Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Luke Punchard a prisoner at HMP Norwich on 2 June 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*

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.

On the morning of 2 June, prison staff discovered Mr Luke Punchard hanging in his cell in the segregation unit at HMP Norwich. Nursing staff attended and attempted to resuscitate him without success. He was 26 years old. We offer our condolences to Mr Punchard's family and friends.

Mr Punchard, who had a history of mental illness and alcohol and drug abuse, believed that he was under threat at Norwich and in three other prisons. There was no evidence to support this belief but Mr Punchard refused to live on a residential wing and of the 143 days he spent in custody before his death, all but 32 were spent in a segregation unit.

Efforts were made to transfer Mr Punchard to other prisons where he said he would feel safe, but his poor behaviour resulted in him being returned to Norwich on each occasion. He engaged in dirty protests on a number of occasions, to avoid being moved from segregation.

Mr Punchard was managed under suicide and self-harm prevention procedures a number of times during his time in custody, although not at the time of his death. He received broadly appropriate support from primary and mental healthcare staff.

We recognise that Mr Punchard's behaviour made him very difficult to manage. However, we are concerned that his frequent moves between prisons meant that the total length of time he had spent in segregation was not recognised, no care plan was drawn up to support his mental health, and no one prison took responsibility for trying to develop a long-term approach to his apparently irrational fear of normal location.

We also consider that HMP Highpoint's decision to move Mr Punchard to a higher security category was premature, motivated by expedience and did not consider the impact on him.

Mr Punchard appeared happy to be back in the segregation unit at Norwich when he returned there shortly before his death and there was little in his presentation to indicate that he was at heightened or imminent risk of suicide. We are concerned, however, that staff at Norwich had come to consider Mr Punchard's extreme behaviour as 'normal' and that, as a result, they did not consider whether his risk factors had increased.

Sue McAllister CB
Prisons and Probation Ombudsman **March 2019**

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Summary

Events

1. On 10 January 2017, Mr Luke Punchard was remanded into custody at HMP Norwich, charged with robbery. He had a long custodial history and had been in custody at Norwich before. When he arrived there, he raised no concerns about his well-being but was identified as requiring alcohol and drug detoxification, and disclosed that he had recently been in a psychiatric hospital. He was prescribed the medication he had been receiving in the community (including anti-psychotic medication).

2. Mr Punchard was placed on a residential wing (where he shared a cell with his brother). On the evening of 30 January, Mr Punchard complained that his food had been tampered with and presented as paranoid and agitated. Later that evening, he set fire to his cell. He was relocated to the segregation unit where he was initially managed under suicide and self harm prevention measures (known as ACCT). He told staff that he wanted to move off the residential wing as he believed there was a price on his head and he was at risk from other prisoners. He provided little information but the prison investigated his concerns in an attempt to identify any potential aggressors. Nothing was found to substantiate Mr Punchard's concerns.

3. Mr Punchard refused all requests to return to the wing, and remained in segregation. On 6 March, he attended court and was sentenced to 18 months imprisonment.

4. On 8 March, Mr Punchard was transferred to HMP Wayland (which he had identified as a prison where he would feel safe). He was initially located on a residential wing but his behaviour – barricading, self-harming, fire setting and a dirty protest - resulted in him being segregated. He was managed on an ACCT from 10 to 20 March.

5. He was returned to Norwich on 23 March. He again refused location on a residential wing at Norwich and returned to the segregation unit where he continued to refuse all requests to return to a residential wing.

6. On 16 April, Mr Punchard was temporarily transferred to the segregation unit at HMP Bure because of a need to create space in the unit at Norwich. He remained in segregation at Bure, where he was managed on an ACCT from 4 to 9 May. On 17 May he was transferred to HMP Highpoint (a prison where he had said he would feel safe) as part of a planned move.

7. On arrival at Highpoint, Mr Punchard raised no immediate concerns and agreed to live on a residential wing. The following morning he climbed onto a shed roof and refused to come down. When he came down, he was placed in the segregation unit. Later that morning, the Governor at Highpoint asked for a review of his security category and on 25 May, Mr Punchard was re-categorised to category B on the basis that his history of poor behaviour made him unsuitable for a category C prison.

8. Mr Punchard remained in segregation at Highpoint. Staff tried to find a suitable prison to accept him but were unable to do so, given his new category and the relatively short time he had left to serve. Highpoint's Governor escalated the matter to the Group Director of Prisons for the Eastern Area who instructed Norwich to accept Mr Punchard.

9. On 31 May, Mr Punchard was transferred back to HMP Norwich. He refused to go on a normal wing and was located in the segregation unit. Staff there knew him well. They said he did not seem distressed and they noticed nothing unusual about his presentation.

10. On the afternoon of 1 June, Mr Punchard was found with an improvised weapon (which he handed over when asked). He later began a dirty protest, and smeared his cell and chest with faeces, saying he was doing so because he did not want to be located on a normal wing. After staff reassured him that this was not going to happen, he asked for materials to clean himself. Staff were not able to open the cell at night but passed him some shampoo sachets under the door. He was checked hourly during the night and at one point was seen cleaning the walls of his cell. A member of staff spoke to him at 4.20 am and said he seemed calm.

11. On 2 June, at 5.00am, staff discovered Mr Punchard suspended from his cell window with a ligature around his neck. When prison staff and nurses entered the cell, no signs of life were present and they began cardiopulmonary resuscitation (CPR.) Paramedics arrived quickly and took over resuscitation. Mr Punchard was pronounced dead at 5.34am.

