Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Martin a prisoner at HMP Norwich on 31 July 2018

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.

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

Mr Kenneth Martin died on 31 July 2018 at HMP Norwich. The cause of death was severe blood loss caused by a cut Mr Martin made to his leg. Mr Martin was 37 years old. I offer my condolences to his family and friends.

Mr Martin was a troubled man. He frequently cut his legs, seemingly as a means of coping with frustration and adversity, and his management was challenging for staff at Norwich. They appropriately opened Prison Service suicide and self-harm prevention procedures when Mr Martin arrived at the prison, and some aspects of his management were positive. However, there were also some basic aspects of the procedures that prison staff did not comply with. There was no appointed case manager and I am not satisfied that staff appropriately assessed Mr Martin's risk of self-harm and suicide.

Of further concern is that Mr Martin was prescribed blood thinning medication after being diagnosed with a deep vein thrombosis (DVT). This medication increased the risk of dangerous bleeding if Mr Martin were to cut himself with the severity he had previously. Prison prescribers should have been faced with a challenging decision over whether to issue the medication or leave the DVT untreated. However, there was no risk/benefit analysis and we found that prison doctors prescribed the medication without considering these risks.

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

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

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Summary

Events

1. On 18 May 2018, Mr Kenneth Martin was remanded to HMP Norwich. He had been to prison many times in the past and was well known to staff at Norwich. Mr Martin had often cut his legs in prison before and reception staff began suicide and self-harm procedures, known as ACCT. No one was named as ACCT case manager.

2. Shortly before he was remanded in custody, hospital doctors had found a deep vein thrombosis (DVT, a blood clot) in Mr Martin's leg. He had been prescribed rivaroxaban (a blood thinner) for this but had not yet been issued with the medication. A prison doctor prescribed rivaroxaban shortly after Mr Martin arrived at Norwich, without seeing or assessing him.

3. Over the following weeks, Mr Martin cut his leg several times, sometimes requiring hospital admission. He initially lived on B Wing, where a wing manager led most of his ACCT case reviews. After he moved to C Wing on 20 June, several different wing managers led his case reviews and no one led consecutive reviews.

4. On 26 July, Mr Martin told his mental health team keyworker that he had an upcoming appointment with a prison doctor to discuss his medication. Mr Martin said a short-term prescription of co-codamol he had been issued for pain in his legs might be stopped, and he would harm himself if this happened.

5. On 27 July, Mr Martin chose not to attend this appointment. At an ACCT case review later that day, he said he felt as well as he had for a long time, but was worried that his co-codamol prescription would be stopped as he had not gone to his appointment. A nurse who was present at the case review rebooked Mr Martin's appointment for 1 August. The wing manager who led the case review concluded that Mr Martin's risk of suicide and self-harm was low.

6. On 31 July, Mr Martin declined to attend a scheduled ACCT case review, as he said he was unwell. During the lunch period, he cut his leg and pressed his cell bell for assistance. The officer who attended did not open the cell or call for assistance on his radio, and five minutes passed before anyone went into the cell. Mr Martin lost consciousness and stopped breathing. Prison staff began cardiopulmonary resuscitation, but paramedics confirmed he had died shortly afterwards.

Findings

Managing the risk of suicide and self-harm

7. Prison staff took some positive, supportive actions to help Mr Martin, and his ACCT case reviews were multidisciplinary with good input from the mental health team. However, several key aspects of ACCT procedures aimed at reducing risk, including appointing a consistent case manager and setting meaningful caremap actions, were not completed. We are not satisfied that prison staff made

appropriate decisions about the level of Mr Martin's risk and frequency of his observations in the last days of his life.

Prescription of rivaroxaban

8. Mr Martin frequently harmed himself by cutting his legs. This was well-known to prison staff and clearly documented in his prison and medical records. The clinical reviewer found that the prescription of rivaroxaban meant there was a risk of dangerous levels of bleeding if Mr Martin cut his legs with the severity he had before. We found that there was no risk/benefit analysis to balance the benefits of treating and preventing Mr Martin's DVT with the potential dangers the medication provided. The clinical reviewer concluded that, in this respect, Mr Martin's clinical care was not equivalent to that he would expect to receive in the community.

