

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Solomon Bygraves, a prisoner at HMP & YOI Norwich on 5 February 2018

A report by the Prisons and Probation Ombudsman

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 Bygraves was found hanged in his cell at HMP Norwich on 6 February 2018. He was 32 years old. I offer my condolences to Mr Bygraves' family and friends.

Mr Bygraves was well-known to prison and healthcare staff at Norwich. He had a long history of mental health issues, self-harm and attempted suicide and substance misuse through which he was supported on many occasions.

Mr Bygraves was at high risk of suicide on the day he died but he was not checked in accordance with the agreed frequency. The investigation identified concerns around the management of ACCT procedures, particularly around about the lack of mandatory checks on his well-being that should have supported him through a volatile period of heightened risk.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

June 2019

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Summary

Events

1. Mr Solomon Bygraves had a history of self-harm and attempted suicide in prison. On 20 June 2016, while serving a custodial sentence at HMP Norwich, he attempted to hang himself in his cell. He was found unconscious and taken to hospital. He made a full recovery and returned to Norwich. Mr Bygraves was released on 10 April 2017.
2. On 1 November 2017, Mr Bygraves was remanded into custody at HMP Norwich, charged with burglary. He was taken to the segregation unit (also known as the Care and Separation Unit (CSU)) under restraint after he became aggressive towards staff. While there, he made a noose and said he would hang himself as he had had enough of prison life. Staff agreed that he should be moved to the healthcare centre and they began Prison Service suicide and self-harm prevention procedures (known as ACCT). Mr Bygraves was moved to A wing, an ordinary residential unit, on 3 November and remained subject to ACCT monitoring until 14 November, when it was stopped because he was no longer regarded as being at risk.
3. On 21 January 2018, Mr Bygraves appeared to be under the influence of an unknown substance. As a result, he lost his job as a wing worker and was downgraded from the enhanced to the basic level of the Incentives and Earned Privileges Scheme (IEPS). On 22 January, he was taken under restraint to the segregation unit after he smashed his cell furniture, including his television, when his methadone medication was stopped due to his suspected use of illicit substances. ACCT procedures were resumed when he told a nurse during his segregation screening that he was feeling low in mood. Mr Bygraves was managed under ACCT procedures until 29 January, when he was moved back to A wing.
4. On 1 February, Mr Bygraves was found under the influence of an unknown substance. He cut his arm and attempted to tie a ligature around his neck. ACCT procedures were re-started and he was taken to the segregation unit where he remained until 3 February when he agreed to move to B wing. During an ACCT case review on 5 February, Mr Bygraves told staff that he wanted his television back otherwise he would hang himself. His level of observations was raised immediately from hourly to four times an hour.
5. At 12.58pm, an officer checked on Mr Bygraves who said he was okay. At 2.33pm, another officer looked into his cell and saw him hanging from a ligature made from a bed sheet. Staff and paramedics were unable to resuscitate him and at 3.10pm, a doctor recorded that Mr Bygraves had died.

Findings

6. Mr Bygraves had several risk factors for suicide and self-harm. His near-fatal attempt to hang himself in 2016, was well-known amongst staff at Norwich who were working there at that time although newer staff, who comprised half of the work force, were unfamiliar with him. Staff used segregation as a means of

managing his volatility but, in doing so, did not address his underlying risk factors. Despite documenting incidents where he was thought to have used PS and being warned about the dangers and risks to his health, his acknowledged use of PS raised his risk of self-harm.

