Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Matthew Gray a prisoner at HMP Norwich on 22 March 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Matthew Gray was found hanged in his cell at HMP Norwich on 20 March 2017. He was resuscitated and taken to hospital but died on 22 March, having never regained consciousness. He was 31 years old. We offer our condolences to Mr Gray's family and friends.

Mr Gray was a vulnerable man, who was a frequent user of drugs in the community and in prison. He incurred debts in prison and engineered moves to avoid those he owed and broke prison rules in order to be segregated from other prisoners. His behaviour was often challenging, but he generally received good support. However, in the weeks before he died, staff failed to support Mr Gray adequately or to investigate his allegations of bullying fully, despite Mr Gray naming prisoners to whom he was in debt and who were threatening him. When Mr Gray was moved back to a residential wing from segregation by force on 20 March, staff failed to put in place an effective violence reduction plan to reduce his risk. He was found hanged in his cell less than two hours later.

Shortly after Mr Gray's death, another prisoner took his life on the same wing at Norwich. Our investigation into that death showed inadequacies in Norwich's management of violence reduction procedures. The Governor needs to address this as a priority.

This version of my report, published on my website, has been amended to remove the names of the staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **December 2017**

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Summary

Events

1. On 23 July 2016, Mr Matthew Gray was recalled to prison after breaching the terms of his licence and sent to HMP Norwich. Mr Gray was a drug user in the community, and his drug use continued in prison. He accumulated drug debts and was supported with a victim support plan on two occasions, as part of Norwich's violence reduction measures. Mr Gray had a history of attempted suicide and self-harm in custody and was managed under Prison Service suicide and self-harm procedures (known as ACCT) on two occasions following his recall to prison.

2. On 8 March, Mr Gray was moved to the segregation unit after jumping onto the safety netting. He said he wanted to be segregated because he was in debt on the wing. He received a punishment of seven days cellular confinement on 10 March which was extended by three days when he refused to return to the wing on 16 March.

3. Mr Gray again refused to return to his wing when his cellular confinement ended on 20 March and was taken back to C Wing under restraint just before 4pm. Shortly afterwards he began to smash his cell. Staff tried to engage with Mr Gray, but by 5pm he had covered his observation panel and did not respond. Sixteen minutes later, staff returned to his cell and discovered Mr Gray hanging by a sheet tied to his bed. Staff and paramedics resuscitated him and he was taken to hospital but never regained consciousness. Mr Gray's life support was switched off on 22 March, and hospital staff recorded he died at 5.59am.

Findings

4. Staff were aware that Mr Gray was under threat from other prisoners but violence reduction measures taken in March 2017 were ineffective. After Mr Gray was segregated, staff started a victim support plan, but no specific objectives to manage or mitigate his risk were identified and the plan was never reviewed. During an adjudication hearing on 18 March, Mr Gray named those prisoners to whom he was in debt, but there is no evidence this was investigated as part of the violence reduction measures. No measures were put in place to provide Mr Gray with reassurance and support when he was returned to his wing.

5. The initial segregation healthscreen was incomplete or inaccurate on two occasions. Nursing staff told the investigator they did not fully understand what they were required to do, and general nurses said they had little mental health training so were not qualified to complete the assessments.

6. While overall the mental healthcare Mr Gray received was considered by the clinical reviewer to be good, there is no evidence an ACCT was considered on 15 March, when Mr Gray told a mental health support worker he had thoughts of self-harm while segregated. Mr Gray's medical record has an entry to say he was subject to the care programme approach (CPA), which was inaccurate and misleading.

7. When Mr Gray was returned to C Wing from the segregation unit, although officers informed the wing manager that Mr Gray had covered his observation panel and was not responding there was a delay before his cell was opened. Information from a prisoner that he thought Mr Gray had made a ligature was not recorded in the wing observation book.

8. The nurse who completed the escort risk assessment for Mr Gray's hospital transfer on 20 March failed to give proper consideration to Mr Gray's medical condition at the time, and advised that there were no medical objections to the use of restraints. Although Mr Gray was not in fact restrained when he left the prison, we are nevertheless concerned at the inaccurate medical risk assessment.

9. We are also concerned that there was no evidence the duty governor debriefed all staff involved in the emergency response.

10. Mr Gray should have had a parole review in October 2016. The case was incorrectly closed by HMPPS, and there were no measures in place at Norwich or Norfolk & Suffolk Probation Trust to identify that a review had been missed.

Recommendations

- The Governor should review the effectiveness of HMP Norwich's violence reduction policy and its delivery, specifically ensuring:
  - The effective identification and management of victims and alleged perpetrators.
  - Effective support and protection for apparent victims, with meaningful objectives and long-term solutions which address their individual situations.
  - The risk of suicide or self-harm to victims of bullying and intimidation is considered.
  - Accurate and timely record keeping.

- The Governor and Head of Healthcare should ensure prison and healthcare staff fully understand the process for assessments of fitness for segregation and for continued segregation. In particular they should ensure:
  - All healthcare staff have access to national guidance and understand what they are required to do.
  - The initial segregation health screen is accurately and fully completed.
  - Medical records are checked to identify any previous history of mental health issues or suicide and self-harm.
  - All staff receive ACCT training.
  - Mental health nurses provide support and advice for the general nurses managing patients on a day to day basis.
  - All staff record all clinical interventions in the medical record.
  - All staff, regardless of grade, understand their responsibilities in accordance with PSO 1700.

