PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in December 2013 at HMP Norwich

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, who was found hanging in his cell at HMP Norwich in December 2013. He was 19 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received in prison was undertaken. HMP Norwich cooperated fully with the investigation.

The man was remanded to HMP Norwich on 7 November 2013. He had not been in prison before. At a reception health screen, he said that he had been receiving treatment for mental health problems. He was not assessed as at risk of suicide and self-harm. There was some delay requesting his hospital mental health records. The nurse who assessed him was satisfied that he did not have a mental illness, but did not consult his previous records before discharging him from the care of the mental health team on 13 December.

During his time at Norwich, the man tended to isolate himself. He did not make any telephone calls or receive any visitors. Although he was an unconvicted prisoner and could not be required to participate in activities, on 10 December, he was placed on the basic regime of the incentives and earned privileges scheme because he refused to attend an education class. On Saturday 14 December, he was moved to a single cell after both he and his cellmate requested a move. On Sunday evening a prison officer discovered him hanging in his cell. Attempts to resuscitate him were unsuccessful.

After the man died other prisoners alleged that, on Thursday 12 December, a prison officer had assaulted and threatened prisoners, including the man, after some items of the officer's property went missing. An internal disciplinary investigation found the officer had threatened prisoners and had conducted illegal searches, but there was insufficient evidence to support the allegation of assault.

The clinical reviewer found that the standard of health care the man received was not equivalent to that which he could have expected in the community. We identify a number of areas for improvement in healthcare, including the need to obtain mental health records earlier, the need to refer to these records before discharging patients from mental health care and the need for a more supportive approach to applications for medical appointments.

I am concerned that, despite having a number of risk factors that indicated his vulnerability, the prison did not identify the man as at risk of suicide and self-harm when he first arrived, an issue I have found at Norwich before. Although it was his first time in prison, there is also no record that he received an induction. Subsequently, he was not reassessed after his court appearance.

It is also a concern that the man was inappropriately reduced to the basic level of the incentives and earned privileges scheme and that no attempt was made by staff to assure themselves that his self-isolating behaviour was not

the result of bullying. These are both issues that this office has identified as linked to suicide and self-harm among young adults.

Finally, I am troubled by the unprofessional actions of the officer on 12 December and I am pleased that the disciplinary action I would have recommended has already been taken. We cannot know whether the officer's actions impacted on the man's state of mind when he hanged himself.

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 2015**

CONTENTS

SUMMARY

1. The man was remanded to HMP Norwich on 7 November 2013, charged with attempted robbery. He was 19 years old and this was his first time in prison. His behaviour was described as erratic and bizarre when he arrived and he was allegedly racially abusive towards a nurse in reception. He told a nurse that he was hearing voices and had been treated for mental health problems. A member of the mental health team assessed him the next day, but the GP did not see him. Staff requested and received his GP records quickly, but a nurse did not request his mental health hospital records until two weeks later. Although he had a number of risk factors indicating his vulnerability when he arrived at the prison, no one assessed him as at risk of suicide or self-harm. Prisoners usually spend the first night in Norwich on A wing, but pressures on space meant that he went to C wing. There is no record that he was given an induction to the prison, even though it was his first time in prison.

2. The man's GP records indicated that he had been prescribed diazepam for anxiety. The reception nurse referred him to the GP, but the prison doctor never saw him and did not re-prescribe diazepam. On 19 November, when he returned from a court appearance, he asked a nurse if he could have some diazepam. Nurses had previously been advised not to make applications on behalf of prisoners so she did not make an appointment on his behalf and did not note he had not yet seem the GP after his reception referral. She told him that he would need to make an application to see the doctor. It does not appear that he did so at that time.

3. On 22 November, the prison received the man's mental health records from hospital, which showed that he had been referred by his GP after allegedly badly assaulting his mother. He had been detained under the Mental Health Act in October and a consultant's letter of 1 November indicated he was being assessed for possible diagnoses of paranoid schizophrenia and anti-social personality disorder. A mental health nurse assessed him on 29 November, but did not read the records and was unaware of this. The nurse recorded that he did not have any problems or any thoughts of harming himself. On 13 December, the nurse concluded that there was no evidence that he had a mental illness and discharged him from the care of the mental health team.

4. The man did not always comply with the prison regime and sometimes refused to get out of bed in the morning to attend education classes. Although he was an unconvicted prisoner and could not be required to participate in activities, he was placed on a basic regime as a result. He was often described as being rude and aggressive towards staff. On Saturday 14 December, his cellmate told an officer he no longer wanted to share a cell with him because he did not keep himself or the cell clean. Shortly afterwards, he also asked to move because he said

his cellmate was spreading rumours about him. Later that day, he moved to a cell on his own.

5. The next day officers on the wing did not have any concerns about the man. Prisoners were locked into their cells for the night at approximately 5.45pm. At a roll check shortly before 8.30pm, a prison officer found him hanging from the bed frame by a ligature made of torn bed sheets. The officer immediately radioed an emergency, went into the cell, cut the ligature and together with another officer, tried to resuscitate him. Nurses arrived and took over the resuscitation attempt until paramedics arrived. Just after 9.00pm the paramedics pronounced that he had died.