Emergency response

9. We found that staff took too long to go into Mr Martin's cell and call for emergency medical assistance when they found he had harmed himself.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
  - A case manager is appointed at the first case review, who should lead all subsequent case reviews whenever possible.
  - Prison and healthcare staff record all information that affects risk in the ongoing record.
  - Case reviews consider all relevant information that affects risk, and staff review the risk of suicide and self-harm and frequency of observations whenever an event occurs which indicates an increase in risk, and only reduce the level when there is evidence that the risk has reduced.
  - ACCT caremap actions are specific and meaningful, and identify all the issues identified at assessment interviews and case reviews.
  - Conversations are carried out as directed and documented in the ongoing record.
- The Head of Healthcare should ensure that prison doctors and nurse prescribers perform thorough risk/benefit reviews of all medications that they prescribe to prisoners who are managed under ACCT arrangements.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
  - Staff go into cells as quickly as possible in a potentially life-threatening situation.
  - Staff communicate a medical emergency as soon as possible, using the appropriate medical emergency response code, by radio where possible, to quickly and effectively communicate the nature of the emergency.

The Investigation Process

10. 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 one responded.

11. The investigator visited Norwich on 6 August, and interviewed four prisoners who knew Mr Martin. He obtained copies of relevant extracts from Mr Martin's prison and medical records.

12. Mr Judd interviewed ten members of staff at Norwich in September.

13. NHS England commissioned a clinical reviewer to review Mr Martin's clinical care at the prison. He accompanied the investigator to interviews with clinical staff.

14. We informed HM Coroner for Greater Norfolk of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. We shared the initial report with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies.

Background Information

HMP Norwich

16. 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

17. The most recent inspection of HMP Norwich was in September 2016. Inspectors reported that provision for prisoners at risk of self-harm was generally appropriate. They found that there was greater consistency in ACCT case management, although most case reviews could have been more multidisciplinary. Inspectors reported that prisoners subject to ACCT management were largely positive about staff and the support they received, although daily entries in the ACCT record needed to be better.

18. Inspectors also reported that the mental health team provided a good response to men with urgent needs, including following the starting of ACCT procedures.

Independent Monitoring Board

19. 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 February 2018, the IMB reported that staff did not always study ACCT documents fully before case reviews, that ACCT case management was not always consistent, and some care plans were lacking.

20. The IMB also reported that the mental health team had an intense workload and could not meet the needs of all patients.

Previous deaths at HMP Norwich

21. Mr Martin was the twenty second prisoner to die at Norwich since July 2015, and the fifth prisoner to die by his own hand during that time. In our investigations into the deaths of men in April 2017 and February 2018, we found that staff did not always fully assess the level of risk of suicide and self-harm, or consider the most up to date risk information.

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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. 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.

Key Events

23. Mr Kenneth Martin was in prison more than 20 times between 2010 and 2018, usually for a few weeks or months at a time. He spent time in various prisons, but from September 2016 onwards he was only imprisoned at HMP Norwich. During his time in prison he frequently cut himself, usually the backs of his legs, and was often admitted to hospital as a result. Prison staff managed him under ACCT procedures for much of his time in prison.

24. Mr Martin had longstanding contact with community and prison mental health teams, having been diagnosed with attention deficit hyperactivity disorder (ADHD), schizoaffective disorder (a combination of schizophrenia symptoms, such as hallucinations, and other mood disorders such as anxiety and depression), bipolar disorder (a condition marked by alternating periods of elation and depression), and a personality disorder (a person with a personality disorder, of which there are several types, thinks, feels, behaves or relates to others differently to the average person).

25. Mr Martin was sent to prison for the penultimate time on 10 January 2018. Prison staff managed him under ACCT procedures throughout this time in custody, and he cut his legs several times. Mr Martin spent much of this time in prison as an inpatient in Norwich's healthcare centre. He was released on 13 April.

26. On 10 May, Mr Martin was admitted to hospital having said he had taken an overdose. Tests carried out at hospital identified a deep vein thrombosis (a blood clot) and Mr Martin was prescribed rivaroxaban (a blood thinner) to treat this. Mr Martin left the hospital before he could be given this medication. On 17 May, a doctor at Mr Martin's community surgery unsuccessfully tried to contact him to discuss his medication.

HMP Norwich

27. On 18 May 2018, Mr Martin was remanded in custody to Norwich charged with supplying class A drugs. A nurse assessed him in reception. She recorded that Mr Martin harmed himself prolifically and had several mental health diagnoses including ADHD, schizoaffective disorder, post-traumatic stress disorder (PTSD), anxiety and bipolar disorder. She recorded that Mr Martin was prescribed medication including quetiapine (an antipsychotic), clonazepam (to treat anxiety), morphine (a strong painkiller prescribed to Mr Martin to treat the pain in his legs caused by frequent cutting) and rivaroxaban. She referred Mr Martin to the mental health team and began ACCT procedures. She recorded in the ACCT document that Mr Martin had said he had thoughts of ending his life as he faced a lengthy sentence.