12. Throughout his time in custody, Mr Punchard was seen and monitored by mental health and primary care staff. Nursing staff expressed no concerns about his safety in segregation, and mental health staff considered that, despite some unusual and extreme behaviour and an apparently irrational fear of being on normal location, Mr Punchard displayed no psychotic symptoms. He was in receipt of anti-psychotic medication, which had initially been prescribed in the community, although he was not always compliant with his medication regime.

Findings

Clinical care

13. The clinical review has concluded that the treatment Mr Punchard received from healthcare was equivalent to that which he could have expected to receive in the community. A variety of mental health professionals regularly saw, assessed and reviewed Mr Punchard. A consultant psychiatrist examined Mr Punchard in April 2017, and concluded that the voices Mr Punchard said he was hearing were not auditory hallucinations and that he did not present as someone who was psychotic or suffering from an acute psychotic episode. The psychiatrist believed Mr Punchard's actions and behaviour were within his own control and that he had good capacity to make his own decisions.

14. When Mr Punchard first arrived at HMP Norwich, he continued to receive the medications that he said he had been prescribed in the community. He was not

always compliant with the medication regime and he was found on at least one occasion to be diverting medication.

15. The clinical review has concluded that, overall, Mr Punchard's physical and mental health issues were managed promptly, appropriately, and in accordance with National Institute of Clinical Excellence (NICE) guidance and Prison Service Orders.

Custodial management

16. Mr Punchard believed that he was at risk from other prisoners on residential wings at Norwich. He said on numerous occasions that this was because of a large drug debt of many thousands of pounds owed by him and his brother (who was also at Norwich). Mr Punchard provided little information to substantiate his claim that he was at risk, and Norwich, in consultation with the police liaison officer, were unable to identify any evidence that he was in danger either in the prison or the community. His brother lived on a normal residential wing without incident.

17. Although it appears that Mr Punchard's fears were not well founded, it is clear that they were very real to him and caused him great anxiety. Norwich responded to this situation appropriately by trying to arrange transfers to prisons where Mr Punchard had said he would feel safe (HMPs Wayland and Highpoint). However, when he was transferred there he engaged in extreme behaviour (barricading, dirty protests, fire setting and occasional self-harm) in what he acknowledged were deliberate attempts to remain in segregation where he felt safest. Over the months before his death, this behaviour became entrenched. He refused to return to a residential wing and spent nearly four months in virtually continuous segregation.

18. The investigation has found that Mr Punchard's segregation at Norwich and other prisons was, in itself, reasonable, appropriate and in line with Prison Service Order (PSO) 1700, *Segregation*. However, we do have some concerns.

19. Mr Punchard spent four months segregated in four different prisons. Although these transfers were arranged with the intention of finding a location where he would feel safe, we are concerned that the moves between prisons masked the total length of time he had spent in segregation. As a result, there was no care plan in place to support his mental well-being (as there should be when a prisoner is segregated for more than 30 days) and there is no evidence that his long-term segregation was seen as a risk factor.

20. The frequent moves also meant that no one prison took a strategic approach to the management of Mr Punchard's behaviour and the underlying reasons for it. Each time his behaviour became a problem, he was moved on and no one took responsibility for trying to understand what motivated it or whether anything could be done to help him modify it. He was seen as Norwich's responsibility but in fact spent less than four weeks there in the last three months of his life.

21. A further problem was that Mr Punchard's extreme behaviour was seen as 'manipulative', in the sense that it was designed to achieve what he wanted, which was not to live on a normal residential wing. As a result, no one seems to

have tried to explore why Mr Punchard's fear of normal location was so great that it seemed preferable to him to smear his cell and his body with faeces whenever he was faced with the prospect of normal location.

22. We also consider that HMP Highpoint's decision to recategorise Mr Punchard was premature and was based chiefly on considerations of expedience. Mr Punchard arrived at Highpoint on 17 May and the Governor asked for his categorisation to be reviewed on the morning of 18 May after Mr Punchard had climbed on a roof. Apart from the incident on the roof, Highpoint's justification for recategorising Mr Punchard was his behaviour in the four months before he arrived at Highpoint – behaviour that Highpoint had been aware of when they agreed to accept him.

23. Once Highpoint had recategorised Mr Punchard to category B, it was almost inevitable that he would have to return to Norwich, as the short time he had left to serve made him ineligible for category B prisons in the region. Mr Punchard had consistently said he felt unsafe at Norwich and refused to leave the segregation unit there. A return to Norwich meant that it was almost inevitable that he would spend the rest of his sentence in segregation there.

24. When Mr Punchard arrived back at the segregation unit in Norwich, staff there, who knew him well, saw nothing to raise concern for his well-being. However, by this point Mr Punchard had spent nearly four months in virtually continuous segregation and had continued to display extreme behaviour in response to apparently irrational fears throughout this time.

25. We are concerned that staff at Norwich had come to see Mr Punchard's behaviour as 'normal'. As a result, they relied on his positive presentation, and his risk factors were not re-evaluated when he returned to Norwich shortly before his death

Recommendations

- The Group Director for the Eastern Region should satisfy himself that effective procedures are in place for the strategic management and support of prisoners who have been in long-term segregation at more than one prison.
- The Governor of HMP Norwich should ensure staff record the options considered and specific steps taken in assisting prisoners to return to normal location from segregation.
- The Governor of HMP Norwich should ensure that long-term segregation is considered as a risk factor when assessing risk of suicide and self-harm.
- The Governor of HMP Highpoint should ensure recategorisation decisions are taken in line with PSI 40/2011 and in particular demonstrate how a prisoner's risk had changed to justify recategorisation.

The Investigation Process

26. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and asking anyone with relevant information to contact him. No responses were received.