6. The day after the man died a prisoner told a member of the prison's Independent Monitoring Board that, on Thursday 12 December, an officer on the wing had assaulted and threatened the man after some personal items had gone missing from the officer's bag. The prison referred the allegations to the police but this did not result in criminal charges. An internal investigation led to disciplinary charges against the officer, who was found to have threatened prisoners and conducted inappropriate searches. Disciplinary action was taken against the officer. There was insufficient evidence to substantiate the allegation that the officer had assaulted the man.

7. The clinical reviewer was not satisfied that the man received a standard of healthcare at the prison equivalent to that which he could have expected in the community. Mental health records should have been requested earlier and should have been fully considered and taken into account before the nurse assessed him and discharged him from the care of the mental health team, two days before his death. While we accept that it would have been difficult to predict his actions, we consider that he should have been identified as at risk of suicide and self-harm when he first arrived at the prison and given appropriate support. He was young, in prison for the first time and had spent several periods in hospital for mental health problems in the previous year. All of these factors are known to increase the risk of suicide and self-harm, especially in the early weeks in custody. We make three recommendations about these issues.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

9. The investigator went to the prison on 19 December. He visited the wing where the man had lived, spoke to prisoners who knew him and obtained copies of his records. He subsequently interviewed members of staff at Norwich. He gave the Governor provisional feedback about the preliminary findings of the investigation.

10. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. She joined the investigator for interviews with healthcare staff and they discussed their findings together.

11. The investigator discussed the circumstances of the man's death with the police officer in charge of investigating the allegations against the prison officer. The officer gave him transcripts of police interviews.

12. We informed HM Coroner for Greater Norfolk District of the investigation who provided the results of the post-mortem examination. We have sent the Coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted the man's mother to explain the investigation and invite her to identify issues she would like the investigation to consider. She did not have any specific additional questions for the investigation.

14. The man's family received a copy of the draft report. The solicitor representing his family wrote to us with a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP & YOI NORWICH

15. HMP & YOI Norwich is a multi-functional prison, predominantly serving the courts of Norfolk and Suffolk. The prison holds up to 767 men. Serco Health and their subcontractors provide health services at the prison. There is a healthcare centre which provides 24-hour nursing cover and a dedicated unit for older prisoners. There is no CCTV coverage on B wing where the man was held.

HM Inspectorate of Prisons

16. In the report of an inspection of Norwich in August 2013, inspectors noted that not all newly arrived prisoners were interviewed on their first night to identify risk and they were not assured that all prisoners received a full induction. They were concerned that staff had too little time to manage prisoners in crisis or feeling anxious during their early days in custody. Levels of violence were relatively high and inspectors said that too many prisoners said their isolation and anxieties about safety led them to self-harm. There were serious weaknesses in case management and planning for prisoners regarded as at risk of suicide and self-harm. Inspectors found that relationships between staff and prisoners were reasonable, but were sometimes superficial and prisoners found it difficult to get basic issues sorted out.

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its latest annual report to the end of February 2013, the IMB was concerned about the effect of staff shortages and sickness on the prison regime. The IMB noted that the personal officer scheme did not work well and that wing officers did not know their prisoners. ACCT documents did not indicate quality interactions with prisoners. The IMB recognised that reception staff were welcoming, but considered that the reception building was an austere introduction to prison life for more vulnerable prisoners arriving at Norwich. The IMB was concerned that some recommendations from Prisons and Probation Ombudsman's reports into death in custody were repeat recommendations and intended to monitor implementation more closely.

Previous deaths at Norwich

18. The man's death was the fifth apparent self-inflicted death at Norwich in the last two years. We have previously made recommendations about the need to improve the identification of prisoners at risk of suicide and self-harm, particularly when they first arrive at the prison. We repeat a recommendation about this in this report.

Assessment, Care in Custody and Teamwork (ACCT)

19. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the 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. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

20. On 7 November 2013, the man was remanded to HMP Norwich charged with attempted robbery. The police were also investigating other possible charges. The person escort record (PER) that accompanied him from court noted that in addition to the robbery charge, he was suspected of assaulting family members.

21. During the reception process, the man was noted to be acting chaotically and bizarrely but it is not clear in what way, except that he said he was hearing voices and kept changing his answers to questions. A nurse alleged that he had been racially abusive to her in the reception area. An officer warned him about his behaviour, but he denied saying anything.

22. A nurse conducted an initial reception health screen and noted the man's erratic behaviour. At first she thought that he might be under the influence of illegal drugs, but a test was negative. He said that he took diazepam to counteract depression and anxiety, that he was hearing voices and had previously been treated in a psychiatric hospital. She referred him to the mental health team. She also referred him to the prison doctor to assess whether he required diazepam and whether a detoxification programme was necessary, because, despite the negative drug test, she was concerned about his presentation. He gave his consent for his previous medical records to be obtained from his doctor and these were requested. She told the investigator that she had had no concerns that he might be at risk of harming himself.