- The Governor should remind staff that when an observation panel is covered and a prisoner fails to respond, arrangements should be made to enter the cell as quickly as possible, especially when they have a history attempted suicide and self-harm.
- The Head of Healthcare should ensure that all healthcare staff contributing to risk assessments for prisoners taken to hospital understand the legal position, and ensure that assessments fully take into account the health of a prisoner so they can be based on the actual risk the prisoner presents at the time.
- The Governor should ensure that all staff, irrespective of status, position or experience, are provided with formal support from the prison, following a death in custody.
- The Head of the Public Protection Casework Unit at Her Majesty's Prison and Probation Service headquarters (HMPPS), the Governor of Norwich, and Norfolk and Suffolk Probation Trust should ensure there are adequate systems in place to identify when a prisoner should be referred for a Parole Board review, following recall on licence.

The Investigation Process

11. The investigator issued notices to staff and prisoners at Norwich, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

12. She visited Norwich on 29 March, and obtained copies of relevant extracts from Mr Gray's prison and medical records. She spoke to several prisoners, staff on C Wing, a nurse and one of the emergency responders.

13. NHS England commissioned a clinical reviewer to review Mr Gray's clinical care at the prison.

14. The investigator interviewed 16 members of staff and seven prisoners at Norwich on 3 and 4 May. The clinical reviewer accompanied her on 4 May. In addition, the investigator interviewed a manager from the Public Protection Casework Section in HMPPS headquarters and conducted three interviews with staff by telephone.

15. We informed HM Coroner for Norfolk of the investigation. She gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Gray's family to explain the investigation. Mr Gray' family wanted to know how Mr Gray was monitored and what procedures were in place to support him.

17. Mr Gray's family received a copy of the initial report. The solicitor representing them wrote to us asking for some clarification on a number of issues that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor. Mr Gray's family remain concerned about poor violence reduction measures and staff saying they do not have sufficient training or knowledge on how to effectively manage prisoners who have serious mental health issues and are at risk of self-harm and suicide.

18. The prison also received a copy of the report and identified factual inaccuracies which we have amended. An action plan for the recommendations is annexed to the report.

Background Information

HMP Norwich

19. HMP Norwich is a local prison, holding up to 769 men and young adults, either convicted or remanded, which predominately serves the courts of Norfolk and Suffolk. Healthcare is delivered by Virgin Care. There is 24-hour nursing cover throughout the site.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Norwich was in September 2016. A violence management strategy was introduced in November 2014. Inspectors reported that the number of fights and assaults had increased, that investigations into these incidents needed to be improved and drug and associated debt remained a significant problem. Inspectors recommended that staff should challenge perpetrators of violent and antisocial behaviour and support for victims should be improved.

21. Inspectors noted that significant efforts were made to reintegrate men with complex issues who were held in segregation and staff were respectful, calm and resilient; some had valuable previous experience of caring for people with mental health problems. Inspectors found written records were not sufficiently detailed, and there were few written reintegration plans for those returning to standard residential units.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 29 February 2016, the IMB reported that they were concerned about prisoner (and staff) safety, as violent incidents had increased. Low staffing levels and a rise in prisoners using NPS had exacerbated this.

23. The IMB noted that Norwich's small mental health team attempted to help prisoners, but this was often limited to those most in need. The IMB found a number of prisoners held in segregation had 'failed' the algorithm completed by healthcare staff regarding their suitability to be held there. However, the Board was satisfied that mental health staff checked each prisoner and would share their view if they did not feel a prisoner was suitable to remain segregated. They noted the personal officer scheme did not function well.

Previous deaths at HMP Norwich

24. Mr Gray is the first prisoner to take his life at Norwich since May 2015. There have been two other self-inflicted deaths since. Our investigation into one of these, that took place two weeks after Mr Gray's death, also identified inadequacies in Norwich's management of violence reduction procedures.

Recall to Prison

25. When prisoners are released on licence, they must comply with certain conditions while they serve the remainder of their sentence in the community. Released prisoners on licence are supervised by probation services. If a prisoner does not comply with the conditions of their licence, are charged with another crime, or behave in a way that causes their probation officer concern, the licence can be revoked and the offender recalled to prison. The recall can be for 28 days (known as a fixed term recall) or to serve the remainder of the original sentence (known as a standard recall). Prisoners are given the reasons for their recall and can make written appeals to the Parole Board.

Segregation Units

26. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air. Norwich segregation unit is known as the Ketts Unit, and comprises ten cells.

Assessment, Care in Custody and Teamwork

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

28. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

29. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Safer Custody*.

Incentives and Earned Privileges Scheme (IEP)

30. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell,

the ability to earn more money in prison jobs and wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

31. On 24 May 2012, Mr Matthew Gray was sentenced to seven years and four months imprisonment for aggravated burglary. This was not his first time in prison.

32. Mr Gray spent time at Norwich, Wayland, Moorland, Wealstun, Highpoint and Stocken prisons, before being transferred to Leicester, from where he was released on licence on 26 February 2016. In each of these prisons, Mr Gray told staff that he was under threat because he had accrued drug and tobacco debts. On one occasion, at Wayland, Mr Gray had his face slashed by another prisoner because of his debt. He was often supported under the violence reduction strategies at these prisons, and managed under victim support plans.