7. Mr Bygraves' ACCT case reviews were multidisciplinary and while staff recognised he was at risk of suicide and self-harm they did not always assess the level of risk accurately or set appropriate observation levels. He had been identified as at raised risk of harm on the day of his death.
8. The failure to observe Mr Bygraves for over an hour and a half before he was found was contrary to the specified frequency of checks. Given his established history of threatening and carrying out acts of self-harm, staff could have anticipated his actions and managers could have directed and supported inexperienced staff to better effect.
9. We did not identify any concerns with Mr Bygraves' medical treatment at Norwich. The clinical reviewer concluded that the care provided to Mr Bygraves' was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including:
 - documenting and recording reasons for keeping prisoners subject to suicide and self-harm procedures in the segregation unit, setting out those reasons and other options that were considered and discounted;
 - identifying and recording effectively the level of risk to themselves the prisoner poses; and
 - consideration at case reviews of relevant up-to-date risk information and setting appropriate future case review dates.
- The Governor should ensure that there is structured support and effective managerial oversight for new staff, in particular ensuring the prioritisation of the protection of vulnerable prisoners.
- The Governor should commission an investigation into the actions of B wing managers and officers which led to Mr Bygraves not being observed in accordance with ACCT procedures between 12.58 and 14.33 on 5 February 2018.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP and YOI Norwich informing them of the investigation and asking anyone with relevant information to contact her. One prisoner wrote to the investigator.
11. The investigator visited Norwich on 12 February 2018. She obtained copies of relevant extracts from Mr Bygraves prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Bygraves' clinical care at the prison. They jointly interviewed nine members of staff at Norwich on 15 March.
13. We informed HM Coroner for Norfolk of the investigation who sent us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Bygraves' mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Bygraves' mother asked how it was possible that her son was found hanging when he was 6'7" and should have been checked every 15 minutes, as he was known to be at risk of suicide and self-harm. She questioned whether her son, who had bi-polar disorder, should have been offered more support by moving him to the healthcare centre after he set fire to his cell a week or so before his death instead of considering arson charges. She asked whether his treatment for bi-polar disorder had been appropriate and why her son's records did not designate her as his next of kin.
15. Mr Bygraves' mother received a copy of the initial report. The solicitor representing her expressed concern that Mr Bygraves had been prescribed medication without a comprehensive review of his clinical needs and it was not clear from the medical records that Mr Bygraves had never been formally diagnosed with bipolar disorder. The solicitor indicated there was a lack of communication between staff who had direct contact with Mr Bygraves on the day he died and a lack of clarity as to who was responsible for monitoring him under ACCT. His family are concerned that staff viewed his behaviour through a disciplinary prism of perceived risk to themselves because of pre-conceptions about his height and appearance. They believe this led to staff overlooking the significance of his self-harm four days before.
16. HMPPS also received a copy of the initial report. They identified two typographical errors which have been corrected.

Background Information

HM Prison and YOI Norwich

17. HMP Norwich serves the courts of Norfolk and Suffolk and holds a mix of up to 769 remanded and sentenced prisoners and young adults. Virgin Care provides healthcare services, including mental health services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Norwich was in September 2016. Inspectors reported that despite increases in violence and psychoactive substances, staff-prisoner relationships were generally good and prisoners were more likely to say they felt safe at Norwich than at comparable prisons. Those subject to ACCT procedures were well supported and staff promoted a culture of respect and decency.
19. Inspectors found that the mental health services provided a comprehensive range of services ranging from self-help to complex case management. There were services designed to support men in crisis with a duty team considering referrals by staff or the physical health team, and providing a good response to men with urgent needs.

Independent Monitoring Board

20. 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 28 February 2018, the IMB reported that staff recruitment had accelerated with the result that 50% of staff had less than a year's experience and 60% of managers had been temporarily promoted. The inexperience of recently recruited staff was affecting the safety and decency of the prison, particularly on residential units and due to shortages, some basic tasks were not being carried out and policies not thoroughly implemented. Nevertheless, staff-prisoner relationships were generally positive although officers and nursing staff with personal knowledge of prisoners on ACCT were not always able to attend case reviews.

Previous deaths at HMP Norwich

21. Mr Bygraves' death was the fourth self-inflicted death at Norwich since 2017. We expressed concerns in investigations into previous recent self-inflicted deaths at the prison about the quality of ACCT documentation.

Assessment, Care in Custody and Teamwork

22. 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. 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 carried out at irregular intervals to prevent the prisoner

anticipating when they will occur. 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. 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.