28. A prison doctor then assessed Mr Martin. He recorded that Mr Martin was a well-known complex man and a prolific high risk self-harmer. He represcribed all of Mr Martin's medication, except rivaroxaban.

29. On 19 May, an officer assessed Mr Martin as part of ACCT procedures. Mr Martin said he had been assaulted by other prisoners who thought he had

smuggled drugs into the prison and had stolen his electronic cigarette. Mr Martin also said he had had enough of life and felt the worst he had ever felt.

30. Shortly afterwards, a supervising officer (SO) led the first ACCT case review, with another officer and a nurse of the mental health team. At the review, Mr Martin said he would hang himself if his electronic cigarette was not replaced. The SO entered one action on the ACCT caremap: for Mr Martin to apply for a replacement electronic cigarette. He concluded that Mr Martin's risk of suicide and self-harm was at 'raised' (on a scale of low, raised or high) and set ACCT observations at a minimum of three per hour.

31. On the same day, two prisoners were identified as potentially having assaulted Mr Martin. Staff placed him on victim support measures.

32. On 20 May, Mr Martin moved to B Wing because of the alleged assault. An SO, a B Wing manager, led an ACCT case review afterwards, with another SO. (One of the SO's is now a custodial manager.) She recorded that Mr Martin said he was much happier since the wing move and had no plans to harm himself.

33. The next day, the SO led another ACCT case review, with a nurse of the mental health team. Mr Martin again said he was happy on B Wing but would like a job, as he thought being occupied during the day would make him less likely to harm himself. The SO added one action to the caremap: for her to find out whether there were any jobs for Mr Martin. She also recorded that Mr Martin had an electronic cigarette and the first caremap action was now complete. She reduced the ACCT observations to a minimum of one per hour, and made no change to his level of risk.

34. On 23 May, a prison doctor added rivaroxaban to Mr Martin's medication list. He did not see or assess Mr Martin.

35. On 25 May, Mr Martin cut his right calf. He told wing staff that he did this because he "kept being promised things that didn't happen". At an ACCT case review that afternoon, the SO recorded that Mr Martin was happier now he had talked things through with her, (a nurse also attended the case review.) The SO noted that he now had a job as a wing cleaner, and recorded that the second caremap action was therefore complete. The SO made no change to Mr Martin's level of risk or observations.

36. On 27 May, Mr Martin made a deep cut to his leg and lost a lot of blood. An emergency ambulance was called and he was admitted to hospital overnight. An SO led an ACCT case review immediately afterwards. He recorded that Mr Martin said he was "fed up" and would not rule out harming himself further. The SO increased Mr Martin's level of risk to high, and set observations at a minimum of three per hour.

37. On 30 May, the SO led an ACCT case review, with a nurse. Mr Martin said he had not taken some of his medication in the last few days, which he said was because no one from healthcare had checked his wound. The nurse reiterated the importance of taking his medication, and Mr Martin agreed to start again. The SO made no change to his level of risk or observations.

38. At an ACCT case review on 2 June, the SO recorded that she had had a very positive conversation with Mr Martin, and that he was now taking his medication and had no other issues. She reduced his level of risk to low and observations to a minimum of one per hour.

39. On 6 June, Mr Martin cut the back of his leg and lost a lot of blood. Paramedics admitted him to hospital overnight. The duty operational manager, led an ACCT case review afterwards. Mr Martin said he was fed up of talking about his issues and did not participate other than this. He recorded that Mr Martin's risk of suicide and self-harm was now high, and increased his observations to a minimum of four per hour.

40. On 7 June, following Mr Martin's return from hospital, an SO led an ACCT case review, with a nurse. There is no record of the case review in Mr Martin's ACCT file. The nurse recorded in the medical record that Mr Martin harmed himself because he did not have an electronic cigarette. Mr Martin said he had not completed a mandatory basic skills course (required of all prisoners before taking employment), because he did not want to go to education to take the course. He had not therefore officially started work as a wing cleaner and, as a result, did not have money to buy an electronic cigarette. The SO told us that she arranged for Mr Martin to complete the course in his cell, so that he did not have to go to the education department. She reduced the level of observations to a minimum of two per hour.

41. On 11 June, Mr Martin cut his leg again. He cut through a vein, lost a lot of blood and was admitted to hospital overnight. An SO held an ACCT case review after Mr Martin harmed himself, with a nurse of the mental health team. The SO recorded that Mr Martin said he "doesn't feel right and doesn't want to be here anymore". He recorded that Mr Martin's was at raised risk of suicide and self-harm, and increased observations to a minimum of four per hour.