27. HMP Norwich provided copies of relevant extracts from Mr Punchard's prison and medical records. The investigator also viewed CCTV and had access to any telephone calls made by Mr Punchard.

28. NHS England commissioned a review Mr Punchard's clinical care at the prison.

29. The investigator interviewed ten members of staff at Norwich in July and August.

30. We informed HM Coroner for Norfolk of the investigation and she provided the post-mortem results, which give the cause of death as hanging. Toxicology indicated that no illicit substances were present in Mr Punchard's system.

31. One of our family liaison officers, contacted Mr Punchard's mother to explain the investigation. Mr Punchard's family raised a number of questions through their legal representative. Some have been addressed in separate correspondence. Those listed below are addressed in the body of our report:

    - There were bruises on Mr Punchard's temples and forehead. How had these occurred and had he had been restrained on 1 June?
    - Had Mr Punchard had been given the wrong medication at HMP Norwich?
    - Had Mr Punchard pressed his cell call bell during the evening of 1-2 June?
    - Was Mr Punchard's location in segregation appropriate and reasonable?

32. The family's legal representative indicated that they had no comments to make on the draft report.

Background Information

HMP Norwich

33. HMP Norwich is a multi-function prison, which predominantly serves the courts of Norfolk and Suffolk. The prison holds up to 769 men. Virgin Care provides healthcare services.

HM Inspectorate of Prisons

34. The most recent inspection of Norwich was in September 2016. Inspectors noted that progress had been maintained since their last inspection in August 2013 and, in some important areas, built upon. The inspectors said that Norwich had experienced similar challenges to other local prisons in recent years, including lower staffing levels, increases in violence, particularly against staff, and the increased use by prisoners of new psychoactive substances (NPS). Nonetheless, prisoners were more likely to say that they felt safer at Norwich than at similar prisons. The inspection said that the prison had taken proactive steps to understand the safety challenges and developed a range of interventions to offset the impact of the poor behaviour of some prisoners. While more needed to be done, the inspection considered that this proactive approach had resulted in a safer and more stable prison.

Independent Monitoring Board

35. 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 most recent annual report published in August 2017, the IMB noted that the segregation unit had been used appropriately and in accordance with Prison Rules. Prisoners were informed of the reasons for their segregation, although some prisoners had demanded more evidence for the reasons behind their segregation decisions. The board said that staff on the unit had shown tolerance and patience and had worked hard to foster improved relationships with all prisoners in their care.

Previous deaths at HMP Norwich

36. Mr Punchard's is the third apparently self-inflicted death to have occurred at Norwich in 2017. There were no significant similarities with the circumstances of the other deaths.

Assessment, Care in Custody and Teamwork (ACCT)

37. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system 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 risk and how best to monitor and supervise the prisoner.

38. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary 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 on the caremap have been completed.

39. 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, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody).*

Segregation

40. Most of the rules about segregating prisoners are set out in PSO 1700, *Segregation, Special Accommodation and Body Belts*. 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 unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and have a daily period in the open air.

41. As we said in our Learning Lessons bulletin on segregation, published in June 2015, segregating prisoners is an extreme form of custody which removes the possibility of activity and interaction with others. It thereby reduces protective factors against suicide and self-harm, and the vulnerabilities of those with pre-existing mental health issues may be exacerbated. It should therefore only be used in exceptional circumstances and be 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.

42. An Initial Segregation Health Screen must be conducted within the first two hours of a prisoner being placed in segregation to assess a prisoner's ability to cope with the effects of being segregated. Regular Segregation Review Boards should then take place throughout the period that the prisoner continues to be segregated to consider how well the prisoner is coping and whether segregation continues to be a suitable option. These should be multi-disciplinary, attended by both prison and healthcare staff, and take into account any current or background risks which have been identified.

43. The PSO says that long periods of segregation have been found to have potentially negative effects on individuals, particularly those with pre-existing mental health problems. For prisoners who have spent a month or more in segregation, the prison should consider implementing a phased return, over several days, to normal location on the wing. The PSO says it is hoped that allowing prisoners to spend time doing activities on their wing alongside other prisoners will assist their readjustment and gradual return to an environment they may otherwise find difficult.

44. The PSO says that, if a prisoner is segregated for more than 30 days, a care plan should also be drawn up to detail how that prisoner's mental health is to be supported during that period of segregation. Proactive steps to safeguard mental

health should be considered, which might include increasing the number of visits from a doctor or nurse, increasing observations, encouraging family contact or participating in exercise.

Categorisation

45. Prison Service policy on security categorisation and recategorisation is set out in PSI 40/2011, *Categorisation and Recategorisation of Adult Male Prisoners.* This provides that all prisoners will be assigned to one of four security categories (A to D, with A being the highest). A prisoner's security category is based on an assessment of the likelihood of escape or abscond; the risk of harm to the public in the event of an escape or abscond; and any control issues that impact on the security and good order of the prison and the safety of those within it. Prisoners must be assigned to the lowest security category consistent with managing those risks.

46. The PSI also says that 'the purpose of the recategorisation process is to determine whether, and to what extent there has been a clear change in the risks a prisoner presents, and to ensure that he continues to be held in the most appropriate conditions of security'.

47. The PSI also specifies the timeframes within which recategorisation reviews should take place, but in addition states 'prisoners may have their security category reviewed whenever there has been a significant change in their circumstances or behaviour which impacts on the level of security required.' The policy also lists a number of changes that might initiate such a review.

Key Events

January – March, HMP Norwich

48. On 10 January 2017, Mr Luke Punchard was sent to HMP Norwich, charged with robbery. He had been at Norwich on previous occasions and staff knew him well.