Psychoactive substances (PS)

23. Psychoactive substances (formerly known as ‘new psychoactive substances’ or ‘legal highs’) are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
24. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
25. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

Background

26. Mr Solomon Bygraves had a history of low mood for which he was prescribed medication. His clinical records show that between 2009 and 2017, Mr Bygraves took deliberate overdoses of prescribed medication, often in response to a request being refused, to avoid being transferred to another prison, or as a means of showing his displeasure. He threatened to harm himself on many occasions and did so by overdose, tying ligatures around his neck or cutting himself. ACCT suicide and self-harm procedures had been initiated at least 35 times since 2010. He also had a history of impulsive confrontational behaviour when challenged. Mr Bygraves had served several remand periods or short sentences at Norwich and was well-known to many staff.
27. On 19 June 2016, Mr Bygraves was warned about his negative behaviour at HMP Norwich by an officer who removed the television from his cell. Mr Bygraves made a noose and tied it to his cell light fitting but staff dissuaded him from harming himself and began ACCT procedures to support him because his risk was heightened. On 20 June, while carrying out an ACCT check at 2.56am, an officer saw Mr Bygraves standing on his bed with a noose tied to the cell ceiling light. She told Mr Bygraves to stop and called for staff assistance. Mr Bygraves placed the noose over his head and stepped off the bed so that his feet were off the floor. He lost consciousness and was taken to hospital. Despite suffering a serious brain injury due to lack of oxygen, he recovered and was returned to custody.
28. Mr Bygraves was released from Norwich in April 2017. He was remanded into custody there from June to September.

1 November 2017- 4 February 2018

29. On 1 November 2017, Mr Bygraves was remanded to Norwich on a charge of burglary. A nurse saw Mr Bygraves for a health screen assessment. He told her he was taking medication for low mood and bi-polar disorder. He was also taking methadone, an opiate substitute. He told her that his mother had died recently but he did not want to discuss his family at that time. (After Mr Bygraves' death, it emerged that his mother was in fact alive.) The nurse noted that he was known to the mental health team due to his previous self-harm and suicide attempts and that he had a history of mental health problems.
30. A nurse discussed Mr Bygraves' drug use with him in more depth as he appeared to be experiencing opiate withdrawal. He said he had taken heroin and crack cocaine three days previously, having relapsed into drug use following his last period in prison when he had successfully detoxified. The nurse decided that Mr Bygraves should be on the substance misuse programme for heroin dependence. He drew up a plan to stabilise him on methadone, as it would have been a risk to detoxify at that time. A specialist Integrated Drug Treatment System GP, prescribed the appropriate medication including methadone.
31. While in the reception area, Mr Bygraves began arguing with a member of staff after being told he could not keep his coat with him. The incident escalated, and

he was restrained by staff and taken to the segregation unit. Mr Bygraves told an officer that he had had enough of prison life and intended to hang himself. The officer began suicide and self-harm prevention procedures and opened an ACCT document. A nurse, a mental health nurse who knew Mr Bygraves, arrived at the segregation unit to assess whether he could be held there while at risk of harming himself. She assessed that it was not a suitable place for him at that time, and at a meeting with segregation unit staff, the nurse and the duty governor, it was decided in the light of Mr Bygraves' previous attempt to kill himself, that he should be held in the healthcare centre.