33. Mr Gray often spent time in the prisons' segregation units for his own protection. His behaviour was often challenging and he was frequently subject to disciplinary action (known as adjudication). Mr Gray had over 40 guilty findings at adjudications.

34. Between 14 May 2015 and 26 February 2016, staff started Prison Service suicide and self-harm monitoring (known as ACCT) on four separate occasions. On two occasions, Mr Gray was found with a ligature around his neck and had set fire to his cell, on another occasion he told staff that he had taken an overdose, and on another, he cut himself.

HMP Norwich

35. On 23 July 2016, Mr Gray was recalled to prison after he breached the conditions of his licence (he had failed to report to his approved premises and was suspected of misusing drugs). He was taken to Norwich. He was due for release on 25 May 2019, unless the Parole Board directed his earlier release.

36. Nurse A, assessed Mr Gray when he arrived at Norwich. He disclosed that he had been in contact with community outreach services and the nurse confirmed he had not collected his daily 40ml of methadone for three days. A 30ml dose of methadone was prescribed and, because he showed signs of withdrawal, the nurse referred Mr Gray to the integrated drug treatment services (IDTS). (His methadone dose was increased to 40ml over the following days.) He was located on the drug treatment wing and a five day alcohol and drug withdrawal care plan was started. She recorded Mr Gray had a history of self-harm and attempted suicide while previously in custody, but that he had no current thoughts of harming himself. Mr Gray told her that he had stopped taking his antidepressants as he had chosen to use other illicit substances as a means of dealing with his symptoms.

37. Nurse B and a drug and alcohol worker from the Rehabilitation of Addicted Prisoners trust (RAPt), spoke to Mr Gray on 27 July, as he had been isolating himself on the wing. They referred him for a mental health assessment. The next day, Nurse C from the mental health team recorded that Mr Gray had thoughts of ending his life, appeared anxious and had withdrawal signs. Mr Gray told her he had been diagnosed with depression 18 years ago and had been prescribed medication for anxiety and depression (mirtazapine and olanzapine)

which he said had helped stabilise his mood. Mr Gray said he had daily thoughts of suicide, but did not want to die.

38. On 3 August, Mr Gray asked Nurse A to prescribe him his previous medication for anxiety and depression and she referred him to the prison doctor. Dr A examined Mr Gray on 8 August, and recorded he appeared tired and low in mood, and was suffering from toothache. The doctor prescribed an antidepressant (mirtazapine) and noted she sought advice from the mental health team. They told the doctor that the visiting psychiatrist, would be consulted regarding other medication if Mr Gray's mood did not improve. Nurse A told the investigator he had an informal discussion with the visiting psychiatrist who did not think his input was required, and advised Mr Gray should be referred back to the prison GP regarding his medication. Nurse A did not record this discussion on Mr Gray's medical record.

39. On 15 August, at 5.53pm, Nurse D began ACCT procedures. The nurse recorded on the concern and keep safe form, that Mr Gray had said he intended to take his own life because he felt he should be on different medication. A prison manager, completed the immediate action plan and set ACCT observations at twice an hour until Mr Gray's ACCT assessment. For the remainder of the day Mr Gray appeared settled and slept through the night.

40. The next day Senior Officer (SO) A carried out an ACCT assessment. Mr Gray told SO A he struggled with depression and believed he should be on different medication. He said he was unsure whether he wanted to be dead. SO B was assigned as Mr Gray's ACCT case manager, and chaired the first ACCT review at 4.50pm with SO A, Mr Gray and a mental health nurse (whose identity could not be established by the investigation) in attendance. The caremap was completed with an action for the GP to review Mr Gray, which was arranged for the next day. Staff considered Mr Gray's risk of self-harm and suicide to be low.

41. On 18 August, at 10am, SO B chaired an ACCT review with SO A, Nurse A and Mr Gray in attendance. SO B recorded Mr Gray was now receiving the correct medication, his sleep had improved and he had started work. Nurse A recorded in Mr Gray's medical record that the doctor had reviewed and increased Mr Gray's antidepressant medication, although the doctor did not make an entry in the record. Staff assessed Mr Gray's risk of suicide and self-harm as low and closed the ACCT. A post closure review was scheduled for 25 August.

42. Mr Gray self-harmed by cutting his arm on 19 August, but refused treatment. SO B reopened the ACCT, noted Mr Gray's risk as raised and recorded he had been threatened due to other prisoners discovering he had a previous sexual offence. Mr Gray also disclosed he was in debt. SO A chaired an ACCT review the next day at 1.50pm, with a mental health nurse and Mr Gray in attendance. There were three further reviews. Although Mr Gray said he had no thoughts of suicide and self-harm, he made cuts to his leg and threatened to continue cutting unless he was moved to another wing.

43. On 1 September, Mr Gray was moved to C Wing, the vulnerable prisoner unit, after he climbed onto the security netting. SO B recorded at the ACCT review that Mr Gray still had thoughts of suicide and had submitted an application to see

the prison psychiatrist. A Safer Custody team member started violence reduction measures and Mr Gray was supported under a victim support plan.