49. When he arrived at Norwich, staff completed reception tasks, including an initial health screen. Mr Punchard raised no concerns and said he had no thoughts or intent to self-harm. A nurse completed the health screen and recorded that Mr Punchard had last been in custody at HMP Peterborough in 2016. He recorded that Mr Punchard had been prescribed medications in the community: pregablin (used to treat a number of conditions including, epilepsy, neuropathic pain and anxiety disorder,) zopiclone (a sleeping tablet,) and risperidone (used to treat schizophrenia and bipolar disorder). Mr Punchard told the nurse that in December 2016, he had spent time in a local psychiatric hospital, and had been diagnosed with schizophrenia and attention deficit hyperactivity disorder (ADHD).

50. Mr Punchard had a long history of both illicit drug and alcohol misuse. A drug screen done on reception indicated that he tested positive for benzodiazepines, cannabis and cocaine. The nurse referred Mr Punchard to the prison drug services for further assessment. The nurse recorded that he had no concerns about Mr Punchard's mental or physical well-being. Mr Punchard was prescribed those medications he had been receiving in the community and, in addition, was prescribed diazepam (to treat any withdrawal symptoms) and quetiapine (an antipsychotic used to treat schizophrenia and bipolar disorder).

51. Over the following two weeks, drug treatment staff saw Mr Punchard and completed further assessments for drug treatment. Mental health staff also saw him to complete mental health assessments and recorded Mr Punchard's mental health history and current medication. The mental health team discussed Mr Punchard at their regular case reviews. They did not consider him to require regular input from the team at that time, but he was added to their caseload and made aware of the support available.

52. Mr Punchard was located in a cell with his younger brother, nothing negative about his behaviour was recorded in the next couple of weeks, and staff raised no concerns.

53. On 28 January, Mr Punchard passed staff a note indicating that he and his brother were under threat from an unknown prisoner. He said that the threat was due to a debt of many thousands of pounds, accumulated in the community. Mr Punchard was asked if he was able to identify the person who had threatened him. He said that he could not and provided no further information. In line with the prison's violence reduction policy, both Mr Punchard and his brother were placed on victim support measures. Staff from the prison's safer custody team offered support, and wing staff monitored them. The prison security department were unable to identify any prisoner that might have been involved and consulted the prison's police liaison officer who also found no evidence from the community to support Mr Punchard's concerns.

54. Mr Punchard and his brother remained in their cell and staff recorded that they were 'self isolating.' On 30 January, at approximately 6.30pm, a nurse was asked by wing staff to see Mr Punchard as he said that he had been poisoned. The nurse recorded that when she went to the cell, Mr Punchard was presenting as paranoid and agitated, and she was unable to complete a physical observation. Mr Punchard claimed his meal had been tampered with.

55. A supervising prison officer (SO,) who was on duty on the wing told the investigator that, as Mr Punchard and his brother had not been leaving their cell, he had collected Mr Punchard's evening meal and taken it to him. The SO said that he had plated the meal and was clear it could not have been tampered with and he said so to Mr Punchard.

56. At 7.15pm that evening, Mr Punchard and his brother set a fire and would not allow staff access to the cell. When the fire brigade arrived, Mr Punchard was threatening and abusive. Staff entered the cell, restrained both prisoners to remove them from the cell for their own safety and took them to the segregation unit. On 31 January, Mr Punchard set fire to his cell in the segregation unit, requiring staff to relocate him to another cell on the unit.

57. As a segregation unit resident, healthcare staff saw Mr Punchard daily and he raised no immediate concerns. His continued segregation was reviewed weekly in line with segregation unit policy, but was justified by his continued non-compliance (refusal to return to normal location) and threat to the good order and discipline of the prison. During the reviews alternatives to segregation were discussed with Mr Punchard, such as location on a vulnerable prisoner wing, which he refused. He consistently refused to return to a residential wing, maintaining that he was at risk from other prisoners.

58. On 1 February, Mr Punchard set another fire. Staff immediately opened an ACCT document and recorded that Mr Punchard said he had intended to kill himself rather than be killed by other prisoners, and that he would continue trying until he succeeded. He was initially monitored five times an hour, then this was reduced to hourly the following day. At an ACCT review held on 8 February, Mr Punchard said he heard voices and thought his food was being contaminated but his medication was working and he had no thoughts of self-harm. His observations were reduced. At a further review the following day, he was calm and relaxed, reiterated that he had no further thoughts of suicide and self-harm and the ACCT was closed.

59. Mr Punchard's brother returned to a residential wing following a period of punishment without further issues. Managers and officers continued to speak to Mr Punchard daily and encouraged him to leave segregation. He said that he would be happy to live on normal location in another prison, indicating HMP Wayland and HMP Highpoint as possible alternatives.

60. A mental health nurse, told the investigator that Mr Punchard had been on her caseload from the beginning of 2017, but she had seen him most regularly after he was located in segregation. The mental health nurse told the investigator that Mr Punchard told her that he was under threat, and had done what he had on the wing to secure a move to segregation.

61. The mental health nurse said that, while in segregation, Mr Punchard seemed calmer than he had been on the wing, and she spoke to him about his belief that he was hearing voices. She raised these concerns with a visiting psychiatrist.

62. On 21 February, Mr Punchard began a dirty protest. He continued his protest until 23 February. Mental health staff and officers told the investigator that they did not consider the dirty protest indicated any deterioration in Mr Punchard's mental health but was behaviour intended to frustrate any attempt to return him to a residential wing or transfer him to a prison he did not want to go to.