32. Three multidisciplinary ACCT case reviews took place with Mr Bygraves. He told staff that he felt sad but did not wish to attend his mother's funeral. A caremap was completed and he was offered support from the chaplaincy department. On 3 November, Mr Bygraves was moved from the healthcare wing to A wing, a normal wing, at his request and officers on A wing gave him various cleaning tasks to keep him busy.
33. On 13 November, staff assessed Mr Bygraves' risk of self-harm as low and the ACCT document was closed. Mr Bygraves continued to receive regular mental health support from the mental health team. A mental health support worker, met Mr Bygraves to check on his wellbeing on 1 and 8 December. Mr Bygraves spoke about his mother's death but said that he did not have thoughts of suicide or self-harm.
34. Mr Bygraves was given a job as a wing orderly. He received positive feedback from staff who wrote in his case notes that he was a credit to the landing, the best cleaner they had and an asset to the wing, even though he sometimes had a short fuse. Mr Bygraves achieved the enhanced level on the IEP scheme.
35. A nurse conducted a review with Mr Bygraves on 15 December. She noted that he appeared stable and that he was feeling settled but that he felt he needed support. Mr Bygraves had been given some information on bereavement, which he said he had read and he planned to visit the cemetery after he was released. Mr Bygraves said he did not have thoughts of self-harm and he would speak to staff if he did. The nurse arranged for him to have a review every two weeks.
36. On 12 January 2018, Mr Bygraves told a nurse he had not collected his medication because he was refused his methadone when he turned up late. She reminded him that it was his responsibility to be there on time and advised him to take his medication. On 15 January, Mr Bygraves told a clinical support worker that he had been struggling since missing his methadone for two days and he was concerned that his bi-polar medication was not as effective as it might be. She advised him to discuss it with his mental health worker and arranged for the specialist Integrated Drug Treatment System GP to review his methadone dosage
37. On 18 January, a nurse wrote in Mr Bygraves' clinical record that she was asked by officers to observe Mr Bygraves as they thought he was under the influence of illicit substances. She saw that he was walking but his speech was slurred and his eyes were red. When she asked him how he was, he said he was "fine" but refused to allow her to assess him. A nurse checked on him throughout the night but he appeared asleep.

38. On 19 January, a nurse went to see Mr Bygraves and asked him why he was not collecting his medication. He shrugged his shoulders and said he did not have any medication. His eyes were red, his speech was slurred and he was stumbling but he refused to let her examine him. She arranged for him to have a urine test and the substance misuse team decided not to give him methadone while he appeared to be under the influence of an unknown substance. On 20 January, the urine test result was negative for all substances except methadone. (Not all psychoactive substances can be identified through testing.) An officer submitted an intelligence report that Mr Bygraves appeared to be under the influence of an unauthorised substance.
39. On 21 January, a healthcare assistant (HCA), visited Mr Bygraves in his cell. He was lying on his bed grinning and seemed lethargic but he allowed the HCA to measure his pulse rate and blood pressure, which were within the normal range. The HCA, told him that, as he had missed three consecutive doses of methadone, the specialist Integrated Drug Treatment System GP would review his treatment.
40. Also on 21 January, Mr Bygraves was sacked from his job as a wing orderly and downgraded to standard IEP level because of his suspected use of psychoactive substances.
41. On 22 January, Mr Bygraves' mental health support worker, discussed substance misuse with him as part of a mental health review. Mr Bygraves said that he had used PS but gave no particular reason for doing so. He said he was aware that they could have negative physical and mental health side effects and he would try to abstain from future use. He said there was nothing the mental health team could do for him at that time but he would be seeing the specialist Integrated Drug Treatment System GP that afternoon. No action relating to Mr Bygraves' suspected PS use was recorded.
42. The specialist Integrated Drug Treatment System GP decided that Mr Bygraves was not suitable for methadone due to the risk of misuse and told him he should start a programme of opiate detoxification using lofexidine, an alternative medication, which would help with the side effects of withdrawal. Mr Bygraves was angry and refused to be locked in his cell despite repeated requests by staff. Eventually, he was restrained and was placed in his cell. He smashed the cell door observation panel and threw his television, which hit an officer on the arm. Mr Bygraves then set fire to three rolls of toilet paper in his cell and flooded it with water. He was taken to the segregation unit under restraint. A nurse accompanied him to ensure that the operation was carried out safely. When he was settled in a cell in the segregation unit, he was 'jovial' and told her he would 'knock [the specialist Integrated Drug Treatment System GP] out' if he saw him again.
43. The duty governor spoke to Mr Bygraves in the segregation unit. He told her he had no reason to self-harm as the segregation unit was where he wanted to be. She authorised his segregation under Prison Rule 45 – Good Order or Discipline until 25 January, citing his aggressive and disruptive behaviour as the reason for his removal from A wing. She wrote in his decision log that other residential locations had been considered although she did not specify which, but that Mr

Bygraves' behaviour was unpredictable and he had been under the influence of what she believed to be a psychoactive substance for the previous three days.