23. Reception staff noted that the police national computer recorded that the man suffered from depression. Because he had allegedly made racist comments, an officer recommended on his cell sharing risk assessment that he should share a cell only with someone from his own ethnic group. The assessment noted that at this stage he was potentially a high risk to a cellmate. Although newly arrived prisoners usually go to A wing, he was allocated to a single cell on C wing. This appears to have been because there was no space on A wing, but this was not recorded. There is no record that he received an induction to the prison.

24. On 8 November, the man was moved to a cell on B wing. That day, the prison received a fax from his doctor confirming that he had been prescribed a low dosage of diazepam, to counteract anxiety and that he had been under the care of the mental health team at West Suffolk Hospital. The prison doctor did not see him, but noted on his electronic record that he did not need a detoxification programme. The doctor noted that his prescription of diazepam had been an acute prescription, meaning for a short-lasting condition that did not require ongoing medication, and did not re-prescribe it.

25. That afternoon, a nurse assessed the man's mental health. He told the nurse that earlier in the year he had admitted himself to a psychiatric hospital in Ireland and had been assessed for suspected schizophrenia. He reported hearing a voice. He said that he sometimes felt too lethargic to maintain his personal hygiene and that since arriving at the prison he had mostly stayed alone in his cell and had not eaten much. He gave his consent for the nurse to obtain further records about his mental health treatment. The nurse noted that he did not have a history of self-harm and was at low risk of harming himself or others. (His cell sharing risk assessment was subsequently changed to standard risk meaning that he could share a cell.)

26. Two prisoners were already on B wing when the man arrived. They noticed that other prisoners were aware that he had never been in prison before and tried to take advantage of him by lending him tobacco then asking for repayment with substantial interest. They recognised that he was vulnerable and said that this stopped after they had intervened on his behalf.

27. On 11 November, one of the mental health team's support workers saw the man in his cell. He said that he appeared to be in good spirits and engaged well in conversation. His cell was clean and tidy and his personal hygiene was acceptable. He told him that he had no problems with staff or prisoners and had no thoughts of suicide or self-harm.

28. The man attended court on 19 November and, when he returned, he asked the reception nurse if he could have the prescription of diazepam he had been receiving before he came to prison reinstated. She did not refer him to see the doctor herself because a previous healthcare manager had advised nurses not to make appointments for prisoners. She told him that he needed to make an application to see the doctor and said she checked with him that he knew how to do this. He did not make an application at the time and never saw a GP while he was at Norwich.

29. On 22 November, two weeks after seeing the man, the mental health nurse contacted the hospital to request his medical records, which were received the same day. The records confirmed that he had been admitted to hospital for mental health care in Ireland, in May and September 2013, and in Suffolk, in October 2013. The nurse said at interview that a two-week gap between the initial mental health assessment and requesting previous records would be average for a non-urgent case.

30. The man attended court again on 25 November. When he came back to the prison a member of healthcare staff did not assess him.

31. On 29 November, the mental health nurse assessed the man. In the consultation, he said that he had been eating and sleeping well. He had not been hearing voices and said that he had no suicidal thoughts.

He did not seem to be delusional and was reasonably presented. The nurse had seen a letter of 17 September from a hospital in Ireland, which indicated that the psychiatrist believed his psychosis was related to substance misuse. The nurse had not read the information from the other hospital which had been sent on 22 November. This contained a letter of 1 November from a consultant psychiatrist explaining that he had been referred by his GP for an assessment due to a bad assault on his mother. During this assessment he had become very abusive and had walked out of the hospital. The consultant had considered that he was a risk to his family and he had therefore been detained under Section 136 of the Mental Health Act. The consultant explained that diagnoses of paranoid schizophrenia and anti-social personality order were being assessed.

32. On 30 November, the man's cellmate required medical attention and a nurse attended the cell. While the nurse was assessing him, the man stuck his middle fingers up at him. The nurse reported this to wing staff and an officer gave him a negative behaviour warning.

33. On the morning of 2 December, the man said that he felt unwell and did not leave his cell to go to an education class. He stayed in his cell for the rest of the day. The next morning, he did not attend education again and stayed in bed. That afternoon, an officer responded to him ringing his cell call bell. He told him that he wanted to work in the waste management department, which was why he was refusing to attend education. The officer said that he tried to explain the procedures when prisoners refused to attend work or education (which can include limiting their access to wing privileges), but he told him to "fuck off out of my cell".

34. On 9 and 10 December the man again said he felt unwell and stayed in his cell and did not go to his education class. As a result, he was placed onto the basic level of the Incentives and Earned Privileges Scheme. On 10 December, he made an application to see the prison doctor about his mental health. An appointment was made for him to see the doctor on 12 December, but he did not attend. No reason is recorded in his medical record.

35. Officer A, who normally worked in the segregation unit in Norwich, was working an extra shift on B wing on 12 December. While working there he left his bag unattended in the unlocked wing office and some items (coffee and toiletries) were taken from it. He looked for these in some prisoners' cells and asked around the wing if anybody knew what had happened to his possessions. A prisoner suggested that the man might have been involved and he was one of a number of prisoners the officer spoke to about the missing items.