63. On 27 February, a visiting psychiatrist saw Mr Punchard with a nurse to see whether he had any underlying mental health issues. In the psychiatrist's opinion, Mr Punchard displayed no obvious underlying mental health problems and was not psychotic.

64. The mental health nurse told the investigator that both she and her colleagues who dealt with Mr Punchard in segregation, felt that his problems were down to anxiety and stress caused by his belief that other prisoners had been paid to harm him. She said that although there was nothing to support Mr Punchard's belief that he was under threat, he strongly believed that he was. She said that in her opinion, the anxiety this caused Mr Punchard was very real.

March, HMP Wayland

65. On 6 March, Mr Punchard attended court and was sentenced to 18 months imprisonment. He was transferred, with his agreement, to HMP Wayland on 8 March. On his arrival at Wayland, Mr Punchard raised no concerns and was located on a residential unit.

66. On 10 March, Mr Punchard barricaded his cell and, after staff intervened, he was relocated to another wing. On 18 March, he again denied staff access to his cell, and at 7.10pm, made cuts to the tops of both ears. When staff entered his cell, he allowed staff to treat his wounds and said he had self-harmed due to being in debt. Staff opened an ACCT document, which acknowledged Mr Punchard's history of mental illness, and he was monitored hourly for the remainder of the night.

67. On the morning of 19 March, Mr Punchard again barricaded his cell and initially refused to engage with staff. However, two fellow prisoners managed to get verbal and visual confirmation that he was well. Mr Punchard removed the barricade and agreed to comply with the regime. A multidisciplinary ACCT case review attended by nursing staff was convened during which Mr Punchard stated his issues were debt, and denied any thoughts or intent to self-harm further. His ACCT checks were set at twice per hour.

68. Despite his assurances, Mr Punchard set fire to his cell later that afternoon. Staff entered the cell and Mr Punchard was relocated to D wing, where he began a dirty protest and was subsequently relocated to the segregation unit. His records stated that relocation to segregation placed Mr Punchard at little risk of suicide or self-harm because he had spent long periods in segregation in the past.

69. Once on the segregation unit, Mr Punchard told staff that his recent behaviour was the result of the issues he had at Norwich following him to Wayland and his behaviour had been intended to secure a move to the segregation unit. There was no evidence to support Mr Punchard's belief that he was under threat at Wayland.

70. During an ACCT review with Mr Punchard held on 20 March, staff recorded that he had not been taking his medication regularly but felt that the staff in the segregation unit would be in a better position to encourage him to do so. He was recorded as being happy and settled in the segregation unit and had no intention of suicide or further self-harm. Following the review, the ACCT was closed.

March- April, HMP Norwich

71. Norwich had agreed in advance that if Mr Punchard displayed poor behaviour at Wayland, they would accept him back. Mr Punchard remained in segregation at Wayland until 23 March, when he was returned to Norwich. On arrival, Mr Punchard refused to go to a residential wing and was placed in the segregation unit. On the morning of 24 March, he began a dirty protest, which he ended later that day.

72. On 29 March, Mr Punchard was ordered to return to a residential wing, which he refused to do, and began another dirty protest. He smashed the observation panel on his cell door and threw urine, excrement and other items onto the landing. Staff wearing protective clothing entered the cell and removed Mr Punchard under restraint, while repairs took place. After he was returned to his cell, he continued his dirty protest and challenging behaviour for the next two days. On 31 March, he said he wanted to end his protest, and staff arranged for him to clean himself.

73. Mr Punchard remained compliant with the segregation unit regime but continued to refuse to go to a residential wing.

74. On 11 April, a consultant psychiatrist, saw Mr Punchard to complete a mental health assessment. He concluded that Mr Punchard's presentation did not indicate someone who was psychotic or suffering from an acute psychotic episode. The psychiatrist wrote that Mr Punchard's actions appeared to be within his own control. Mr Punchard remained on his medication regime. No additional treatment or assessment was planned.

75. Given Mr Punchard's refusal to relocate from segregation and the need to create space on the unit at Norwich, Norwich liaised with HMP Bure, a long-term category C prison, for Mr Punchard to be located in their segregation unit, which was only holding one other prisoner at the time. Bure agreed to take Mr Punchard, to give him and the staff at Norwich a period of respite, while Norwich arranged an onward progressive transfer for him.

April – May, HMP Bure

76. Mr Punchard transferred to Bure on 16 April. He remained in segregation there and was compliant with the regime, apart from a few minor infractions. According to his records, the justification for keeping Mr Punchard in segregation

mainly referenced his earlier actions at Norwich. In relation to specific concerns around his mental health, staff recorded 'Nil known' and 'Not at this time'.

77. Norwich arranged a transfer to HMP Peterborough and, on 4 May, staff from Norwich arrived at Bure to take Mr Punchard to Peterborough. When they arrived, Mr Punchard made superficial cuts to his leg and threatened to start a dirty protest, stating that he did not wish to transfer to Peterborough.

78. Peterborough were informed and declined to accept Mr Punchard. ACCT procedures were started and the transfer to Peterborough was cancelled. During an ACCT review Mr Punchard denied any intent to self-harm any further, stating that he did not wish to transfer to Peterborough as he had "issues" there. The ACCT remained open until 9 May when, following a further case review, it was closed. On 11 May, Mr Punchard began a dirty protest, which only lasted a few hours, before he asked to clean himself up. From 11 May, he was fully compliant and remained in the segregation unit at Bure until 17 May.