44. Using a standardised segregation health screen, a nurse assessed Mr Bygraves as stable enough to remain in the segregation unit, as he was no longer undergoing methadone detoxification. Mr Bygraves admitted to the nurse that he had been smoking PS and said that he was not happy about his methadone being stopped. He said that he had been having some thoughts of self-harm and suicide but did not have any plans and felt he would be alright in the segregation unit as he knew the staff and would talk to them if he needed to. The nurse asked him if he would act on his suicidal thoughts and he said he did not know. She decided to open an ACCT document to support him and set his frequency of observations at five times an hour. The decision that Mr Bygraves should remain in the CSU with an open ACCT document was not reviewed by a senior manager.
45. Later that day, a Supervising Officer (SO), carried out an ACCT assessment interview. Mr Bygraves told her that he did not have a next of kin or support from family and friends in the community. When asked if he wanted to die, Mr Bygraves replied 'not really'.
46. At 2.45pm on 23 January, an officer (signature in the ACCT illegible) in the segregation unit had had a conversation with Mr Bygraves during which Mr Bygraves said he would kill himself because he had had enough. Mr Bygraves spoke to another officer at 3.35pm, saying that he would kill himself that night but he wanted to speak to a governor the next day. The officer wrote in the ACCT document that Mr Bygraves' comments could be explored further at a case review, which had been scheduled for later that afternoon.
47. Mr Bygraves attended the case review with the SO and a mental health nurse. There was no discussion of the earlier comments he had made to the officers. No assessment of his risk of harm was made at the review, the caremap (a record of actions taken to reduce risk) was not completed and the next case review was set for 29 January. The frequency of observations was reduced to once an hour.
48. On 25 January, Mr Bygraves attended an adjudication hearing for the breaches of prison discipline which had led to his removal from A wing on 22 January. He pleaded guilty to disobeying a lawful order to return to his cell and to setting fire to prison property. The hearings were adjourned until 2 February, so that an independent adjudicator (a district judge) could decide on a suitable punishment.
49. Later that day, it was decided that Mr Bygraves should return to A wing after a segregation review. An ACCT review took place with a nurse and a SO. They reviewed his risk of self-harm as low and initiated a caremap action for a medication review.
50. On 27 January, Mr Bygraves refused to go into his cell at lunchtime and said he would cut himself unless he was given his newspaper. The incident was resolved 25 minutes later when the newspapers were delivered. The ACCT document was closed on 29 January, after a review where Mr Bygraves

appeared to be in good spirits and was very talkative with no thoughts of self-harm. He was moved from the segregation unit to A wing, a normal wing.