44. On 7 September, Mr Gray was found with prescribed medication in his cell (he was not allowed any medication in possession) and placed on report. Mr Gray cut his leg the next day, and Nurse E referred him to the mental health crisis team. On 9 September, Mr Gray told the Safer Custody team member during their victim support review meeting, that he would not stop taking illicit medications as he felt they helped him to cope. She encouraged him to avoid getting into debt on C Wing and arranged for RAPt to meet with him. On 13 September, Mr Gray reported he felt more settled since he had moved wings and the ACCT was closed. On 19 September, Mr Gray was assessed by Nurse F and the next day, after his case was discussed at the primary mental health team meeting, Mr Gray was discharged form their services.

45. Officer A reviewed Mr Gray's victim support plan on 22 September (although there is no entry on the prison file). An officer from safer custody, recorded in Mr Gray's prison file the next day that Mr Gray had told the officer his medication issues had been resolved, and he felt safer since moving wings and starting work in textiles. The officer closed the victim support plan.

46. On 12 November, Mr Gray climbed onto the security netting on C Wing because he wanted to be segregated. Mr Gray told Officer B, that he had accumulated debts for tobacco and from buying prescribed medication from other prisoners and that, as a result, he felt pressured and bullied by some prisoners on the wing. Staff started a victim support plan. Mr Gray was moved from C3 to C1 landing the next day, away from the alleged perpetrators. Over the next few weeks, despite being on the basic IEP regime because of his bad behaviour, Mr Gray caused no further problems. (He was upgraded to the standard IEP regime on 16 December.)

47. Mr Gray moved back to C3 landing on 3 December. The reason for this move was not recorded in his prison record. On 14 December, Mr Gray told Officer C that he was still under threat from prisoners on C3, and remained in debt. Supervising Officer (SO) C met Mr Gray on 29 December, and Mr Gray told him his tobacco debts had spiralled out of control.

48. Over the next month, Mr Gray tried to give up smoking and received support as part of the smoking cessation programme. The mental health team continued to support him and recorded that his mood had improved, although he still struggled to sleep. There are no entries in Mr Gray's prison record between 30 January and 8 March.

49. In mid-February, wing staff reported to healthcare staff that Mr Gray's mental health appeared to have deteriorated and he had started to self-isolate on the wing, although they were unaware of any specific issues. The secondary mental health team discussed Mr Gray's case and, on 19 February, he was added to their caseload. On 21 February, Mr Gray told Nurse G he still struggled to sleep. She prescribed sleeping tablets until his appointment with the prison psychiatrist.

50. The visiting psychiatrist assessed Mr Gray, with Nurse A, on 24 February 2017. , It was incorrectly recorded in Mr Gray's medical record that he was part of the

care programme approach (CPA - an NHS system of delivering community mental health services to individuals diagnosed with a severe mental illness or other vulnerabilities such as a history of violence or self-harm). It was also recorded that Mr Gray would be seen on a weekly basis and his mental health monitored while his medication changed and reached therapeutic levels. There is no documented evidence he was reviewed. A consultant psychiatrist, increased Mr Gray's antidepressant medication and prescribed a short course of sleeping tablets on 7 March 2017. The consultant psychiatrist recorded Mr Gray should continue to be reviewed weekly, but again there is no documented evidence that this happened.

Wednesday 8 March – Sunday 19 March 2017

51. On Wednesday 8 March at around 6.20pm, Mr Gray climbed over the railings onto the security netting of his landing (C3), and then jumped onto the netting on the landing below (C2). Officer D negotiated with Mr Gray to climb off the netting and, after around 45 minutes, he did. Mr Gray told the officer that he was in debt (tobacco) and that another prisoner who he had upset a few months earlier, would pay off this debt if he threw faeces and urine over her. Mr Gray was moved to the segregation unit on good order or discipline (GOoD) grounds.

52. Officer D told the investigator she did not know why she had been identified as a target. When interviewed, the other prisoner said he had given Mr Gray tobacco and expected to get it back, but that the rest of the allegation was untrue Other prisoners on the wing told the investigator they knew Mr Gray was in debt, but did not know to whom.

53. The head of security completed the segregation record at 7.20pm. He noted that Mr Gray had refused to climb down from the C2 landing netting unless he was segregated and that this appeared to be due to debts. Nurse H signed the initial segregation healthscreen at 8.05pm. She did not complete the algorithm (used to determine if there are any healthcare reasons against holding a prisoner in segregation and to provide information about a prisoner's mental wellbeing at the time of the healthscreen), but endorsed the form to note there were no clinical objections to Mr Gray's segregation. Mr Gray's segregation review was scheduled for 11 March.

54. During the next few days, Mr Gray was fully compliant with the segregation regime, was seen by a nurse each day and caused no further problems. On 10 March, the head of residence and safety, chaired the adjudication hearing. Mr Gray pleaded guilty and received a punishment of seven days of cellular confinement and 21 days loss of privileges. He remained segregated. Nurse E completed the initial segregation healthscreen at 12pm, noted Mr Gray was already in the segregation unit and completed the algorithm stating that there were no concerns about Mr Gray's mental health. He incorrectly recorded that Mr Gray had never been managed under ACCT procedures.

55. Officer E made an entry on Mr Gray's prison record on 13 March at 10.25am. He noted that he had spoken to Mr Gray after he had been segregated on 10 March, as part of Norwich's violence reduction measures. The officer recorded that Mr Gray had expressed concerns that there may be recriminations from (the prisoner he said he was in debt to) if he returned to the wing and asked the

officer to be cautious with any investigation as he did not want to be labelled 'a grass'. The officer updated Mr Gray's prison record with a vulnerability alert and started a victim support plan (VSP), but did not record any specific objectives.