May, HMP Highpoint

79. Mr Punchard had told staff at Norwich which prisons he would be willing to transfer to. One of these was HMP Highpoint and Mr Punchard was transferred there on 17 May as part of an arrangement which saw a prisoner moved from the segregation unit at Highpoint to a residential wing at Norwich. On arrival at Highpoint, Mr Punchard raised no immediate concerns and agreed to go onto a residential unit.

80. At around 8.30am on 18 May, during a routine movement of prisoners to work, Mr Punchard climbed onto a shed roof. Staff negotiated with him for around 30 minutes, he came down and was escorted to the segregation unit.

81. During the morning management meeting on 18 May, the Governing Governor raised concerns about Mr Punchard's suitability to be in a category C prison. He asked a custodial manager (CM) to review his categorisation.

82. On the morning of 19 May, Mr Punchard began a dirty protest and was placed in a different cell.

83. The CM told the investigator that she tasked an Offender Supervisor (OS) with the responsibility for reviewing Mr Punchard's categorisation and this was completed later the same morning. The OS completed the RC1 form which indicated that Mr Punchard's risk had increased because he had offended against Prison Rules 18 times since January. It also stated that 'due to Mr Punchard's continuing poor behaviour of disrupting regimes and endangering the health and safety of himself and others, recategorisation to category B is recommended.' On 24 May, the Governing Governor authorised the recategorisation stating on the record, 'continued poor pattern of behaviour, threats, damage etc. Not suitable for Cat C conditions.'

84. The CM told the investigator that she then tried to arrange Mr Punchard's transfer to another prison through the Population Management Unit (PMU) at Prison Service headquarters. The PMU said that they could not arrange a move until another prison agreed to take Mr Punchard.

85. The CM told the investigator that by Friday 27 May, every category B prison in the Eastern region had declined to accept Mr Punchard, including Norwich, Bedford and Chelmsford. The Governing Governor then escalated the matter to the Acting Director of Prisons for the Eastern Region. The Acting Director of Prisons for the Eastern Region spoke to the Governor at Norwich on 30 May, and instructed him to accept Mr Punchard.

Norwich – 31 May to 2 June

86. Mr Punchard arrived back at Norwich at lunchtime on 31 May. He was asked to go to a residential wing, refused and was taken to the segregation unit. Segregation staff said that when he arrived back onto the unit he raised no concerns, indicated no objections to being back at Norwich and appeared pleased to see them.

87. On 1 June, Mr Punchard was seen by a nurse from the mental health team who completed an assessment of his mental health and well-being. Mr Punchard told the nurse that he was "fine" and, when asked, denied any thoughts of self-harm or suicidal intent.

88. The nurse knew Mr Punchard, and had dealt with him on many occasions and had seen him in segregation several times in the past. The investigator asked her whether Mr Punchard appeared in any way different, or if she had concerns about his risk to himself when she spoke with him on 1 June. She said that his presentation was no different. She said that there were no indicators to suggest to her that Mr Punchard was at increased risk to himself or others.

89. An SO who works in the segregation unit at Norwich had also known Mr Punchard for a number of years. He said that he had always had a good relationship with Mr Punchard, and would often share a joke with him. The SO said that, unlike other periods of custody, on this occasion, Mr Punchard seemed preoccupied with the belief that he was under threat. He said that both he and other staff would often talk to Mr Punchard about his concerns, reassure him that he was safe and encourage him to comply with the prison regime. The SO did not believe that there was any foundation to Mr Punchard's concerns.

90. On the afternoon of 1 June, after Mr Punchard had spoken with the nurse, he spoke with the SO about his return to Norwich. The SO told the investigator that it became apparent that Mr Punchard had an improvised weapon (a sharpened eating utensil) in his hand. He said that, when asked, Mr Punchard handed over the item.

91. The SO said that for the remainder of the afternoon there were no other issues with Mr Punchard. He said that several staff members who knew Mr Punchard well were on duty and spoke with him during the afternoon, including when he collected his evening meal from the servery at around 4.30pm.

92. Another SO, who had been on duty on the unit during the afternoon, was about to finish his shift when he was called onto the landing by another prisoner. He said that when he went onto the landing he became aware of the smell of faeces. He found Mr Punchard covering his torso with faeces. The SO said he asked him what he was doing but Mr Punchard did not reply and just carried on. The

SO said that he told the duty manager that Mr Punchard had begun another dirty protest and relevant paperwork was completed.

93. On the evening of 1 June, two operational support grades (OSGs), were on night duty in the segregation unit. On a night shift, there is normally only one OSG on duty in the segregation unit. However, that week, prison managers had decided to deploy two members of staff because another challenging prisoner was being held on the unit.

94. One of the OSG's told the investigator that he had known Mr Punchard previously and had dealt with him prior to his transfer to Bure. He said that when Mr Punchard returned to Norwich on 31 May, he did not notice anything untoward in his presentation, and had never had any concerns about Mr Punchard's risk of harm to himself. The OSG's were both told when they arrived for duty on 1 June that Mr Punchard had just begun a dirty protest.

95. During the evening, Mr Punchard was checked hourly in accordance with segregation unit policy, and both OSG's spoke with him. One of the OSG's said that he asked Mr Punchard why he had engaged in his protest. Mr Punchard replied, "Because they want to put me back on the wing." The OSG said he reassured Mr Punchard that this was not the case and said Mr Punchard knew they would not be able to move him if he refused. The OSG said, at this stage, Mr Punchard was calm and had asked for some cleaning materials so he could clean himself.

96. The OSG explained that he was unable to unlock a cell door at night, but he passed some sachets of shampoo to Mr Punchard under his door. During the night, Mr Punchard continued to be checked and the other OSG said that, on one occasion, she saw Mr Punchard cleaning the walls of his cell. The OSG's said that they had last checked on Mr Punchard at approximately 4.20am and one of them had a brief conversation with him. Mr Punchard told him that he was "going to get his head down." The OSG said he did not appear upset or distressed.