36. On 13 December, the mental health nurse reviewed the man again. He said that he heard voices all the time, but during the consultation he said that the voices were really his own thoughts. He repeated that he

wanted to be prescribed something to calm him down, but then agreed that he had been calm through his time in prison. The nurse concluded that there was no evidence of mental illness, and he discharged him from the care of the mental health team. At interview, he said he made this decision based on his own observations and the letter from the hospital in Ireland. He had still not read the information from the other hospital, which had said the man was being assessed for possible paranoid schizophrenia and anti-social personality disorder.

37. Officer B was the man's personal officer on B wing. (Personal officers should be the first point of contact for any problems and get to know and support the prisoners they are responsible for.) He told the police that on Saturday 14 December, the man's cellmate asked to move cells. He said that the man was dirty and did not clean up after himself and he thought he would end up hitting him. Soon after, the man told the officer that his cellmate was spreading rumours about him and that they needed to be separated from each other as he might hit him. That afternoon cell B2-29, a double cell on the same landing, became free, so the officer decided to move him there as the only occupant. He said that he seemed happy with that outcome.

38. The officer was working on B wing a few days later. He told the police that the man seemed positive that day. He had interacted well, had a shower and cleaned his cell. At approximately 5.35pm, prisoners were locked into their cells for the night. He said that he had locked the man's cell and had noticed nothing untoward. He had not appeared distressed in any way. The only thing that struck him as different was that his cell was clean and tidy which was a contrast to what it was like usually.

39. At approximately 8.25pm, Officer C began a roll check on B wing. When he reached the man's cell, about five minutes later, he looked through the observation panel and noticed bedding hanging over the frame of the bed. He switched on the cell light and could then see him hanging from a ligature made from bed sheets attached to the bed frame. (Although he was the only person in the cell, the cell contained bunk beds.) The officer radioed a code blue emergency to indicate a life threatening situation. At night, officers do not carry cell keys on their key chain, but have a key in a sealed pouch for use in an emergency. He used his emergency key to unlock the cell. The man had placed a chair behind the door, which made it difficult for him to get into the cell immediately. Officer D arrived in response to the emergency call just as the officer managed to open the door. The control room requested an ambulance at 8.31pm.

40. Officer D supported the man's body while Officer C cut the ligature and laid him on the floor. Officer D said that the man was motionless, his eyes were open, and there were no signs of breathing. The prison officers began cardiopulmonary resuscitation, and at this point a nurse arrived. He applied a defibrillator, which did not indicate any shockable

heart rhythm. Officer C applied oxygen. The nurse noted that the man was pale, had no pulse, his pupils were fixed and he was not breathing. Other nurses arrived and the prison officers left the cell to allow the healthcare staff to continue attempting to resuscitate him. Paramedics arrived at the cell at 8.40pm and took over the attempts to revive him. Sadly, these were unsuccessful and, at 9.04pm, the paramedics agreed that he had died.

Liaison with the man's family

41. The man had nominated his mother as his next of kin and the Governor and an officer who acted as the prison's family liaison officer (FLO) went to her home that evening to break the news of his death. The FLO continued to liaise with the family in the days that followed.

42. The funeral was held in Ireland on 3 January 2014. In line with national guidance, the prison contributed to the funeral costs.

Support for prisoners

43. Prisoners who had been friends of the man were identified and informed individually of his death and told how to access additional support if they needed it. Prisoners who had been identified as at risk of suicide and self-harm and managed under ACCT procedures were reviewed in case they had been adversely affected by his death.

Support for staff

44. Prisons are expected to hold a 'hot' debrief for the staff involved in a traumatic incident such as a death quickly afterwards to allow the staff to discuss together what happened, identify any concerns and ensure they are appropriately supported. A debrief meeting was not held, but each member of staff involved was debriefed individually by the duty governor. Those who had already left the prison were debriefed the following day. The staff care team was available to provide support to any staff who needed it.

Post-mortem

45. A post-mortem examination concluded that the man had died from hanging. No bruising was found on his face at the examination. A triangular pink mark was noted, but this was not a bruise, such as would have been expected from an assault.

Allegations made after the man's death

46. On 16 December, Officer B was on duty on B wing when a group of prisoners told him that Officer A had either threatened or assaulted the man the previous week. He submitted a Security Information Report (SIR).

47. That same morning, Monday 16 December a member of Norwich's Independent Monitoring Board was at the prison reception area to support a prisoner who was being released. The prisoner asked to speak to him in private. He then told him that the man had been threatened by a member of staff. He said that on Thursday 12 December, when Officer A was trying to recover the items stolen from him, he had searched prisoners and their cells, and had assaulted and threatened prisoners, including the man. Officer A had been due to work on B wing on the Sunday evening and the prisoner said that the man had been worried that this would result in the officer assaulting him. The IMB member passed this information on to the deputy governor. The allegations were then referred to the police, and the Governor also commissioned an internal investigation.