42. The next day, an SO led an ACCT case review on Mr Martin's return from hospital, with a nurse. Mr Martin said he was due in court in a few days and wanted to be sentenced so he knew where he stood. The SO recorded that Mr Martin had now completed the mandatory education course and could start to work as a cleaner. The nurse recorded that Mr Martin said that thoughts of self-harm "pop into his head and he can't get them out". Mr Martin said he needed more help from the mental health team, but the nurse noted that he could not say what this was. The SO made no change to the level of risk or observations.

43. On 13 June, an SO held an ACCT case review, with a nurse, who had now been appointed as Mr Martin's keyworker in the mental health team. She recorded that Mr Martin had been out cleaning in the morning and engaged well in the review, and that he had court on Friday and hoped to be sentenced. The nurse recorded that Mr Martin appeared bright and showed no signs of psychosis or depression. He noted that Mr Martin's most fitting diagnosis was a personality disorder, which Mr Martin accepted could not be treated. The SO recorded that Mr Martin's level of risk was low, and made no change to the level of observations. She did not record why she thought Mr Martin's risk was now low, but told us that Mr Martin stressed in several ACCT reviews that he was focused on getting sentenced and progressing through prison.

44. Mr Martin expected to attend court on 15 June, but this was postponed until 27 June. An SO and the keyworker held an ACCT case review on 15 June, at which Mr Martin said he was "okay" about the postponement and would speak to his solicitor. The SO recorded that Mr Martin had been busy cleaning, appeared focused, and had no current thoughts of harming himself. She reduced his observations to a minimum of two per hour.

45. On 19 June, the keyworker assessed Mr Martin. He recorded that Mr Martin had a long history of self-harm, which was usually used to deal with frustration and create a favourable outcome. He recorded that Mr Martin would remain on the mental health team's caseload until his needs became stable.

Move to C Wing

46. On 20 June, Mr Martin told wing staff that other prisoners on B Wing were pressuring him to cut himself so that he could go to hospital and collect a package of drugs for them. Staff arranged for him to move to C Wing and to continue working as a cleaner on that wing.

47. On 22 June, an SO led an ACCT case review, with the keyworker. Mr Martin said he felt better to have moved away from the prisoners who had pressured him to harm himself, and he felt settled on C Wing. The SO did not change the level of risk or observations.

48. On 26 June, Mr Martin cut his calf several times. He lost a lot of blood and was admitted to hospital. He told the duty manager that he was anxious about his court appearance the next day. She increased Mr Martin's level of risk to high, and increased observations to a minimum of four per hour.

49. Mr Martin appeared in court by videolink on 27 June. The court postponed sentencing and asked for an additional medical report. An SO led an ACCT case review afterwards, with the keyworker. She recorded that Mr Martin did not seem too concerned about the outcome of his court appearance. Mr Martin told her that he cut his leg because "it's just how his mind works". The SO made no change to the level of risk or observations.

50. On 29 June, an SO led an ACCT case review, with the keyworker and a prison chaplain. He recorded that Mr Martin communicated well and said he felt a lot better. The SO concluded that Mr Martin's risk was low and reduced observations to a minimum of two per hour.

51. On 2 July, a prison GP reviewed Mr Martin's medication. Mr Martin said that he continued to feel pain in his legs in the areas that he had harmed himself. He prescribed a one-month course of co-codamol (a painkiller) for Mr Martin to take at night.

52. On 6 July, an SO led an ACCT case review, with another SO, the keyworker and a prison chaplain. Mr Martin said he was pleased to have been prescribed co-codamol as he struggled with pain at night. He said that he was frustrated at awaiting sentencing as he wanted to transfer to a therapeutic community (therapeutic communities provide group based therapy to promote positive relationships, personal responsibility and social participation), which he thought

would be beneficial for him. The SO reduced the level of observations to a minimum of one per hour during the day and five in total overnight.

53. On 13 July, an SO led an ACCT case review with the keyworker and a nurse. She noted that Mr Martin had not harmed himself for over two weeks and felt less stressed now he had co-codamol at night. The SO also recorded that Mr Martin was focused on the future and what he needed to do to address his issues. The keyworker recorded that Mr Martin had no current symptoms of mental ill health. The SO reduced the level of observations to a minimum of three each morning, afternoon and evening, and five overnight.

54. On 17 July, Mr Martin cut his right calf. A nurse treated the wound and Mr Martin did not require hospital admission. A nurse recorded that Mr Martin refused to talk about the issues that led him to harm himself.