97. On 2 June, at approximately 5.00am, one of the OSG's began checking the prisoners on the unit. On reaching Mr Punchard's cell, she opened the observation panel and looked towards the bed but could not see Mr Punchard. She then looked towards the corner where the toilet is located to see if he was there. The OSG saw Mr Punchard seated on the floor, slumped against the wall.

98. The OSG said that the observation panel had been smeared with faeces. Mr Punchard had attempted to clean it but it was still slightly obscured. The OSG could see that he had a bulky towel around his neck. The OSG called the other OSG who was also on the landing. He said that when he looked into the cell he made out what appeared to be a piece of bedding leading from Mr Punchard's neck towards the window, and that he was hanging. The OSG immediately called a medical emergency code blue (indicating that a prisoner is unconscious or having difficulties breathing) on his radio. The call was recorded by the control room at 5.05am and an ambulance was called at 5.06am.

99. A Custodial Manager (CM) who was the orderly officer and senior manager on duty on 2 June and, the only person who could access keys to move around the prison during the night state, said that when she heard the code blue, she

immediately went to the gate. She drew keys for the gate officer so that he would be able to provide access to the ambulance. She also collected additional keys for use by other members of staff.

100. The CM then ran to B & C wings as there was a nurse based there. After collecting the nurse and an additional officer, she made her way to the segregation unit. The investigator has viewed CCTV, which shows staff arriving onto the unit shortly after Mr Punchard was discovered. When the CM arrived, one of the OSG's was standing at the cell door with his emergency key in the lock and, as staff entered the unit, he unlocked the door. The CM said that she went into the cell first, followed by an officer and a nurse. The CM said that Mr Punchard was suspended at the back of the cell with a ligature around his neck.

101. The CM said that the smell caused by the dirty protest was "horrific" and had briefly stopped the staff in their tracks. The officer used his anti-ligature tool to cut the ligature and they laid Mr Punchard flat on the floor and started cardiopulmonary resuscitation (CPR.)

102. The nurse requested a defibrillator - the closest one was in reception (a short distance away) - and the CM went to collect it. The CM gave a set of keys to the other OSG and instructed her to collect staff from A wing and then to go to the gate and assist with providing access to the ambulance.

103. When the CM returned to the segregation unit with the defibrillator, two further officers and an additional nurse had arrived from A wing. The defibrillator was attached and efforts to resuscitate Mr Punchard continued until the arrival of paramedics. The defibrillator indicated three times that there was no shockable rhythm. Paramedics continued resuscitation but, at 5.38am, pronounced Mr Punchard dead.

Contact with Mr Punchard's family

104. Norwich allocated a Supervising Officer (SO) as family liaison officer, and identified Mr Punchard's mother as his next of kin. Together with the Deputy Governor, the SO visited Mr Punchard's mother at around 8.30am on 2 June, and informed her of her son's death.

105. Mr Punchard's mother visited the prison later that day and a private visit was facilitated between her and her other son who was also in custody at Norwich. The prison offered support with funeral arrangements and reasonable costs in line with national guidance. Mr Punchard's family declined to have any representatives from the prison present at the funeral.

Support for prisoners and staff

106. Following Mr Punchard's death, the prison safer custody team reviewed all those prisoners subject to ACCT monitoring.

107. A duty governor chaired a hot de-brief with those staff involved on 2 June and support was offered by the staff care team.

Post-mortem report

108. The post-mortem examination found that the cause of death was hanging. Toxicology tests found no potentially fatal concentrations of medication.

Findings

Clinical care

109. When Mr Punchard arrived at HMP Norwich, he continued on the medications that he had been prescribed in the community.

110. Mr Punchard was frequently seen, assessed and reviewed by a variety of mental health professionals during his time in segregation. He was seen and examined on 11 April 2017 by a consultant psychiatrist who concluded that the voices Mr Punchard said he was hearing were not auditory hallucinations and that he did not present as someone who was psychotic or suffering from an acute psychotic episode. The psychiatrist believed Mr Punchard's actions and behaviour were within his own control and that he had good capacity to make decisions.

111. The clinical review has concluded that Mr Punchard's physical and mental health issues, were managed promptly, appropriately, and in accordance with National Institute of Clinical Excellence (NICE) guidance and Prison Service Orders.

112. Mr Punchard's family were concerned that Mr Punchard might have been given the wrong medication, or not provided with medication that he required. The investigation found no evidence of this, and Mr Punchard was prescribed the same medication he had been receiving prior to custody. The only issues recorded in respect of medication were Mr Punchard's occasional refusal to take his medication.

Custodial management of Mr Punchard

113. Mr Punchard spent just over two weeks on a normal residential wing in a cell with his brother when he first entered custody in January 2017. He then told staff that he believed he and his brother were at risk from other prisoners and committed an offence – setting fire to his cell - with the apparent intention of securing his relocation to the segregation unit.

114. The prison investigated Mr Punchard's claims with the assistance of the police liaison officer, but with the limited information provided, were unable to identify evidence to support his concerns. Mr Punchard's brother was able to return to normal location and remain there without incident, and this appears to suggest that Mr Punchard's fears were not well founded. However, it is apparent that, whether or not he was genuinely at risk, for Mr Punchard his concerns were real and caused him a great deal of anxiety. His concerns were so great that he engaged in extreme behaviour (such as dirty protests) rather than relocate to a normal residential wing.