56. On 15 March a mental health support worker, recorded that Mr Gray's mood was low, which he attributed to his current situation. Mr Gray told him he did not want to return to his wing as he was in debt. Mr Gray also reported thoughts of self-harm, although he said he had no plans or intent. There is no record that staff considered starting ACCT procedures.

57. On 16 March, Mr Gray refused to return to C Wing when his cellular confinement ended. Officer E placed him on report and he remained segregated. Nurse I completed the initial healthscreen at 2.45pm, noted Mr Gray was already segregated, correctly noted he had previously been managed under ACCT and assessed that continued segregation would not adversely impact on his mental health. The head of residence and safety signed the authority for segregation at 3.30pm.

58. On 18 March, a member of staff chaired the adjudication hearing. Mr Gray wrote a statement for the hearing where he explained that he had refused to return to C Wing as he had been threatened by two prisoners and was in debt to six prisoners (all of whom he named) who lived on all three landings on C Wing. Mr Gray wrote that he had been in debt for four months and had told staff, but nothing had been done. Mr Gray said the head of residence and safety had told him he would be transferred and wrote that he would not return to the wing, and if moved by force, would jump on the netting in order to be segregated. Mr Gray pleaded guilty and received a punishment of a further three days of cellular confinement. The member of staff chairing the adjudication hearing recorded that he would speak to the head of residence and safety about Mr Gray transferring to another wing, but there is no evidence of a discussion recorded in the prison record. Over the next three days, Mr Gray complied with the regime in the segregation unit and caused no problems.

Monday 20 March 2017

59. Mr Gray again refused to return to C Wing on 20 March, when his cellular confinement ended. The head of residences and safety authorised the use of force to move Mr Gray back to C Wing. Officer B gave Mr Gray a number of opportunities to walk back to C Wing, he then gave Mr Gray a direct order to move, but he still refused. The officer said Mr Gray initially resisted when being restrained, by straightening his arms, but was not abusive, did not threaten staff and very quickly complied. Mr Gray did not tell the segregation staff why he did not want to return to C Wing. Mr Gray had his hands cuffed behind his back by a custodial manager, and was escorted to C Wing by three officers (Officer B, officer E and another member of staff). During the walk back to C Wing, Mr Gray told Officer B he would be back in the segregation unit and said he intended to seek compensation.

60. Closed circuit television (CCTV) shows Mr Gray walked calmly back to C Wing. He arrived on the wing at 3.50pm, and a minute later was located in his cell towards the far end of the corridor on the ground floor landing (C1). Officer B removed the restraints and shut the door at 3.52pm. An entry was made in the

wing observation book (author's name not recorded) that, on the instruction of the head of residence and safety. Mr Gray was not to be allowed on the 2's or 3's landings because of his history of jumping on the security netting.

61. Nurse J examined Mr Gray in his cell as force had been used to move him to C Wing. At 4pm, the nurse recorded that Mr Gray said he had no injuries or health concerns and raised no issues following the use of force.

62. At 3.56pm, Officer F opened Mr Gray's cell door, and explained that he was on the basic IEP level and she had come to collect his television. Mr Gray threw his television on the floor. The officer removed the television and locked the door. Mr Gray started to smash his cell and at 4.25pm, Officer G switched off the electricity and water to Mr Gray's cell. Mr Gray told him that he would do anything to go back to the segregation unit and would not be staying on C Wing. A few prisoners looked into Mr Gray's cell and helped staff place towels outside the cell door to soak up water as Mr Gray had smashed his sink and toilet. Officer G updated the wing observation book at 4.25pm to warn staff Mr Gray may possibly be in possession of a weapon, as a prisoner had seen him place a piece of broken porcelain down his trousers.

63. At 4.35pm, officers spoke to Mr Gray through his door. An acting SO told the investigator that Mr Gray had calmed down and asked about receiving his medication and food. The acting SO told Mr Gray they would bring his food and medication to his cell and tasked Officer H with collecting Mr Gray's meal.

64. A short while later, Officer G said a prisoner, had told him he believed Mr Gray may have a ligature. The prisoner said he heard what he believed to be the sound of ripping sheets and had tried to look through the crack in the door, because Mr Gray had covered his observation panel. The officer did not record this conversation in the wing observation record.

65. CCTV shows a prisoner on C Wing, spoke to Mr Gray at 4.38pm for several minutes through his door and went back again a few minutes later. He said he did not know Mr Gray, but as he understood the prison system well, and thought he may be able to help calm Mr Gray down more effectively than officers. The prisoner said Mr Gray uncovered his observation panel; he gave him a cigarette through the crack in the door, and reassured him that he would help him sort out his debts. He said he offered to help Mr Gray clean up his cell, which he accepted, but staff did not allow him to do this. The Acting SO said he had to consider the health and safety of everybody on the wing and they would not open a cell door in this type of situation so soon after Mr Gray had been disruptive.