48. Also on the morning of 16 December, a prisoner told the prison Imam that Officer A had threatened the man. He said that another prisoner would corroborate this and the Imam spoke to the other prisoner. They both agreed to make statements and the Imam passed the information to one of the prison's operational managers.

49. Staff asked prisoners on B2, where the man had lived, to make statements and the police interviewed some of them. We also interviewed some of the prisoners. There were a number of allegations that Officer A had threatened prisoners and some prisoners said that they had specifically heard him threaten the man. Some alleged that he had assaulted him, although most of these were hearsay accounts. One prisoner told the police that he had witnessed the officer assault the man, but later withdrew the allegation. Two prisoners said that they had noticed red marks on his face later that day. Some prisoners reported that other prisoners had bullied the man. (Possibly relating to the incidents that two prisoners recounted when they had intervened.)

50. Police interviewed Officer A. He said that on Thursday 12 December he discovered that he had had some coffee stolen from his bag prior to conducting fabric checks on the cells on B wing. While conducting the checks he therefore also looked out for his coffee and anything else that may have been taken from his bag. He said that he had no success, so asked around the wing to see if he could identify the culprits. A prisoner told him that it was the man and his cellmate. He said that he spoke to them, but did not search them or their cell, as he had already searched it during the fabric check. He denied threatening or assaulting any prisoners. He told the internal prison investigation that he had conducted some rub-down searches on some prisoners during the fabric check. During the internal investigation he said that either the man or his cellmate had admitted stealing his possessions and said that they would try to recover them for him and he had said that he might not be able to get back to the wing until Sunday, 15 December.

51. Another prisoner on the wing told the police that early in the afternoon of Sunday 15 December he saw Officer A go into the man's cell. He emerged with a pack of face wash. The officer told the police that while visiting B wing to distribute some papers he had looked into some cells and in the man's cell he had noticed a pot of cream that he recognised as his. He went into the cell and asked him if it was his. He said that he told him that it was and apologised that he had been unable to recover any more of his property. The officer said that he thanked him and left the cell. He said that he did not go back onto B wing again until he responded to the emergency call that evening.

52. Some prisoners reported that, on the afternoon of Sunday, 15 December, the man had been upset when in the exercise yard. Officer A was scheduled to be on duty on B wing that evening and he had said that he was concerned about what he might do. Another prisoner said that the man had told him that the officer had visited him earlier and had said that he would return and assault him later.

53. The police did not bring any charges against Officer A. As a result of the internal prison inquiry, a disciplinary case was brought against him. He was found guilty of three charges of threatening prisoners and making inappropriate searches. A charge that he assaulted the man was not upheld.

ISSUES

Healthcare

54. The clinical reviewer notes that some aspects of the man's care at the prison was not equivalent to that he could have expected to receive in the community. Healthcare staff did not request record of his previous mental health care until 22 November. The clinical reviewer considers they should have been requested when he was first assessed by the mental health team on 8 November. This is especially important when a prisoner indicates that they have a significant history of mental illness, as he had reported. We make the following recommendation:

The Head of Healthcare should ensure that previous records are requested promptly when prisoners indicate a history of mental health problems.

55. When the mental health nurse assessed the man on 29 November and 13 December, he had not read the information that had been received from the hospital on 22 November. This showed that the man was being assessed for paranoid schizophrenia and anti-social personality disorder. Without knowing this the nurse discharged him from the care of the mental health team, and considered that he was not suffering from any mental illness and was not at risk of harming himself. The nurse said that had he seen the information he might have considered discussing him with the secondary care mental health team but he believed that this would not have a significant difference to his management as he was not presenting as acutely unwell at the time. We are surprised that the nurse would still have regarded it as appropriate to discharge him from the care of the mental health team when he was being assessed by a consultant psychiatrist for serious mental health problems.

56. The clinical reviewer concludes that the failure to review all the available documentation was unacceptable. She considers that procedural changes need to be made at Norwich to ensure that there is no repeat. We agree and make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff fully prepare for patient reviews and read all available relevant information.

57. The man never saw a GP during his time at the prison. The reception nurse referred him so that his prescription of diazepam could be considered, but the doctor decided that, as it had been an acute prescription (i.e. for a short-term condition), it was not needed. A young man's first time in prison could well be a trigger for depression and anxiety and we are surprised that the doctor did not want to see him in person to reach that decision.

58. When the man returned from court on 19 November, he asked if he could see a doctor to request diazepam. The nurse followed previous guidance from a former Head of Healthcare advising staff that prisoners should make their own applications for appointments and suggested that he should do so. The current Head of Healthcare said that this was no longer the preferred way of dealing with such requests, but the healthcare staff seemed to be unaware of this. Many prisoners are unfamiliar with administrative procedures in prisons and should not have obstacles put in their way which impedes access to help such as from a GP. He was a young man, in his early days in custody, had never been in prison before and had not attended a prison induction programme. We make the following recommendation:

The Head of Healthcare should ensure that nurses refer prisoners to the GP or help them make an appointment when they ask to see a doctor about an appropriate health concern.

