PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the circumstances surrounding the death of a man at HMP Norwich in December 2012

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man, in December 2012, at HMP Norwich. He was found hanged in his cell. He was 44 years old. I offer my condolences to his family and friends.

One of my investigators had conduct of this case and a clinical reviewer was also appointed to review the man's clinical care at Norwich. The prison cooperated fully with the investigation.

The man was released from a prison sentence in February 2012, but was recalled on 3 September 2012, after being charged with violent offences against his ex-wife. At a health screen when he arrived at Norwich, he said he had no physical or mental health problems, although later in his time at the prison he said he suffered from palpitations and anxiety and also had problems with alcohol. He was not assessed as a risk of suicide or self-harm, despite having a number of known risk factors. On 15 November, the man returned to court, where he was convicted of one offence and remanded in custody for trial on another. When he arrived back at Norwich, he was not assessed by healthcare staff. Shortly before he died, he told another prisoner that he was having problems in his current relationship, but prison staff were unaware of this and he was never regarded as a risk to himself.

On a morning in December, during a routine roll check an officer found the man hanging with shoelaces around his neck attached to the cell window. The officer radioed an emergency call. The nurse who responded was unable immediately to find the bag containing emergency equipment, so went straight to the man's cell to begin cardiopulmonary resuscitation. Another member of staff brought the emergency bag containing a defibrillator shortly afterwards. Paramedics arrived about ten minutes later, but found that he had died.

Although we cannot know whether this would have affected the outcome, too much reliance appears to have been placed on the man's personal presentation when assessing his risks when he first arrived. In particular, the nature and circumstances of his further charges were not given sufficient weight when assessing his level of risk of suicide or self-harm, although domestic violence is a known risk factor identified in local and national suicide prevention guidance. I am also concerned that a further opportunity to assess his state of mind was missed when he returned from court after sentencing.

The prison has accepted all three recommendations.

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 **September 2013**

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SUMMARY

1. The man was released from prison on licence in February 2012, but was recalled on 3 September 2012, after being charged with violent offences against his ex-partner. He had previously spent time in prison and was used to the regime. He reported no problems at a health screen when he arrived and was not assessed as at risk of suicide and self-harm. However, there is no record that his static risk factors were taken into account, which included the circumstances of his offence and that he had been recalled to prison. On 19 October, the man told healthcare staff that he was having palpitations and anxiety. He was prescribed colecalciferol tablets and the doctor suggested he ate a vegetarian diet. In November, he sought help for alcohol problems.

2. On 15 November, the man attended court and was sentenced and remanded back into custody on a further charge. When a prisoner attends court, healthcare staff are required to assess his well-being before he goes and on his return. The man was not seen by healthcare when he returned to Norwich.

3. A few days before his death, the man spoke to a fellow prisoner and said that he was having problems in his relationship and was worried about his potential sentence. Although he discussed his religious and spiritual beliefs regularly with a member of the chaplaincy team, it seems that he did not mention his problems to any members of staff.

4. On a morning in December, at approximately 5.45am, an officer checked the man's cell as part of a routine roll check. She noticed that he was not in his bed and then saw him apparently hanging at the bottom of the bed. The officer radioed an emergency and a colleague from the next wing and a nurse arrived very quickly. When she heard the call the nurse said she could not immediately find the emergency bag as it was not where it was usually kept so she decided to go to the cell to start resuscitation. Another nurse arrived shortly afterwards with a bag of emergency equipment. An ambulance was called at 5.50am.

5. The nurses attached a defibrillator to the man, which advised them to continue resuscitation. Approximately 10 minutes later, paramedics arrived and pronounced the man dead.

6. We make three recommendations, about the need to take all risk factors into account when assessing risk of self-harm, ensuring that prisoners are assessed when they return from court and the accessibility of emergency equipment bags

THE INVESTIGATION PROCESS

7. The Ombudsman's office was informed of the man's death on 28 December 2012. Notices were issued to staff and prisoners inviting anyone with information to contact the investigator. No one came forward as a result.

8. The investigator visited Norwich on 7 January. She met the Governor and the duty manager at the time of the man's death. She also spoke to the prison family liaison officer.

9. The investigator obtained the man's prison and clinical records and visited the cell where he had lived. She spoke to two prisoners on his landing who told her that they had been very shocked to hear of the man's death and that he had never given them any reasons to think he would take his own life.