66. CCTV shows Officers G, Officer F went back to Mr Gray's cell at 4.55pm. Officer G said he managed to open the door sufficiently to see Mr Gray and his bed, and saw no sign of a ligature, although he did not ask him specifically if he had a ligature. The acting SO checked the cell at 4.57pm. At 5pm, Officer H and, Officer F went back to Mr Gray's cell with a tray of food. CCTV shows them outside talking and kicking the door, apparently in order to get a response from Mr Gray. They told the investigator they did not get a response, and CCTV shows they left the cell just over a minute later. They informed the acting SO that Mr Gray's observation panel was blocked and had not got a response from him. The acting SO instructed the officers not to open the cell door until he was

present, because of Mr Gray's earlier poor behaviour and the possibility he had a weapon. The acting SO told the investigator it was a busy time on the wing and he could not respond immediately.

67. At 5.16pm, CCTV shows the acting SO went to Mr Gray's cell, followed by Officers H and F. He tried to open Mr Gray's door. He could not because of the debris from the broken furniture inside, but was able to look through the gap and saw Mr Gray hanging from the bed frame by a sheet. The acting SO used his radio and called an emergency code blue (indicating that a prisoner is not breathing and urgent support is required). The acting SO kicked the door open, entered the cell, cut Mr Gray down and began cardiopulmonary resuscitation (CPR).

68. Officer H removed the broken furniture while Officer F locked up prisoners who were still on the landing. Nurse J responded to the emergency request at 5.18pm, and the duty governor, also arrived at Mr Gray's cell. Mr Gray was taken out of his cell at 5.20pm, as the floor was wet and they needed to attach the defibrillator. The duty governor used tables to act as a screen to preserve Mr Gray's dignity. The nurse took over CPR at 5.21pm. Two physical education instructors (PEIs) also responded to the code blue and assisted with resuscitation until paramedics arrived.

69. East of England Ambulance Service records show they received a request for an emergency ambulance at 5.17pm. Paramedics arrived at the prison at 5.26pm. Mr Gray was resuscitated, but remained unconscious. Mr Gray left the wing at 6.09pm and paramedics took him to hospital. Despite duty governor endorsing the escort risk assessment to say Mr Gray should be double cuffed, restraints were never applied.

70. Hospital staff assessed Mr Gray to be brain dead at 4.32pm the following day (21 March). However, he was kept on a life support machine until a decision was made as to whether he could donate his organs. The next day, Mr Gray's organs were considered unsuitable for transplant and the life support machine was switched off at 5.55am on 22 March. Mr Gray was pronounced dead at 5.59am.

Contact with Mr Gray's family

71. On 21 March, the prison appointed Officer I as the family liaison officer. After a delay because of incorrect contact details, the prison informed both Mr Gray's biological and adoptive family that he had been admitted to hospital. Mr Gray's family visited him in hospital. Officer I offered condolences and ongoing support to all family members. The prison contributed towards the costs of Mr Gray's funeral, in line with national policy.

Support for prisoners and staff

72. The duty governor, held a debrief for prison staff involved in the emergency response, but not the healthcare staff. He also debriefed staff who were with Mr Gray when he died.

73. The prison posted notices informing other prisoners of Mr Gray's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide

and self-harm, in case they had been adversely affected by Mr Gray's death. On 6 May, a memorial service was held in the prison chapel.

Post-mortem report

74. A pathologist concluded that Mr Gray had died from lack of oxygen, due to hanging. A toxicology report confirmed there were no substances in Mr Gray's blood at the time of his death, other than those prescribed.

Findings

Assessment and management of Mr Gray's risk

Violence Reduction Measures

75. A PPO publication in October 2011, *Violence reduction, bullying and safety*, noted the links between bullying and violence and self-inflicted deaths of prisoners of all ages. In our PPO thematic report into self-inflicted deaths in 2013 - 2014, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated and responded to robustly. In their most recent inspection, HMIP identified the need for Norwich to improve investigations into incidents of bullying.

76. Norwich has a violence reduction policy, issued in July 2016, which sets out the process for raising and investigating any identified or suspected acts of aggression, bullying, intimidation or violence. There are various mandatory actions that wing staff should complete if a prisoner is identified as a bully or is witnessed demonstrating violent or antisocial behaviour. This includes staff challenging the prisoner, giving clear guidance on expected improvements in behaviour, and activating bullying perpetrator alerts. The policy requires prisoners to be reviewed by a member of safer custody after one week, with daily entries on the prison record by wing staff. The alert should remain in place for a minimum of 14 days, with a review to take place then.

77. Norwich's violence reduction policy also advises staff to consider starting a victim support plan (VSP). Where a prisoner is supported by a VSP, staff should consider moving the victim to a different cell, the victim should be supported by his personal officer or the safer custody officer, and staff should make daily case note entries.

78. Mr Gray regularly found himself in debt, and told staff that he was fearful and was being bullied. Staff started a VSP for Mr Gray in September 2016 and we found this was managed effectively. However, staff failed to take any action to support Mr Gray in December 2016, after he was moved to C3 landing (where he had previously been bullied), although he told staff on two separate occasions that he was in debt and under threat from other prisoners. Staff also failed to submit security intelligence reports.

79. When Officer E started violence reduction measures on 10 March, he did not update Mr Gray's prison record until 13 March and did not set any specific objectives to support Mr Gray. He told the investigator he often did not have time to complete all tasks before his shift finished, but accepted not making timely entries was poor practice. Victim support plans should be recorded on the prison's computer system, in the violence reduction folder (violence reduction spreadsheet), but this was not done. There is no evidence of any action being taken against the alleged perpetrator.