59. When the man returned from court on 19 and 25 November he was not assessed by a nurse. (The conversation with the nurse on 19 November was when he approached her for help about his medication.) Prisoners returning to Norwich from court are assessed only if there has been a change in their circumstances. Prison Service Order (PSO) 3050 notes that appearances at court can have a significant impact on the health of the prisoner and states that prisons should have a protocol that screens prisoners passing through reception for any potential healthcare or suicide/self-harm issues.

The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health or suicide and self-harm issues after all court appearances.

60. The man made an appointment to see doctor on 12 December, but did not attend. When Her Majesty's Inspectorate of Prisons inspected Norwich, in August 2013, they found a high rate of non-attendance at healthcare appointments. Prisoners said that they did not always receive appointment slips informing them of their appointments. Prisoners need to be escorted to healthcare appointments and it cannot be assumed that a failure to attend is a result of the prisoner's decision. There is no reason recorded to explain why he did not attend on 12 December, and nothing on his file to show that he was told of the appointment. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners are notified of their appointments and, if they do not attend, the reasons for non-attendance are written on the prisoner's medical record.

Assessment of risk

61. When prisoners arrive at Norwich, prison reception staff use a risk assessment form to gauge whether the prisoner has any factors which can indicate that they are at heightened risk of self-harm or suicide. These factors are listed as:

- Have they returned from court with a change in status?
- Do they have the potential to or received a long sentence?
- Are they on an alcohol/drug detox?
- Are they a licence recall?
- Are they a Foreign National subject to deportation?
- Is their current offence violence towards a family member, another person, or arson related?

The form states that if a prisoner has an accumulation of these factors then serious consideration must be given to opening an ACCT.

62. The form is a useful reminder to reception staff of some of the factors that increase the risk of suicide and self-harm. We accept it cannot be fully comprehensive, but it does not refer to a number of other highly significant risk factors such as it being the prisoner's first time in prison, their age (especially if they are young), or a history of mental illness. All of these factors applied to the man. Although it was not the offence for which he was remanded, the person escort record (PER) that accompanied him from court noted that he had assaulted family members, which is on the prison's list.

63. There is nothing to suggest that the man's presentation gave any indication to staff that he was a particular risk of self-harm when he arrived at Norwich and we note that someone from the mental health team (although not aware of his full psychiatric history) saw him several times and did not identify any concerns about suicide or self-harm. However, he had a number of risk factors when he first arrived at the prison that staff do not seem to have taken into account when they assessed his level of risk. Staff working in reception (and all staff working with prisoners) need to be aware of all the potential risk factors to allow them to make a decision whether the prisoner needs the additional support of being managed under ACCT suicide and self-harm prevention procedures.

64. We made a recommendation about this issue, after the death of a prisoner at Norwich earlier in 2013. In response, the prison said that they had introduced a new risk assessment form for reception staff to help them identify the known risk factors of newly-arrived prisoners. The prison said that the form focussed 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. We were told that a full list of triggers for increased risk is available in reception and the medical screening room.

65. We have recently completed another investigation into a death at Norwich in November 2013. In that case, the prisoner said that he did not intend to harm himself, but there was no record to indicate what factors had been considered when staff decided that he was not at risk of suicide and self-harm and to explain why an ACCT was not opened. There are similar issues in the man's case. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception, first night staff and all others who assess risk:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Note and consider all information from suicide and self-harm warning forms and PERs.**
- **Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm.**
- **Open an ACCT when a prisoner appears at high risk, irrespective of his stated intentions.**

Induction

66. New prisoners in Norwich are usually held on A wing unless they are prisoners who need to be kept apart from others because of the nature of their offence, or require medical care, including detoxification. The man did not fall into these categories, but went to C wing on his first night and from there to B wing. The reason for him bypassing A wing is not recorded in his record but seems to have been because there was no room on A wing at the time. As a result, it does not appear that he received an appropriate prison induction. This is a particular concern as he was a young person experiencing prison for the first time. This means that he might not have understood how to get help if he needed support or how to make a healthcare appointment. Prison Service Instruction 74/2011 covering early days in custody, requires all prisoners to have an appropriate induction so that they "understand how to access support and facilities available to them in this establishment". We make the following recommendation:

The Governor should ensure, in line with PSI 74/2011, that all prisoners receive essential induction information.

Incentives and Earned Privilege (IEP) Scheme

67. After refusing to attend education on more than one occasion, the man was downgraded to the basic level of the IEP scheme on 10 December. At Norwich unconvicted prisoners and convicted prisoners are held

together and the prison expects all prisoners to participate in the regime.

68. Guidance on the IEP scheme is contained in Prison Service Instruction (PSI) 30/2013. This says:

> "Unconvicted prisoners have not been found guilty of an offence and their time in prison should not be seen as punitive. For this reason, they hold certain rights under Prison Rules. For example, they are not required to engage in sentencing planning discussions or work, but may choose to do so where sufficient work is available. They are, however, required to comply with the regime and should be encouraged to take part in activities. If they refuse to participate, they may be locked up while the activity is taking place. If no work or activity is available, they may be unlocked and allowed to associate where operationally possible. They may receive as many visits as they wish within reasonable limits and are not required to wear prison issue clothing."