10. An Assistant Ombudsman visited Norwich on 26 February. He interviewed several members of staff and one prisoner.

11. NHS Norfolk appointed a clinical reviewer to review the clinical care the man received in custody.

12. The investigator contacted the Coroner for Norwich who provided a copy of the post-mortem report. The Coroner has been sent a copy of this report.

13. One of the Ombudsman's family liaison officers contacted the man's family to explain about the investigation and allow them to identify any relevant matters which they wished the investigation to consider. The man's family did not have any specific issues for the investigation.

HMP NORWICH

14. 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 Waveney and provided by Serco Health and their subcontractors. There is a healthcare centre which provides 24-hour nursing cover and a dedicated unit for older prisoners.

Her Majesty's Inspectorate of Prisons. (HMIP)

15. HMIP last inspected Norwich in January 2012. Inspectors noted that the suicide prevention policy was well promoted and analysis of trends in self-harm was good, although management arrangements and the quality of self-harm documentation indicated that some of the care for prisoners at risk was inadequate.

Independent Monitoring Board (IMB)

16. Each prison has an IMB 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 the most recently published IMB annual report the IMB expressed concern that Serco, the healthcare provider, was not represented at managerial level at safer custody meetings.

Previous deaths at Norwich

17. In the twelve months before the man's death, there were two other self-inflicted deaths at the prison. Following an investigation into one of these deaths, in January 2012, we also identified the need to assess prisoners before and after court attendances.

KEY EVENTS

18. The man was released on licence from a prison sentence in February 2012 but recalled to prison in September 2012, when he was also charged with a violent offence against his ex-partner. A nurse conducted a reception health screen and recorded that there were no concerns about risk of deliberate self-harm or suicide. He told the nurse that he had not been involved with psychiatric services outside prison and the nurse described him as calm and stable. He had previously spent time in other prisons and was familiar with the prison regime. There was no reference to the factors that increased his risk of suicide and self-harm, including being recalled to prison and the circumstances of his alleged offences.

19. On 19 October, the man asked for a doctor's appointment because he was suffering from panic attacks. An appointment was made for 22 October but he did not attend. The reason is not recorded and another appointment was made for 25 October. He told the nurse practitioner that he was suffering from intermittent palpitations and, after examination, she referred him to see the doctor. A locum GP examined him at 4.13pm that day. The man told him that his heartbeat felt like it jumped or bounced and that this had been happening for the past ten days. The GP noted that the man's pulse indicated that he had an extra heart beat and that this could be an early indication of heart disease. He prescribed colecaciferol tablets, a vitamin D tablet, to help prevent heart disease. He also suggested that he ate a vegetarian diet and contacted the kitchen about a diet plan.

20. The man had previously used drugs and alcohol. On 12 November, he asked for a referral to receive help for his problems. He was referred to CARAT service (Counselling, Assessment, Referral, Advice and Throughcare) which provides assessment and services for prisoners with drug and alcohol problems. He attended appointments with a CARAT worker and completed an intervention about his use of alcohol.

21. On 15 November, the man was assessed as being fit to attend court the next day for a hearing. He was remanded back into custody until his next appearance, which was due on 18 February 2013. There is no record that healthcare staff assessed him when he returned from court as they are required to do. He did not have any further contact with healthcare staff before his death.

22. During his time in prison, the man discussed his religious needs with the Roman Catholic chaplain. At the man's request, the chaplain arranged for a spiritualist minister to come to the prison to speak to him. The chaplain told the investigator that he had received several letters from the man discussing religious matters and that they often spoke about religion when they met on the wing. They last spoke the week before he died. The chaplain did not recall the man mentioning any relationship problems.

23. A prisoner who was a friend of the man, said that he had told him that he was very worried and troubled about his potential sentence. He said that two or three days before his death, the man became "really negative" and said that he had been experiencing some family problems.

24. The prisoner said that he saw the man on the evening preceding his death, when he talked about his family issues and said that he appeared upset and "uptight". (The man's telephone records indicate that he spoke to his wife at approximately 4.40pm the evening preceding his death. After his death, prisoners told staff that he said that they had argued.) The man's friend and fellow prisoner said that they did not have time for a good chat before they were locked in their cells. The man lived in a double cell by himself. At about 8.00pm, the man's friend said he shouted across the landing to him when they were both in their cells and that the man seemed upset. Later, around midnight he looked through a gap in his cell door to see if the man's cell light was on. As it was not, he assumed that he had gone to sleep.

