strengthen their risk assessment evidence and are currently working on this. All patients on their caseload are being placed onto the CPA process with the assistance of the primary mental health service.*

3. The Head of Healthcare should ensure that a policy is agreed and followed, to provide appropriate recorded clinical supervision for all healthcare staff, including support workers.
   Accepted: *Secondary mental health services (PIC) have a supervision map and a recording template in place. Serco have a clinical supervision policy in place with appropriate recording tools. The Deputy Healthcare Manager is leading the task to ensure all staff have a supervision facility in place and are using it.*

4. The Governor and Head of Healthcare should ensure that there is effective liaison and sharing of information between prison and healthcare staff to allow appropriate scheduling of appointments and activities, so that prisoners do not miss healthcare appointments and to allow continuity of care.
   Accepted: *This is work in progress, regular meetings are taking place between health and discipline to ensure an effective system is in place so that the scheduling of appointments ensures that staff and prisoners are aware of times and dates.*

5. The Head of Healthcare should ensure that there is a prescribing policy that sets out clear lines of accountability and responsibility and that changes in medication and compliance are appropriately recorded in a prisoner's computerised medical record.
   Accepted: *All medication changes have to be accessed through a patient's medical record on System 1. There is a policy in place which addresses how prescribing should involve the patient. A further policy, in draft at present, details how compliance should be managed; this currently sits with IDTS but will be extended to all dispensing areas.*

6. The Governor should ensure that all relevant staff, including representatives from healthcare attend ACCT reviews, in order to take into account all aspects of a prisoners care and management when taking decisions about risk.

Accepted: *ACCT case reviews are publicised to all staff at the beginning of each day and healthcare are invited to attend all initial case reviews or case reviews for prisoners under their care. If they wish to attend case reviews for prisoners who are not under their care this is perfectly acceptable. Agencies including mental health teams, that are involved in the care and support of prisoners in crises are invited to attend their case reviews and, where this is not possible, written submissions are requested. A RMN was present at all reviews held with the man.*

7. The Governor should ensure that staff consider all known risks and triggers when assessing the risk a prisoner poses to himself as part of the ACCT process.
Accepted: *This is in place, and is also part of the ongoing Safer Custody and Case Manager training package which is provided to all staff and case managers.*

8. The Governor and Head of Healthcare should ensure that all healthcare staff are trained in ACCT procedures and fully understand their responsibilities to open an ACCT when a prisoner is regarded as at risk of suicide or self-harm.
Accepted: *ACCT training is conducted by the establishment and is open to healthcare staff. Healthcare staff who have not received this training will be allocated in due course. ACCT training is provided in the prison every two months.*

9. The Governor and Head of Healthcare should ensure there is an agreed procedure for appropriate sharing of information about risk between all staff groups in health services and others in the prison, with the informed consent of the individual when necessary.
Accepted*: Following a recent clinical governance meeting the healthcare manager for HMP Norwich has been tasked with developing the Information Sharing Policy, the prison will be required to collaborate with this development.*

10. The Governor and Head of Healthcare should implement regular auditable checks of all emergency equipment to ensure it is in good working order at all times.
Accepted: *All emergency equipment is checked on daily basis and endorsed by a member of the healthcare team. These checks form part of the Serco mandatory audit schedule.*

11. The Governor should ensure that a hot debrief is always carried out in line with national policy, after any potentially traumatic event.
Accepted: *This is now in place, and a hot debrief will take place immediately after the traumatic event. This is part of the Duty Manager's checklist.*

12. The Head of Healthcare should ensure that all clinicians have access to the computerised medical record system (SystmOne) and ensure that all interactions and interventions with prisoners are recorded.
Accepted: *System 1 training now forms part of the induction process for all staff that require security clearance. The training focuses on read code*

entries, clinic organisation, entries and appointments. This is a relatively new introduction and has proved to be effective for all new starters.

13. The Governor should examine the issues raised by the consultant psychologist and discuss with the healthcare commissioner, healthcare provider and his managers at Norwich to ensure any necessary action is taken.
    Accepted: *The issues raised by [the consultant psychologist] will be examined by the prison, healthcare, and the healthcare commissioner.*