69. The Head of Residence and Services at Norwich said that part of their IEP requirement is to participate in the regime. If a prisoner refuses to attend work or education, this is challenged through the IEP scheme, and often results in a downgrade of the prisoner's IEP level until they participate. The man's record shows that he was downgraded to the basic level of IEP because of "persistent refusal" to attend education. This is not consistent with the rights of an unconvicted prisoner who chooses not to take part activities, outlined in the PSI. If unconvicted prisoners choose to exercise their legal rights they should not be penalised under the incentives and earned privileges scheme. The prison is entitled to lock them in their cells, but not to remove standard privileges.

70. The man had mental health problems and other vulnerabilities which are likely to have been exacerbated by the more restricted regime available to vulnerable prisoners. The Prisons and Probation Ombudsman's recent learning lessons bulletin on self-inflicted deaths among prisoners aged 18-24 found that at the time of their death, 16% of the 18- 24 year olds were on the basic level compared with 6% in other self-inflicted deaths for older prisoners, underlining the need to ensure that decisions to move young prisoners to the basic level are fully justified. We make the following recommendation:

The Governor should ensure that unconvicted prisoners are not placed on the basic level of the incentives and earned privileges scheme because they chose not to work or participate in other activities.

Allegations of bullying

71. One prisoner told the investigator that other prisoners had tried to take advantage of the man because it was his first time in prison, by lending

him tobacco then asking for repayment with interest. He said that he had intervened on his behalf and this put an end to it. Another prisoner said that he had also intervened and that he had not had any further problems from other prisoners. Some prisoners speculated that he might have refused to attend education because he was frightened of being bullied there.

72. A sudden decision not to attend a particular activity can often be a sign that a prisoner is being bullied. Although the man was put on the basic regime as a result, the possibility that he was being bullied does not appear to have occurred to staff and was not investigated. While there is no evidence that he was subject to bullying, beyond the incidents reported, it is important that all indicators of potential bullying are investigated. The recent Prisons and Probation Ombudsman's learning lessons bulletin on self-inflicted deaths among prisoners aged 18-24 found evidence of bullying or intimidation from other prisoners in 20 percent of the deaths examined. This does not mean that bullying led to their deaths but it can increase stress for prisoners already vulnerable in other ways. We make the following recommendation:

The Governor should ensure that indicators such as lack of engagement and refusal to go to work and activities are recognised as signs of potential bullying and recorded and assessed as part of the prison's violence reduction strategy.

Allegations against Officer A

73. Information that the man was worried because Officer A had threatened him was only brought to the prison's attention after he had died. Officer B spoke to him on Saturday 14 and Sunday 15 December and he told the police that he did not say he had been assaulted, bullied, or threatened by anyone. Both the police and the prison have investigated whether Officer A assaulted him, and have found that there was insufficient evidence to prove this. However, it is concerning that Officer A was found to have threatened and searched prisoners without proper justification. We are satisfied that there has been an appropriate investigation by the prison into the allegations against him and that disciplinary action has been taken as a result.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that previous records are requested promptly when prisoners indicate a history of mental health problems.

2. The Head of Healthcare should ensure that all healthcare staff fully prepare for patient reviews and read all available relevant information.

3. The Head of Healthcare should ensure that nurses refer prisoners to the GP or help them make an appointment when they ask to see a doctor about an appropriate health concern.

4. The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health or suicide and self-harm issues after all court appearances.

5. The Governor and Head of Healthcare should ensure that prisoners are notified of their appointments and if they do not attend, the reasons for non-attendance are written on the prisoner's medical record.

6. The Governor should ensure, in line with PSI 74/2011, that all prisoners receive essential induction information.

7. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception, first night staff and all others who assess risk:

    - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
    - Note and consider all information from suicide and self-harm warning forms and PERs.
    - Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm.
    - Open an ACCT when a prisoner appears at high risk, irrespective of his stated intentions.

8. The Governor should ensure, in line with PSI 74/2011, that all prisoners receive essential induction information shortly after their arrival.

9. The Governor should ensure that unconvicted prisoners are not placed on the basic level of the incentives and earned privileges scheme because they chose not to work or participate in other activities.

10. The Governor should ensure that indicators such as lack of engagement and refusal to go to work and activities are recognised as signs of potential bullying and recorded and assessed as part of the prison's violence reduction strategy.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that previous records are requested promptly when prisoners indicate a history of mental health problems.	Accepted	The Mental Health Manager has implemented a Standard Operating Procedure (SOP) containing clear guidance on how to promptly obtain patient's records when presenting with mental health problems. The new SOP has been disseminated to all healthcare professionals within the Norfolk Cluster. There is a single page pro forma that both the requesting nurse and the prisoner sign. A copy of the request is scanned and placed on the prisoners system 1 record.	Complete. Head of Mental health	
2	The Head of Healthcare should ensure that all healthcare staff fully prepare for patient reviews and read all available relevant information	Accepted	This requirement has been communicated to all staff via all staff meetings and minuted to ensure there is evidence that healthcare staff have been informed.	Complete Head of Healthcare	
3	The Head of Healthcare should ensure that nurses refer prisoners to the GP or help them make an appointment when they ask to see a doctor about an appropriate health concern.	Accepted	The new healthcare triage system was implemented on the 1st September 2014 to ensure that prisoner patients are referred to the appropriate healthcare professional in 2 days. The triage system operates when a patient applies to see the GP, which results in the triage	Complete Head of Healthcare	