25. At about 5.45am on a morning in December, an officer was conducting a routine roll check on B wing when she came to the man's cell. She said that she knew the man and had spoken to him often in the previous three months and that he had always seemed settled. He had a job as a wing cleaner because of his good attitude. When she looked into his cell she turned on the light and noticed that he was not in his bed. She said that he normally slept on the top bunk. She then checked the bottom bunk but still could not see him. She then noticed an outline of a shoulder at the far end of the bed, in front of the window.

26. As the light was dim, she could not make out exactly what she could see but could tell that the man had his face towards the cell door. She was concerned that he did not appear to be moving and could not understand why he would be standing so still between the window and the bed. She banged on the cell door and shouted to him but got no response. She immediately called a code blue emergency over the radio. (A code blue is an emergency call when a prisoner is considered to be unconscious or when there is another life threatening situation.)

27. An operational support grade (OSG) was checking the cells on C wing and immediately came to help. He said it took him about 30 seconds to get to the cell. A nurse, who was in her office on the landing below the man's cell, said that when she heard the call she went immediately to get the emergency bag from the central office on A and B wing, but when she got there she could not find it. She then decided to go straight to the cell because she knew it was likely to be a serious situation and that starting (CPR) quickly might be important. For security reasons, staff based on wings at night do not routinely carry keys but have a cell key in a sealed pouch for use in an emergency. The officer broke the seal and used the emergency key to go into the cell closely followed by the OSG and nurse. She turned the cell light on and saw that the man was suspended from shoelaces tied around his neck and attached to the top of the cell window frame. The officer said that the man's face looked blue and his tongue was swollen and she suspected he was dead.

28. The OSG used his anti-ligature knife to cut the shoe laces. The nurse immediately started to perform cardiopulmonary resuscitation (CPR). She asked for an emergency bag and the officer went to get it but by that time a further nurse and the night orderly officer in charge of the prison were on their way with another bag, which the nurse had collected in case it was needed.

29. When the night orderly officer arrived at the cell, one or two minutes later, he asked control room to call an emergency ambulance. The nurses continued with CPR while they attached the defibrillator to the man. (A defibrillator is a machine which measures electricity in the heart. It can be used to deliver shocks which can help to restart the heart if there is a detectable rhythm.) The defibrillator could find no rhythm so advised that CPR should continue. The nurses continued until paramedics arrived at the cell at 5.55am. One of the nurses said that she had tried to give the man some rescue breaths but was unable to open his mouth. The paramedics checked the man and formally pronounced him dead.

30. A hot debrief was held after the man's death to offer support to the staff involved in the emergency incident. The prisoners on the wing were informed of his death and offered support. Prisoners who were being monitored as at risk of suicide and self-harm were reviewed in case they had been adversely affected by the man's death.

31. The prison family liaison officer and a prison chaplain went to inform the man's wife of his death later that morning. They offered support in arranging the funeral and a financial contribution was offered in line with national guidance.

32. After the man's death, a number of letters were found in his cell in which he indicated his intention to take his life. In one of these letters, he expressed concerns about his relationship with his wife. Several of the letters were to members of his family about personal issues. In one letter, he set out his spiritual beliefs and gave some background into his reasons for taking his life. Another of the letters was addressed to the prisoners and staff on B wing. He said in the letter that it had been a pleasure being in their company and that they had become his last family.

ISSUES

Assessment of risk of suicide and self-harm in reception

33. Prisoners who are regarded as at risk of suicide and self-harm are managed under a system known as Assessment, Care in Custody and Teamwork (ACCT). Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation.

34. Prison Service Instruction (PSI) 64/2011 states that "all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence, and take appropriate action." The PSI indicates that prisoners charged with a violent offence against another person, especially against family members, are at an increased risk of suicide. The man had also been recalled to prison, had problems with alcohol misuse and had difficulties in his relationship with his wife and ex-wife; all factors known to increase a prisoner's risk of suicide.