115. Mr Punchard's behaviour was challenging and difficult to manage, but staff tried to support him, addressed instances of self harm using the ACCT process appropriately and encouraged him daily to comply with prison rules. During regular segregation reviews, staff discussed alternatives with him that would enable him to live in the general population, such as location on a vulnerable prisoner unit, but he consistently refused.

116. For the next four months, Mr Punchard remained in virtually continuous segregation, spending only 11 days on normal location at Wayland and less than 24 hours at Highpoint. When he was on normal location, he behaved in a way that led to him being segregated, even at prisons where he had previously said he would feel safe. Once in segregation, he refused to leave and whenever there was any suggestion that he might be returned a residential wing, he embarked on dirty protests. He told staff he was behaving in this way because he was at risk and wanted to remain in segregation.

117. The effects and risks of long term segregation are well known, feature regularly in our investigations into self inflicted deaths and are addressed though the safeguards set out in Prison Service policies. Our Learning Lessons Bulletin underlines the need to comply with the safeguards set out in those policies and stress the need to for strategies for supporting prisoners who spend extended periods in segregation. We are concerned that his frequent moves masked Mr Punchard's effective long term segregation and that opportunities to consider the dynamics of his risk were missed.

118. We accept that Mr Punchard's continued refusal to leave segregation made him difficult to manage. Staff at Norwich made appropriate attempts to transfer him to suitable prisons, including two where he said he would feel safe, but without success. Staff at Wayland appear to have made a real effort to help Mr Punchard remain on normal location, but after he barricaded his cell three times, self-harmed and set fire to his cell, they had little alternative but to segregate him.,

119. The investigation has narrowly found that Mr Punchard's location, and overall management in the segregation units at Norwich, HMP Wayland and HMP Bure was, in itself, reasonable and appropriate, based on his behaviour, and managed in line with Prison Service Order (PSO) 1700, *Segregation*. However, although Norwich acted appropriately in trying to arrange transfers for Mr Punchard as an alternative to remaining in the segregation unit, this had some unintended consequences.

120. First, Mr Punchard's behaviour meant that, in order to facilitate a move, Norwich had little choice but to agree with Wayland and Bure that they would accept him back if his behaviour deteriorated. As a result, both Wayland and Bure saw Mr Punchard as Norwich's responsibility. This meant in practice that neither prison made an attempt to understand Mr Punchard's apparently irrational fear of normal location or to develop a plan to help him overcome it.

121. Second, the fact that Mr Punchard was segregated in four different prisons may have had the effect of masking the total length of time he had been segregated. Prison Service policy, set out in PSO 1700, is that, if a prisoner is segregated for more than 30 days, a care plan should be drawn up setting out how his mental health will be supported. However, although Mr Punchard had spent nearly four months in virtually continuous segregation by the time of his death, he had not spent 30 days in segregation at any one prison. It appears that no one saw Mr Punchard's segregation in its totality and that, as a result, no consideration was given to developing a care plan to support his mental health.

122. We also found no evidence that any consideration was given to whether Mr Punchard might be at an increased risk of self-harm on his return to Norwich on 31 May, following his recategorisation. Staff at Norwich repeatedly emphasised that they were very familiar with Mr Punchard and that he appeared no different when he returned to the prison shortly before his death. However, Mr Punchard had been away from Norwich for a month and a half, during which time he had been recategorised to B and his apparently irrational fear of normal location had become entrenched. In addition, he had now been in virtually continuous segregation for nearly four months, and faced the prospect of remaining at Norwich (a prison where he felt unsafe) until his release. This should have prompted a re-evaluation of his risk, particularly when he was found to have an improvised weapon and then began smearing his torso with faeces in another dirty protest.

Recategorisation

123. Mr Punchard arrived at Highpoint on 17 May and the Governor asked for his categorisation to be reviewed the following morning, after Mr Punchard had climbed on a roof. Apart from the incident on the roof, Highpoint's justification for recategorising Mr Punchard was his behaviour in the four months before he arrived at Highpoint – behaviour which Highpoint had been aware of when they agreed to accept him as a 'swap' in exchange for one of their prisoners with whom they were having problems. This does not appear to meet the criterion for recategorisation, which is that the prisoner's risk has increased.

124. In our view, the recategorisation was premature. We consider that, having agreed to accept Mr Punchard, Highpoint should have made an attempt to make the placement work instead of starting the recategorisation process within less than 24 hours. We have seen no evidence that Highpoint made any attempt to support Mr Punchard to settle there. Following his actions on 18 May, the prison's first and only response was to recategorise him and seek to move him on as quickly as possible.

125. We consider that Highpoint acted in their own interests and did not take into account the likely impact recategorisation would have on Mr Punchard's management. Given his custodial history and the fact that he had less than six months left to serve, there was little likelihood that any category B prison in the Eastern region would be prepared to accept him. The recategorisation decision, therefore, made it virtually inevitable that Mr Punchard would have to return to Norwich, a prison where he was known to fear for his safety and where it was, therefore, probable that he would have to spend the rest of his sentence in segregation.

Recommendations

- The Group Director for the Eastern Region should satisfy himself that effective procedures are in place for the strategic management and support of prisoners who have been in long-term segregation at more than one prison.

- The Governor of HMP Norwich should ensure staff record the options considered and specific steps taken in assisting prisoners to return to normal location from segregation.

- The Governor of HMP Norwich should ensure that long-term segregation is considered as a risk factor when assessing risk of suicide and self-harm.
- The Governor of HMP Highpoint should ensure recategorisation decisions are taken in line with PSI 40/2011 and in particular demonstrate how a prisoner's risk had changed to justify recategorisation.

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