51. On 1 February, Mr Bygraves was suspected of being under the influence of psychoactive substances in the Education Department and an intelligence report was submitted. Mr Bygraves was escorted back to A wing and was locked in his cell. He reacted to this by cutting his arm. An officer opened Mr Bygraves' cell door to allow a nurse to dress his wound and saw him standing on a chair, tying a ligature around his neck. Staff restrained him and removed all items that could be used as a ligature from his cell. As staff were leaving the cell, Mr Bygraves removed the drawstring from his tracksuit. He refused to give it to officers and the situation became confrontational, leading to him being restrained and taken to the segregation unit. An ACCT document was opened and the frequency of observations was set at five times an hour.
52. A nurse carried out a health screen to assess Mr Bygraves' suitability for segregation. She concluded that his health would deteriorate significantly if he was segregated. However, a senior manager authorised segregation for 48 hours on the grounds of good order or discipline pending a medication review for 'a period of reflection' and that Mr Bygraves should 'think positively'. He wrote in the decision log that he had not considered other locations where Mr Bygraves could be located.
53. A SO interviewed Mr Bygraves asking why he had harmed himself. Mr Bygraves replied that he wanted to kill himself as he had had enough and blamed himself for his mother's death but he did not want to be dead. Asked whether he had any reasons for living, he mentioned his young daughter. The SO summarised the key issues for discussion in the case review as a medication review. He assessed Mr Bygraves' risk as high and a caremap action was initiated to address a medication review and low mood.
54. On 2 February, the independent adjudicator heard the disciplinary charges against Mr Bygraves and gave him a total of 30 prospective added days to his sentence. A multidisciplinary ACCT case review took place where Mr Bygraves' attitude was described as more positive and he was told he would remain in the segregation unit until 5 February. A summary of the review noted that Mr Bygraves had seen the doctor that morning and his medication would not be increased, although his clinical notes do not show an interaction with a GP.
55. A senior manager, completed a decision log for Mr Bygraves detention in the segregation unit on 2 February. He wrote that the healthcare centre had been considered as a possible alternative location for Mr Bygraves but previous experience indicated that a small unit was the best location for him where staff had a good rapport and there were clear boundaries.
56. On 3 February, Mr Bygraves had an IEP review. It is not clear whether Mr Bygraves was present. At 7.47am an officer wrote in Mr Bygraves computerised case notes that he was to remain at the basic level for another seven days as he had used PS, resisted and been aggressive towards staff.
57. Also on 3 February, a senior manager spoke to Mr Bygraves during a combined ACCT and segregation review about his situation. Mr Bygraves said he would

not return to A wing while he was on basic so she said that he would remain in the segregation unit. At 2pm, Mr Bygraves told her that he accepted he had been placed on the basic regime for a reason. She replied that he would remain on basic, he would not have a television and that he needed to “grow up and take responsibility for his actions”. His level of risk to himself was regarded as low and his frequency of observation remained at once an hour. His next ACCT review was scheduled for 5 February. After the reviews took place, Mr Bygraves moved from the segregation unit to B wing, an ordinary residential location.

5 February

58. A SO told the investigator that four ‘problematic’ prisoners who absorbed much of staff time were on B wing on the morning of 5 February. One was subject to ACCT monitoring four times an hour for regular self-strangulation and appeared to be feigning unconsciousness, another had moved to the wing from the segregation unit under restraint then smashed the contents of his cell. A third rang his cell bell continuously and the fourth, in a cell next to Mr Bygraves, had banged his cell door for much of the previous evening and night. Mr Bygraves had threatened the prisoner in the cell next to him because of the noise as it had affected his sleep. In addition, B wing was expecting three potentially disruptive prisoners from the segregation unit.
59. From about 9.00am on 5 February, Mr Bygraves appeared agitated and was shouting at staff on B wing that he wanted to speak to an SO or a custodial manager, asking why he was on basic, demanding a television and saying that he would smash up his cell and kill himself if he did not receive one. At 11.30am, a SO held an ACCT review with a nurse and an officer at Mr Bygraves’ open cell door. The SO described Mr Bygraves as angry and confrontational. He told the investigator that Mr Bygraves told him to get a television ‘or see what will happen’ adding that he could hang himself. As the review progressed, Mr Bygraves became calmer and was talking in a normal way. The SO evaluated the review and because Mr Bygraves had attempted to hang himself in the past, increased the frequency of observation to four times an hour with immediate effect.
60. Mr Bygraves collected his lunch from the servery at about 11.55am and at 12.15pm refused to be locked in his cell. He told two SO’s who were in a ground-floor office, that he wanted to go back to the segregation unit and would ‘kick off’, and make their life difficult unless he could do so. He said he would wait until a SO had spoken to the duty governor after lunch. Mr Bygraves went back up to his cell and shut his door at 12.30pm.
61. An officer, who was covering the lunch hour on B and C wings with another officer, checked Mr Bygraves at 12.40pm. He was lying on his bed. An officer asked Mr Bygraves how he was at 12.58pm, he replied that he was okay. It was the last time Mr Bygraves was seen alive.
62. At 1.30pm, the two SO’s held a B wing staff briefing. They discussed several prisoners and told the officers on duty that Mr Bygraves’ frequency of observation had been increased from one to four times an hour. As several of the officers were relatively new officers, a SO gave a brief history of Mr Bygraves’ behaviour and said that they should seek staff assistance if an incident developed involving him.