80. Nobody reviewed Mr Gray. Segregation staff made daily entries about his behaviour, but not as part of his VSP. The, head of safer prisons, told the investigator Officer E was not a dedicated safer custody officer and simply made

a mistake by not setting clear objectives on the violence reduction spreadsheet. She said he would receive training and advice.

81. Officer E said all staff could access the violence reduction folder on the prison's computer system and he assumed staff would be alerted to the violence reduction measures via the alert on Mr Gray's prison record. Healthcare staff told the investigator they would not be aware if a prisoner was subject to a VSP. Officer B told the investigator he was unaware that Mr Gray was on a VSP, and said the segregation unit manager would have been responsible for checking a prisoner's file. The Acting SO confirmed that all prison staff can access the violence reduction folder on the computer system. However, he said accessing the system was not always a priority, especially when staffing levels were low. He added that although all prisoners identified as a bully, perpetrator or victim should be discussed during staff handovers each day, this did not routinely happen.

82. When Mr Gray was in the segregation unit he told prison staff he felt unsafe and did not want to return to his wing, and he refused to relocate back to C Wing. Despite Mr Gray naming six alleged prisoners to whom he was in debt during his adjudication hearing on 18 March, there is no evidence this was followed up by the adjudicator, or officers in the segregation unit.

83. We consider that Norwich made inadequate attempts to resolve Mr Gray's concerns about his safety. Staff failed to put in place sufficient measures to protect Mr Gray, particularly when it was clear that Mr Gray was fearful about returning to C wing from segregation. We make the following recommendation:

The Governor should review the effectiveness of HMP Norwich's violence reduction policy and its delivery, specifically ensuring:

- **The effective identification and management of victims and alleged perpetrators.**
- **Effective support and protection for apparent victims with meaningful objectives and long-term solutions, which address their individual situations.**
- **The risk of suicide or self-harm to victims of bullying and intimidation is considered.**
- **Accurate and timely record keeping.**

Management of Mr Gray's mental health

84. The clinical reviewer concluded that the overall care Mr Gray received form the mental health team was 'over and above' the service he would have received in the community.

85. Mr Gray's mental health needs (depression, anxiety and history of self-harm) were identified at an early stage. Mr Gray received mental health input from primary mental health, secondary mental health and the well-being service and was regularly reviewed. He received medication for his mental health needs,

although he continued to report thoughts of self-harm and suicide, coupled with anxiety. A number of different medications were tried in order to support Mr Gray.

86. The clinical reviewer has identified a number of other issues in her report, which the Head of Healthcare will need to address.

Segregation

87. We are concerned that procedural failings in the management of Mr Gray's time in the segregation unit meant that possible opportunities to identify his underlying risk and vulnerability were missed. In particular we consider that there should have been a better understanding of the implications of his return to normal location. Mr Gray's previous history of self harm, his concerns for his safety and underlying mental health needs were not adequately considered before returning him to the wing.

88. Prison Service Order (PSO) 1700 - *Segregation* states, 'Segregation should be used only as a last resort whilst maintaining a balance to ensure it remains an option for disruptive prisoners'.

89. PSO 1700 requires a doctor or registered nurse to complete the initial segregation healthscreen within two hours of a prisoner being segregated. When Mr Gray was first segregated on 8 March 2017, Nurse H signed but did not complete the assessment. The segregation healthscreen completed by Nurse E on 10 March 2017, when Mr Gray was further segregated and awarded a period of cellular confinement, was inaccurate as it had no record of Mr Gray's history of self-harm.

90. Healthcare staff told the investigator that responsibility for completing initial segregation health screens had recently moved to general nurses, who had no formal training, and were not qualified to fully assess the impact of segregation on a prisoner's mental health. Healthcare staff told the investigator they were not aware of the requirements of Prison Service Instructions (PSI) 64/2011 Safer Custody or Prison Service Order 1700 – Segregation.

91. On 15 March 2017, the, mental health support worker, saw Mr Gray in the segregation unit, where he reported low mood which he attributed to his current situation and lack of sleep. Mr Gray said he did not want to return to ordinary location as he was in debt. He also reported thoughts of self-harm, although he said he had no plans or intent. Despite this, there is no evidence an ACCT was considered. The mental health support worker and other Registered General Nurses reported during interview that they did not receive any formal mental health awareness training to support them in their role working in the prison environment and all nurses reported they did not receive formal ACCT training, despite requests to access it.

92. PSO 1700, paragraph 2.3, states that a member of healthcare staff must attend and contribute to segregation review boards, which should include the decision to return a prisoner to a standard residential wing. There is no evidence that a

member of healthcare assessed Mr Gray's mental health on 20 March. We make the following recommendation:

The Governor and Head of Healthcare should ensure prison and healthcare staff fully understand the process for assessments of fitness for segregation and for continued segregation. In particular they should ensure:

- **All healthcare staff have access to national guidance and understand what they are required to do.**
- **The initial segregation healthscreen is accurately and fully completed.**
- **Medical records are checked to identify any previous history of mental health issues or suicide and self-harm.**
- **All staff receive ACCT training.**
- **Mental health nurses provide support and advice for the general nurses managing patients on a day to day basis.**
- **All staff record all clinical interventions in the medical record.**
- **All staff, regardless of grade, understand their responsibilities in accordance with PSO 1700.**

Delay entering Mr Gray's cell

93. Mr Gray smashed his cell up at about 4.25pm. Despite the fact that he had a history of self-harm and was thought to have secreted a piece of broken porcelain, he was left in the damaged cell. Prison staff had no interaction with Mr Gray after 4.57pm. When officers went to deliver his food at 5pm, Mr Gray had covered his observation panel and did not respond. The Acting SO was informed immediately, but it was not until 16 minutes later that staff entered Mr Gray's cell. While we cannot say whether earlier intervention would have prevented Mr Gray's death, it is critical that staff act quickly in situations such as this. We make the following recommendation:

The Governor should remind staff that when an observation panel is covered and a prisoner fails to respond, arrangements should be made to enter the cell as quickly as possible, especially when they have a history attempted suicide and self-harm.