			nurse reviewing the prisoner in person and an initial consultation will then take place. A triage template is completed for each prisoner seen and retained within the prisoner's medical notes. After the initial triage consultation, nurses will arrange an appointment with the GP within 2 working days, and details of the GP appointment are provided to the prisoner at the triage appointment. If it is deemed necessary for the prisoner to be seen more promptly, the triage nurse will arrange a GP appointment for either the same day or within 1 working day.		
4	The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health or suicide and self-harm issues after all court appearances	Accepted	All prisoners returning from court who have a change of circumstance, or who reception staff have any concerns about, are seen in reception by Health Care. Reception staff will be reminded of the fact that a court appearance that does not result in a change of circumstances can also have the effect of increasing the risk of self-harm or suicide, and that it is their responsibility to be vigilant in their interactions with returning prisoners. They will be reminded that: - where they identify a clear risk of self-harm or suicide they must open an ACCT; - where they have some concerns or have received information that there may be an issue, but are not sure that an ACCT is warranted, they should refer the prisoner to healthcare staff for a more detailed assessment of risk.	Complete Head of Healthcare	
5	The Governor and Head of	Accepted	All prisoners are given an appointment slip to	Complete	

	Healthcare should ensure that prisoners are notified of their appointments and if they do not attend, the reasons for non-attendance are written on the prisoner's medical record.		notify them of any appointment. If they do not attend, this is documented on medical notes as DNA (did not attend) and the reasoning why they did not attend. If a patient does not attend, then the medical record is reviewed and a further appointment booked if any health concerns. A DNA letter is then sent to the prisoner containing the details of the new appointment.	Head of Healthcare	
6	The Governor should ensure, in line with PSI 74/2011, that all prisoners receive essential induction information.	Accepted	HMP Norwich has a full induction programme, which takes place over 2 days. The programme is time bound and includes health care secondary screening on the second day. A local spread sheet is updated to record the names of newly received prisoners and those who have completed their induction programme. This is available through the Head of Residence and Safety.	Complete Head of Residence and Safety	
7	The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception, first night staff and all others who assess risk: • Have a clear understanding of responsibilities and the need to share all relevant information about risk. Note	Accepted	A list of identified potential risks and triggers to self harm/suicide, as set out in PSI 64/2011, is available in Reception and the medical screening room in order for both reception and healthcare staff to refer to when assessing new receptions. Newly received prisoners are asked if they have any current thoughts of self-harm/suicide and whether or not they have a history of self-harm or suicide attempts. ACCT trained prison and nursing staff will make an assessment of potential risk of harm using this information, and any available recorded risk related information, recording a summary the information available on	Complete Head of Safer Custody	

	and consider all information from suicide and self-harm warning forms and PERs. • Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm. Open an ACCT when a prisoner appears at high risk, irrespective of his stated intentions		NOMIS and SystmOne, or within an ACCT if one is opened. If they have any concerns regarding the prisoner's risk, they will make an urgent referral to mental health staff. Returning prisoners who status changes at court are also seen by staff, prior to returning to their rooms, assessed for risk of harm and a summary of any new risk related information is recorded on NOMIS and SystmOne or within an ACCT if one is opened.		
8	The Governor should ensure, in line with PSI 74/2011, that all prisoners receive essential induction information shortly after their arrival.	Accepted	A first night induction booklet is issued to all new arrival prisoners in reception. This provides details of what they can expect to do and who they will be seen by within the first 24 hrs. All newly received prisoners are then met with at the first night interview with staff, to discuss any immediate concerns they have.	Complete Head of Residence and Safety	
9	The Governor should ensure that un-convicted prisoners are not placed on the basic level of the incentives and earned privileges scheme because they chose not to work or participate in other activities.	Accepted	A notice to staff has been published to highlight the actions to take if an unconvicted prisoner chooses to not participate in the regime.	Complete.	
10	The Governor should ensure that indicators such as lack of engagement and refusal to go to work and activities are recognised as signs of potential	Accepted	More prisoner representatives will be recruited and issued with new job descriptions, terms of reference and agenda to incorporate safer custody and violence reduction. A training programme will be put in place to ensure prisoner	Complete.	

	bullying and recorded and assessed as part of the prison's violence reduction strategy.		representatives are skilled to support prisoners with equality and safety issues. A newly recruited safer custody officer has been tasked to review local violence reduction (VR) policy in its entirety, in conjunction with prisoners, staff and managers at Norwich. This policy will also act on feedback from prisoner safety survey and consultation exercises. The policy will be multidisciplinary in nature across all functions, and address the need to ensure that staff understand that a prisoner's lack of engagement may be a result of bullying and be assessed as part of the violence reduction strategy.		