55. Later that afternoon, Mr Martin climbed onto the netting on C Wing and held a razor blade to his throat. He told an acting SO that he had not received a payment for his job. The SO persuaded Mr Martin to leave the netting, and then telephoned the Regimes department to resolve his payment issue. She increased Mr Martin's level of risk to raised and observations to a minimum of one per hour. The SO also downgraded him to the basic level of the Incentives and Earned Privileges scheme (IEP, which aims to encourage and reward responsible behaviour in prisons).

56. On 20 July, an SO led an ACCT case review, with the keyworker and a prison chaplain. He recorded that Mr Martin was in "very good spirits", the issue with his pay was resolved, he was happy with his medication, loved being a cleaner and he had no thoughts of harming himself. Mr Martin also said he was looking forward to being sentenced, which was now scheduled for 7 September. The SO concluded that Mr Martin as at low risk of suicide and self-harm and reduced his observations to two each morning, afternoon and evening, and three at night.

57. On 26 July, the keyworker visited Mr Martin to speak to him about a blood test he was due to take. Mr Martin said he had an upcoming GP appointment to discuss his medication, and said he would harm himself if any changes were made. The nurse recorded this conversation in the medical record, but not in Mr Martin's ACCT document.

58. On 27 July, Mr Martin declined to attend a GP appointment. The prison GP recorded that he would therefore stop Mr Martin's co-codamol prescription at the end of the course, and that Mr Martin would need to book another appointment if he wanted it to be restarted. He also represcribed rivaroxaban for another four weeks, but noted that a further appointment should be made to assess the need for this.

59. At an ACCT case review later that day, led by an SO with a nurse, Mr Martin said he felt the best he had for a long time and was learning to deal with his frustrations. He also said he was worried that his pain medication (meaning co-codamol) would be stopped as he did not attend his GP appointment that morning. The nurse booked Mr Martin another appointment (for 1 August) to discuss his medication. The SO told us that Mr Martin was very positive at the case review and probably the best she had seen him. She said that Mr Martin

spoke for a long time about his plans to progress through his sentence. The SO did not change Mr Martin's level of risk or observations, but noted that this might change depending on the outcome of the medication review.

60. On 29 July, an SO reviewed Mr Martin's IEP level. She increased him to the standard level as he had not broken any prison rules since his earlier downgrade. The SO recorded that Mr Martin spoke about how he had come a long way during his current imprisonment in terms of how he dealt with frustration and issues. Mr Martin told her that this was because he was getting older and more mature.

61. Two officers completed ACCT observations in the afternoon and evening of 30 July. They recorded that Mr Martin appeared in good spirits and had no issues. Mr Martin collected his afternoon medication, including co-codamol.

62. After Mr Martin's death, a prisoner with whom he was friends told an SO that Mr Martin was "in a right state" on the evening of 30 July. The prisoner said that Mr Martin told him he had been threatened by three prisoners to cut himself so he would be sent to hospital. Mr Martin said that these prisoners had told him he must collect a parcel of drugs that they would arrange to be left in the hospital. Mr Martin's friend told an officer that Mr Martin did not want to do this and was very upset about it. None of the staff we spoke to, including those who worked on C Wing on 30-31 July, said they had any knowledge of this until after Mr Martin died.

31 July 2018

63. At around 7.30am on 31 July, Mr Martin collected his morning medication. A prisoner told us that he saw Mr Martin at this time and he appeared fine. At around 8.30am, an officer unlocked Mr Martin's cell so that he could start his cleaning job. Mr Martin told the officer that he did not feel well. He therefore stayed in his cell.

64. At around 10.00am, an SO went to Mr Martin's cell to collect him for an ACCT case review. He recorded that Mr Martin said he felt unwell and did not want to attend the review. The SO told us that Mr Martin said he felt physically, rather than mentally, ill. He recorded that the keyworker was present at the case review, although he did not go to Mr Martin's cell. The SO told us that he discussed with the keyworker when to reschedule the case review. They did not discuss the threat to harm himself that Mr Martin had made five days earlier. The SO rescheduled the case review for 2 August. He made no change to the level of risk or observations.

65. At around 10.30am, an officer unlocked Mr Martin's cell. He spoke to Mr Martin for around a minute, and recorded that Mr Martin said he was okay and had stayed in bed because he did not sleep very well that night. The officer left Mr Martin's cell unlocked so he could socialise with the other cleaners if he wished.

66. Mr Martin then left his cell for around one hour and twenty minutes. He told a prisoner that he was going for coffee. The prisoner told us that it was unusual for Mr Martin not to come out to clean and he thought he was worried that his co-codamol prescription would be stopped.

67. At around 12.05pm, Mr Martin spoke to a prisoner. The prisoner said that Mr Martin appeared troubled and said he did not have an electronic cigarette. The prisoner gave Mr Martin a capsule to use. An officer locked Mr Martin in his cell at around 12.20pm.