63. At 1.50pm, officers unlocked B wing prisoners who were leaving for various activities. At 2.33pm, an officer looked into Mr Bygraves cell and saw him hanging from a ligature attached to the ceiling light fitting. The officer radioed a code blue emergency (indicating that a prisoner is unconscious, or having breathing difficulties) and an ambulance was called. An officer started cardiopulmonary resuscitation assisted by another officer. Two nurses arrived at Mr Bygraves' cell at 2.33pm. Ambulance staff arrived at 2.43pm and took over his emergency treatment. Resuscitation efforts continued until Mr Bygraves' death was confirmed at 3.10pm.

Contact with the family

64. At 5.00pm on 5 February, the prison family liaison officers (FLO), broke the news of Mr Bygraves' death to a friend he had nominated as his next of kin, at her home. As she told a FLO she did not know Mr Bygraves that well, he examined some of Mr Bygraves' previous prison records and found a telephone number for his sister who he contacted at 6.45pm. When his sister asked whether their mother had been notified, the FLO explained that Mr Bygraves had said that his mother had died recently. His sister confirmed that their mother was alive and could not understand why her brother would have said she was not. Mr Bygraves' mother telephoned Norwich at 8.19pm.
65. The prison offered to contribute to the cost of Mr Bygraves' funeral, in line with national instructions.

Support for prisoners and staff

66. After Mr Bygraves' death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
67. The prison posted notices informing other prisoners of Mr Bygraves' death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Bygraves' death.

Post-mortem report

68. A post-mortem examination concluded that the cause of Mr Bygraves' death was asphyxia as a consequence of hanging. Toxicology tests did not find evidence of illicit drug use.

Findings

Management of the risk of suicide

69. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include previous self-harm and suicidal ideation, a history of substance misuse and a history of mental health problems. All of these factors applied to Mr Bygraves.
70. Staff correctly began ACCT suicide and self-harm prevention procedures on the day of Mr Bygraves' arrival at Norwich, based on his stated intention to take his life and his previous attempts to do so. Mr Bygraves was monitored under ACCT procedures for most of his time there and the case reviews included mental health team staff. We do, however, have some concerns about the assessment and management of Mr Bygraves' risk.

The ACCT process

71. The case review on 23 January took place after Mr Bygraves had two conversations which were recorded in the ACCT document saying that he intended to kill himself that evening. Despite this, the focus at the review was on his positive body language, there was no consideration of his earlier statements, no formal assessment of risk or completion of a caremap and the frequency of observation was reduced.
72. Given Mr Bygraves' volatility in mood, we consider that setting a case review date six days away was too far. We acknowledge, though, that, in the event, a case review took place two days after, on 25 January.

Location in segregation with an open ACCT

73. PSI 64/2011 states that prisoners on open ACCT plans must only be located or remain in segregation units in exceptional circumstances. The reasons for segregation should be clearly documented and include other options that were considered but discounted. Segregation increases the risk of self-harm especially where a prisoner is thought to be under the influence of PS.
74. A senior manager documented her reasons for authorising Mr Bygraves' detention in the segregation unit on 22 January, but that decision was not reviewed, as it should have been, when an ACCT was opened later that day.
75. A senior manager decided to keep Mr Bygraves in the segregation unit on 1 February, even though the healthcare safety screen assessment highlighted reasons why it was not advisable at that time. In those circumstances, the decision log should have been comprehensive, showing all other options that had been considered. It did not.
76. Although segregation had been used to manage Mr Bygraves' outbursts and his return to a normal location in the past and appears to have been an established approach to the challenges he posed, it remains an environment that can heighten risk rather than reduce it and reasons for locating a prisoner there must be robust. Stating that Mr Bygraves was there for a period of 'reflection' seems

to have minimised the real risks of locating a vulnerable person in a potentially unsuitable environment. Similarly, another manager's comments to Mr Bygraves in segregation on 3 February before he moved to B wing that he needed to grow up risked overlooking potential signs of mental distress or other unresolved issues as poor behaviour.

77. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including:

- **documenting and recording reasons for keeping prisoners subject to suicide and self-harm procedures in the segregation unit, setting out those reasons and other options that were considered and discounted;**
- **identifying and recording effectively the level of risk to themselves the prisoner poses; and**
- **consideration at case reviews of relevant up-to-date risk information and setting appropriate future case review dates.**

Use of illicit drugs and psychoactive substances (PS)

78. Mr Bygraves had significant issues with substance misuse which were appropriately addressed. On his arrival at Norwich on 1 November, he disclosed that he had been using heroin and crack cocaine prior to being remanded. A specialist healthcare team gave him appropriate medication and monitored his detoxification treatment.

79. When he was suspected of being under the influence of PS on 19, 20, 21 January and 1 February, the prison took a measured approach which involved submitting intelligence reports, disciplinary hearing, review of his incentives and earned privileges status, healthcare staff support and a review of his medication, all designed to encourage him to address his PS use.

80. We consider this to have been a proportionate and tailored response to Mr Bygraves' behaviour, which was unpredictable on occasions, and gave staff who knew him well opportunities to engage with him. We make no recommendation.

Mr Bygraves' management on 5 February

81. On 5 February, in light of Mr Bygraves' volatile behaviour, his threats to harm himself, and his previous history of doing so, an ACCT case review increased his frequency of observation to four times an hour and communicated this to staff and the reasons why it had been necessary.

82. Mr Bygraves was not observed at all from 12.58 to 2.33pm when he was found hanging. The failure to observe Mr Bygraves for an hour and a half was a very serious omission. It is worrying that actions designated to safeguard vulnerable prisoners were not followed.

83. The officer who was responsible for the landing Mr Bygraves was located had only been in post for two months. She told the investigator she accepted she had not acted as required but that the number of tasks she had to deal with at the same time had accumulated. She did not know Mr Bygraves and was not aware that Mr Bygraves' death followed a similar pattern to the 2016 incident when he hanged himself over loss of a television.
84. Norwich's most recent IMB report highlighted the disproportionate number of new staff with comparatively little experience and the damaging effect this was having on Norwich's ability to complete even basic tasks. We accept that the environment on the wing that day was particularly challenging. However, the officer tasked with ensuring the observations were carried out clearly had difficulty prioritising her tasks.
85. We make the following recommendations:

The Governor should ensure that there is structured support and effective managerial oversight for new staff in particular ensuring the prioritisation of the protection of vulnerable prisoners.

The Governor should commission an investigation into the actions of B wing managers and officers which led to Mr Bygraves not being observed in accordance with ACCT procedures between 12.58 and 14.33 on 5 February 2018.

Clinical care

86. The clinical reviewer considered that although Mr Bygraves' clinical records did not indicate that he had received specific treatment for self-harming behaviour, the healthcare Mr Bygraves received at Norwich was equivalent to that which he could have expected to receive in the community.
87. Although Mr Bygraves had described himself as having bipolar disorder, he had been diagnosed with a personality disorder in 2016 and he did not have a formal diagnosis of bipolar. He was given anti-depressant, anti-psychotic and anti-convulsant medications to try to treat symptoms of low mood, excitability and impulsive behaviour. He was seen regularly by members of Norwich's mental health team who knew him well and had established a good rapport with him. Similarly, members of the substance misuse team had built positive relationships with Mr Bygraves for several years and supported him through periods of detoxification.

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