35. There is no evidence that the man's risk assessments took these factors into consideration when assessing his risk. Too much reliance appears to have been placed on his personal presentation. We cannot know whether a more thorough assessment of his risk factors at reception would have led to greater levels of support or affected the eventual outcome. However, it is important that all risk factors are considered and where necessary an ACCT is opened. We make the following recommendation:

    The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of suicide and self-harm and that an ACCT is opened when there is an indication that the prisoner is at risk.

Clinical issues

36. The clinical reviewer has made several recommendations about the care provided to the man. These recommendations relate to treatment for palpitations, cholesterol and the prescription of vitamin D. She has made further recommendations about support for locum doctors and the patient triage system. As these issues are not directly related to the man's death, we do not repeat these recommendations here, but refer the Head of Healthcare to the clinical review.

37. Before he attended court on 16 November, the man was assessed by healthcare staff and was considered fit to attend court. When he returned to Norwich later that day, he was not assessed by healthcare staff.

38. Prison Service Order (PSO) 3050 states:

    > "Events that require a prisoner to leave the prison and pass back through prison reception [as [the man] did] can have significant impact on the health of a prisoner."

39. The PSO refers to attendance and sentencing at court, and states that prisons must have protocols in place for screening returning prisoners for any potential healthcare, or suicide and self-harm issues. There is no evidence that the man received such screening when he returned to Norwich on 16 November. While it seems unlikely that this would have impacted on the man's eventual decision to take his own life, this was a missed opportunity to assess his mental state and offer any support if he needed it. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all prisoners returning to the prison after events which could involve a change in status, including court appearances and being questioned by the police, should be assessed for potential health or suicide and self-harm issues.

Emergency response

40. The man was found in his cell by an officer at approximately 5.45am. She radioed an emergency code to which other staff responded quickly. A nurse was on the floor below the man's cell. She responded immediately and went to the healthcare office to get the emergency bag but she could not find it as it was not where it was usually kept. She decided to go straight to the man's cell without the bag to administer cardiopulmonary resuscitation (CPR) if it was needed and then ask for an emergency bag to be brought. She arrived at the cell just as the shoelaces around the man's neck were being cut and she immediately started CPR. She asked another member of staff to get the emergency bag, but one of her colleagues had already collected one.

41. We note that, although the officer immediately called an emergency code blue, the emergency code did not result in an ambulance being called automatically and it was not until the orderly officer arrived that this was done. While this happened very quickly, guidance to prisons about medical emergency response codes, in PSI 03/2013, issued after the man's death, now requires an ambulance to be called automatically when a code blue emergency is called and we draw this to the prison's attention. On this occasion, we do not consider that appropriate emergency treatment was delayed. However, we are concerned that the emergency bag was not where it should have been and it was only by chance that a further nurse collected a bag on his way to the emergency. We therefore make the following recommendation.

The Governor and Head of Healthcare should ensure that emergency bags are kept in the same location on each landing of the prison and are returned there after use.

RECOMMENDATIONS

1. The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of suicide and self-harm and that an ACCT is opened when there is an indication that the prisoner is at risk.

   The prison has accepted this recommendation. They said, "A newly created SASH risk assessment form has been created in order for the risk on newly arrived prisoners to be assessed. This is completed in conjunction with the Primary Mental Health Team. It focuses on key triggers to self harm/suicide alongside factors such as mental health issues, current offence, length or potential length of sentence and general presentation. Following this assessment a decision is made by the Custodial Manager on duty and the Primary Mental Health on an ACCT.

   In addition, a full list of triggers to self harm/suicide is available in Reception and the medical screening room in order for staff to refer to when assessing new receptions."

2. The Governor and Head of Healthcare should ensure that all prisoners returning to the prison after events which could involve a change in status, including court appearances and being questioned by the police, should be assessed for potential health or suicide and self-harm issues.

   The prison has accepted this recommendation. They said, "Reception staff are fully aware and been reminded of the importance of this task. Head of Healthcare is to ensure that this consultation is recorded on System One for reference."

3. The Governor and Head of Healthcare should ensure that emergency bags are kept in the same location on each landing of the prison and are returned there after use**.**

   The prison has accepted this recommendation. They said, **"**The emergency response bags are located within the main offices on every wing. All staff has been briefed as to their location. The Head of Healthcare is to also ensure that all nursing staff are aware of the locations of these bags and that they are maintained in relation to their contents."