68. At 12.50pm, an officer went to Mr Martin's cell as he had pressed his cell bell. (Norwich does not have records of when cell bells are pressed. The officer told us that he was dealing with another request when Mr Martin pressed his bell and that he went to Mr Martin's cell as soon as he could.) He told us that Mr Martin had a towel around his leg and said he had cut himself. He said that Mr Martin seemed okay and there was no sign that he was unwell other than the cut. The officer said that he could not see much blood in the cell, although it was dark inside. At 12.51pm, the officer left Mr Martin's cell to find a nurse, and told us he did this because he knew that when Mr Martin cut himself it was usually quite serious. He said he did not use his radio to call for assistance because he knew that there was a member of healthcare staff nearby.

69. The officer found another officer in the wing office, and a pharmacy technician. The pharmacy technician telephoned the on-call nurse and asked her to attend.

70. At 12.54pm, the two officers and the pharmacy technician returned to Mr Martin's cell. An officer said that Mr Martin was now slouched on the bed and appeared "half unconscious". The pharmacy technician then left the wing to fetch surgical gloves for them to wear when treating Mr Martin. At 12.55pm, the officers opened Mr Martin's cell and went in. An officer said that Mr Martin's leg was in a bucket and he was conscious but not fully responsive. They sat Mr Martin up on the bed. An officer radioed a code blue medical emergency, indicating a life-threatening situation. The control room operator, telephoned for an ambulance immediately, and diverted the call so that an officer could speak to the ambulance service operator.

71. At 12.56pm, the pharmacy technician returned to Mr Martin's cell, followed shortly afterwards by a nurse. The nurse recorded that Mr Martin had lost a lot of blood, filling around half a bucket. (An officer told us that Mr Martin sometimes added water to blood when he cut his leg, so that it appeared he had lost more than he had. He was unsure whether Mr Martin had done this on 31 July.) Both Mr Martin's blood pressure and oxygen saturation level were low and he did not respond to the nurse's attempts to communicate with him. The nurse gave Mr Martin oxygen but, shortly afterwards, he stopped breathing. The nurse began cardiopulmonary resuscitation (CPR). Prison staff attached a defibrillator three times, and each time it instructed them not to apply a shock and to continue CPR.

72. An officer spent around nine minutes on the telephone to the ambulance service. The operator told him that she understood a blue light ambulance was required due to an immediate threat to life, but that there were delays of up to 30 minutes for the service.

73. At around 1.10pm, the control room operator telephoned the ambulance service for an update. She reiterated that the incident was life-threatening. She spoke to the operator for around six minutes, at which time the operator said an ambulance was now available.

74. The first paramedics arrived at Norwich at 1.28pm, and at Mr Martin's cell at 1.30pm. Several other paramedics, including an air ambulance crew, joined them. At 2.07pm, paramedics confirmed that Mr Martin had died.

Contact with Mr Martin's family

75. Mr Martin did not name any next of kin and prison staff could not trace any of his family after his death. Norwich contributed to the cost of Mr Martin's funeral in line with Prison Service instructions.

Support for prisoners and staff

76. After Mr Martin's death, the head of residence debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

77. The prison posted notices informing other prisoners of Mr Martin's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Martin's death.

Post-mortem report

78. A post-mortem examination established the cause of death as exsanguination (severe loss of blood) due to incision of the right saphenous vein.

Findings

Managing the risk of suicide and self-harm

79. Prison staff appropriately began ACCT procedures when Mr Martin was remanded to Norwich. It is apparent that many staff knew Mr Martin well and some positive, supportive actions were taken. The ACCT case reviews were multidisciplinary and had good input from the mental health team, and staff generally responded to Mr Martin's needs. However, some of the ACCT procedures were poorly managed and were not in line with Prison Service policy.

Case management

80. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It instructs that a case manager must be appointed at the first case review. The case manager should lead all case reviews, where possible, to promote consistency in managing the ACCT plan. No one was named as Mr Martin's case manager.

81. When Mr Martin lived on B Wing, an SO led most of his case reviews. She told us that she was not the case manager, but as she knew Mr Martin well she tried to ensure his case reviews were scheduled for when she was on duty. After he moved to C Wing, there was much less consistency in case management. Several different supervising officers led Mr Martin's case reviews, and no one ever led consecutive case reviews. The lack of case manager could potentially have contributed to some of the underestimated risk judgements that we discuss below.