Escort risk assessment

94. A nurse completed Mr Gray's escort risk assessment for his hospital transfer on 20 March. Despite the fact Mr Gray had only just been resuscitated and remained unconscious, the nurse recorded that there were no medical objections to the use of restraints and that Mr Gray's medical condition did not restrict his ability to escape unaided.,. The nurse told the investigator he completed the risk assessment as a 'paper exercise' to ensure Mr Gray got to hospital without delay. The nurse reflected that he should have completed the form more accurately.

95. The duty governor endorsed the escort risk assessment completed by the SO, indicating restraints should be applied to Mr Gray. However, the person escort

record (PER), a document which accompanies all prisoners when they move between police stations, courts, hospitals and prisons, is clear no restraints were applied. The duty governor said he told staff that restraints should not be applied, but did not know why he had not updated and endorsed the escort risk assessment to reflect his decision; the duty governor accepted he had made a mistake.

96. We are satisfied that Mr Gray was not restrained. However, we are concerned that accurate medical information was not recorded and that healthcare staff who spoke to the investigator said they did not fully understand what was required when completing the escort risk assessment form and had had no specific training. We therefore make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff contributing to risk assessments for prisoners taken to hospital understand the legal position, and ensure that assessments fully take into account the health of a prisoner so they can be based on the actual risk the prisoner presents at the time.

Staff Support

97. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed (or indeed good practice). It also provides those directly involved with an opportunity to process events. There is no evidence the duty governor held a debrief for all staff involved in the emergency response, as healthcare staff did not attend, which is a mandatory requirement set out in PSI 08/2010, *Post Incident Care.* We make the following recommendation.

The Governor should ensure that all staff, irrespective of status, position or experience, are provided with formal support from the prison, following a death in custody.

Parole Review

98. The Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012 requires that the Secretary of State refers all recalled offenders' cases to the Parole Board where they remain in custody beyond a period of 28 days. It is not unusual for cases not to be referred where the sentence end date (SED) means that the offender will not be in custody at day 28.

99. On 26 July 2016, the Public Protection Casework Section (PPCS), which is responsible for prisoners who are subject to recall, identified Mr Gray had been returned to custody. A recall dossier was issued to him the next day at Norwich, explaining the reasons for recall. PPCS received a risk management report on 2 August from Mr Gray's offender manager, which did not support his re-release. A dossier was due to be submitted to the Parole Board by PPCS around 20 August, but it was not completed. On 10 September, Mr Gray's electronic case file was incorrectly minuted with 'SED less than 2 weeks away', despite the correct SED (25 May 2019) being recorded on the file. The case file was closed

by PPCS. Mr Gray never made any comment to prison staff about his parole review.

100. When interviewed, the Head of Post-Release Casework in PPCS, accepted PPCS was responsible due to 'human error' for failing to refer Mr Gray's case to the Parole Board. He explained that the Parole Board typically reviews the decision to recall 2-3 weeks after the referral (and in Mr Gray's case the target date was 20 August). The Board then has a further week to issue the result/direction to PPCS. Mr Gray could, therefore, have been expected to receive the Parole Board's decision in the first two weeks of October 2016. He said once this mistake had been identified, PPCS reviewed all outstanding recalls, and there were no similar cases.

101. The investigator spoke to Mr Gray's offender manager who confirmed there was currently no system for checking parole reviews for licence recalled prisoners, but that it would be sensible to introduce a mechanism for doing so. She said that she and her colleagues would typically be reactive to requests for reviews from prisons and PPCS, rather than being proactive and checking. She visited Mr Gray at Norwich on 14 October, with her police colleague, but did not consider inviting his offender supervisor, SO C, to this meeting.

102. The investigator spoke to SO C and the manager of the offender management unit (OMU), who confirmed the OMU at Norwich did not have a system to identify any missed reviews (although they would probably identify anyone held for over a year who had not been reviewed) and relied on PPCS to inform them.

103. PPCS closed Mr Gray's parole review incorrectly and denied him the opportunity of a review of his suitability for early release. There was no protocol or system in place to identify such errors. The head of post-release casework in PPCS told us processes have been revised since, and the member of staff who made the error has received advice. However, we are concerned that neither PPCS, Norwich Prison or Norfolk and Suffolk Probation Trust identified Mr Gray's review had been missed, which is unacceptable. Although the missed parole review is not directly linked to the circumstances surrounding Mr Gray's death, we are sufficiently concerned by the identified deficit to make the following recommendation:

The Head of the Public Protection Casework Unit at Her Majesty's Prison and Probation Service headquarters (HMPPS), the Governor of Norwich, and Norfolk and Suffolk Probation Trust should ensure there are adequate systems in place to identify when a prisoner should be referred for a Parole Board review, following recall on licence.

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