Assessing risk and setting observation levels

82. The ACCT document provides staff with guidance on how to assess the level of risk of suicide and self-harm. It says that risk is high, for example, when the prisoner has frequent suicidal ideas not easily dismissed, there is evidence of acute or ongoing mental illness, or there are escalating patterns of self-harm. Risk is raised when suicidal ideas are frequent but generally fleeting, there is evidence of acute or ongoing mental disorder, or there is current self-harming behaviour. Risk is low when suicidal thoughts are fleeting and soon dismissed and there is no self-harming behaviour.

83. Prison staff appropriately increased Mr Martin's level of risk and observations when he harmed himself. However, we are concerned that the level of risk was too often reduced to low a short time after he seriously harmed himself. The staff we spoke to, most of whom knew Mr Martin well, agreed that he cut his legs as a way of coping with frustration and adversity. With some exceptions (such as in the last days of his life, as we discuss below), these incidents largely came with little warning. We appreciate that several members of staff told us that Mr Martin cut himself less frequently than during previous imprisonments. However, his self-harm was still frequent with at least eight incidents in the little over two months he was in Norwich. While the trigger for each incident was usually dealt with at the time, there is little evidence of protective factors being put in place to reduce the longer-term risk of Mr Martin repeating his actions. Our view is that Mr Martin displayed consistent self-harming behaviour and his risk should

therefore have been considered as at a minimum of raised during his time in prison.

84. We are also particularly concerned that Mr Martin's risk and observations were set at inappropriately low levels towards the end of his life. In the days before he died, Mr Martin said that that he was worried that his co-codamol would be stopped. He told his keyworker that he would harm himself if this happened. The keyworker did not record this in the ACCT ongoing record. Had he done so, this would ensure that all staff, including those leading case reviews, were aware of this important risk information.

85. At the ACCT case review on 27 July, Mr Martin said he was worried about his medication. As he had missed a GP appointment that morning, it was now more likely that he would stop receiving co-codamol in the near future. The staff present at the case review were not aware of what he had said to the keyworker the previous day. The SO told us that Mr Martin was very positive at the review and probably the best she had seen him. She also said he had learnt to cope with frustration better, evidenced by him climbing on the netting ten days earlier rather than harming himself. We appreciate that the SO knew Mr Martin well and had spent a lot of time with him. But we also note that he had previously harmed himself within a few days of staff recording that he was feeling positive, and that he had in fact cut his leg shortly before he climbed on the netting.

86. While Mr Martin might have made some progress during this time in prison, it is apparent to us that he still had the potential to harm himself should a trigger arise. His co-codamol issue was such a trigger and this had not been resolved when he died. In these circumstances, we think that it was inappropriate that his risk was judged as low.

87. We are also concerned about the level of observations that was set. In the last ten days of his life, Mr Martin's observations were set at a minimum of two in the morning, two in the afternoon, two in the evening and five overnight. Many of the day time observations took place when Mr Martin was out of his cell (as a cleaner, he spent more time out of cell than most prisoners), yet his self-harming behaviour often took place when he was locked in his cell. Following our finding that Mr Martin's risk was underestimated in the last days of his life, it follows that we conclude that he should have been observed more frequently, and that, in any case, the observations should have been tailored to ensure that most took place when Mr Martin was locked in his cell, when he was more vulnerable.

Case review on 31 July

88. Mr Martin said he was too unwell to attend the case review scheduled for 31 July. As a result, a SO postponed the review. He and the keyworker, who was also due to attend, did not discuss Mr Martin's level of risk or current issues. This would have been particularly pertinent given Mr Martin's apparent concern about his medication and the nature of his conversation with the nurse a few days earlier.

89. It is always beneficial for a prisoner to attend their ACCT case reviews, but PSI 64/2011 does not mandate it. There will be times when the prisoner declines to attend, for a variety of reasons. In these circumstances we would expect prison

staff to hold the case review as scheduled to ensure, among other outcomes, that they consider the latest information about risk or triggers and review and record the level of risk and observations.

Caremap

90. A caremap must be completed at the first case review for all prisoners' subject to ACCT monitoring. PSI 64/2011 says that the caremap should reflect the prisoner's needs, the triggers of their distress, and must aim to address the issues identified at the assessment interview. The caremap should set time bounded actions and be aimed at reducing the risk the prisoner presents to themselves. Caremap actions should be updated at future case reviews, with new actions added when appropriate.

91. Mr Martin had several issues that troubled him during his time at Norwich. The caremap was used to progress two of these in his early days (obtaining an electronic cigarette and a job) but otherwise his issues were addressed outside the caremap. This did not always impact on Mr Martin or prison staff's ability to help him. (For instance, when he was frustrated by a missed payment, an SO resolved the issue quickly and effectively.) However, the caremap is the appropriate tool for managing and reducing risk issues and triggers, and its use ensures that the case review team can quickly check the prisoners' progress against identified actions. This is particularly important when there is inconsistency in case review management. It would have been appropriate to include Mr Martin's co-codamol issue in the ACCT caremap, to ensure that staff did all they could to support him.

Completing and recording observations and conversations

92. PSI 64/2011 states that staff must follow the level of observations and conversations stated on the ACCT document and must record these immediately or as soon as is practical. It also states that staff must actively engage with the prisoner, encouraging them to talk and participate in activities where appropriate.

93. There is no evidence that wing staff held good quality conversations with Mr Martin outside of the case review process, and most of the observations recorded in the ACCT record simply described what he was doing and gave no indication that a conversation had occurred. Mr Martin did not have any visits or telephone calls to family or friends and, in these circumstances, it is particularly important that staff try to engage with a vulnerable man.

94. After Mr Martin died, a prisoner said that he had been pressured to cut himself so badly that he would be sent to hospital, so that he could pick up an illicit package for them. We do not know whether this information is accurate. However, if staff had held more meaningful daily conversations with Mr Martin they would have given themselves a better chance of identifying any additional issues or vulnerabilities. We make the following recommendation:

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

- **A case manager is appointed at the first case review, who should lead all subsequent case reviews whenever possible.**

- **Prison and healthcare staff record all information that affects risk in the ongoing record.**
- **Case reviews consider all relevant information that affects risk, and staff review the risk of suicide and self-harm and frequency of observations whenever an event occurs which indicates an increase in risk, and only reduce the level when there is evidence that the risk has reduced.**
- **ACCT caremap actions are specific and meaningful, and identify all the issues identified at assessment interviews and case reviews.**
- **Conversations are carried out as directed and documented in the ongoing record.**

Prescription of rivaroxaban (blood thinner)

95. Mr Martin was prescribed rivaroxaban (a blood thinning medication) in the community for a DVT, but he did not begin the course until after his imprisonment. Mr Martin was well known at Norwich as a man who frequently cut himself, often seriously and who often required hospital admission due to the amount of blood lost from these wounds. His actions were clearly evidenced in his medical record. The clinical reviewer, a prison GP noted that the prescription of rivaroxaban brought a risk of dangerous bleeding if Mr Martin cut his legs with the severity he had before. He found that rivaroxaban was prescribed at Norwich without Mr Martin being seen by a GP and, significantly, without any risk/benefit analysis to consider the risk of bleeding against the benefit of treating and preventing the DVT.

96. A prison GP found that, in the community, it would be expected that a patient with such conflicting needs would be subject to a risk assessment before medication was prescribed. He concluded that the clinical care Mr Martin received with regard to the prescription of rivaroxaban was not therefore equivalent to that he would expect to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that prison doctors and nurse prescribers perform thorough risk/benefit reviews of all medications that they prescribe to prisoners who are managed under ACCT arrangements.

Emergency response

97. PSI 64/2011 instructs that, “All staff must be aware that the preservation of life is the first priority …Justifiable decisions on when to enter a cell where life is endangered … must take account of the need to preserve life”.

98. PSI 03/2013 on Medical Emergency Response Codes sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors and directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays

in calling an ambulance and it should not be a requirement for a member of the healthcare team or a manager to attend the scene before calling an ambulance.

99. Norwich's local instruction on emergency response codes (Governor's Notice 193/2017) instructs the use of emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which staff should use code red are when there is a severe loss of blood.

100. An officer said that Mr Martin had a towel around his leg and had cut himself. He said the cell was dark and he could not be certain how much blood Mr Martin had lost. The officer said he knew that Mr Martin often cut himself and it was usually "quite serious" when he did so.

101. We recognise that it can be difficult for staff in such situations to make instant decisions, but when there is a potentially life-threatening situation it is essential to act quickly. The officer was unsure of the severity of Mr Martin's wound when he went to the cell and thought there was a good chance it was serious. Given his knowledge of Mr Martin, in the circumstances we would expect the officer to go into the cell as soon as possible. He could then assess the severity of the wound and make an appropriate radio call for assistance. As it was, around five minutes passed from when the officer first attended the cell to when staff opened the cell and made a medical emergency radio call.

102. We cannot say whether any of these delays affected the outcome for Mr Martin. Nevertheless, it is important that prison staff understand their roles in a medical emergency, as early intervention when someone is found bleeding severely might save their life. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **Staff go into cells as quickly as possible in a potentially life-threatening situation.**
- **Staff communicate a medical emergency as soon as possible, using the appropriate medical emergency response code, by radio where possible, to quickly and effectively communicate the nature of the emergency.**

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