

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Sparrow, a prisoner at HMP Norwich, on 5 June 2019

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.

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 David Sparrow was found hanged in his cell at HMP Norwich on 4 June 2019, his birthday, and died in hospital on 5 June 2019. He was 36 years old. I offer my condolences to his family and friends.

Mr Sparrow had been recalled to prison 17 days earlier. He had a history of serious mental health issues and alcohol misuse and was prescribed antipsychotic medication at Norwich. On the afternoon of the day he hanged himself, he made superficial cuts to his arm and expressed paranoid ideas. Staff acted appropriately and placed him on suicide and self-harm procedures (known as ACCT), with hourly observations. Mr Sparrow had no significant history of attempted suicide or self-harm, and I have concluded, on balance, that given the information available to them at the time, staff could not reasonably have predicted that Mr Sparrow was at imminent risk of suicide.

However, there were a number of missed opportunities to identify Mr Sparrow's needs and support him appropriately.

I am concerned that there were deficiencies in healthcare reception procedures. In particular, healthcare staff did not complete Mr Sparrow's initial reception screening within the required timescale and failed to recognise his significant history of mental health issues, including the fact that he had previously been sectioned under the Mental Health Act. If this had been known on 4 June, it is possible that it would have influenced the assessment of his risk.

During the eight hours Mr Sparrow was managed under ACCT before he was found hanged, staff managed him appropriately on the whole, but failed to monitor him hourly as they had agreed. I am also concerned that the roll check was not properly completed the night before Mr Sparrow's death.

Finally, I am very concerned that there was a delay of 25 minutes in staff entering Mr Sparrow's cell after he was found to have blocked his cell door observation panel and failed to respond. I consider that both the junior member of staff who could not get a response and the night orderly officer, did not react with any sense of urgency. As Mr Sparrow was being managed under ACCT procedures at the time, this was unacceptable. I cannot say if this delay would have changed the outcome for Mr Sparrow but it could make a significant difference in other emergencies. I am particularly concerned that Norwich agreed to implement a recommendation about a similar issue following the death of a prisoner last year. I have therefore escalated our concerns to the Prison Group Director.

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

April 2020

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Summary

Events

1. On 18 May 2019, Mr David Sparrow was recalled to prison and sent to HMP Norwich. He was last released from prison in January 2019. He had longstanding mental health problems, including a personality disorder and a history of psychosis, and he was an alcoholic. He had been an inpatient in a psychiatric hospital in 2017.
2. Prison staff completed Mr Sparrow's reception interview. However, due to staff shortages, no one from the healthcare team was available to complete Mr Sparrow's initial health screen. Instead, a prison GP saw him and noted that he was an alcoholic and had alcohol withdrawal symptoms. The GP prescribed him alcohol detoxification medication and olanzapine (an antipsychotic).
3. Healthcare staff eventually completed Mr Sparrow's first health screen on 20 May and referred him to the mental health team. The mental healthcare manager completed a desktop review of Mr Sparrow's medical record and concluded that, despite his diagnosis of a personality disorder and being prescribed antipsychotic medication, he had no identifiable mental health problem. Mr Sparrow did not receive a face-to-face mental health assessment and was discharged from the mental healthcare caseload.
4. On 29 May, Mr Sparrow told staff that he was under threat from other prisoners because they believed that he was a sex offender. By 3 June, staff recorded that Mr Sparrow had started to isolate himself and did not want to leave his cell because he feared for his safety. Mr Sparrow did not provide staff with evidence or details about the alleged perpetrators. Staff opened a 'self-isolating log' to monitor Mr Sparrow. They also allowed him time out of his cell when other prisoners were locked in their cells.
5. As a result of Mr Sparrow's concerns, staff moved him to G Wing at around 1.45pm on 4 June. Around an hour later, staff started suicide and self-harm procedures, known as ACCT, after Mr Sparrow was found to have made superficial cuts to his arm. Mr Sparrow told staff that he believed that prisoners on the whole wing were "out to get him". Staff agreed to monitor him hourly until the ACCT assessment and first case review could be completed (normally within 24 hours). However, a mental health nurse immediately saw Mr Sparrow and reassured him that he would be safe on the wing. Prison staff also reassured him. Mr Sparrow denied that he had any further intention to harm himself. The mental health nurse noted that she would complete a full mental health assessment for him the next day and would attend his first ACCT case review.
6. At 11.25pm on 4 June, an operational support grade officer, while completing an ACCT check, found that Mr Sparrow had blocked his cell door observation panel and failed to respond. However, the officer did not act with sufficient urgency in raising the alarm and there was a delay of 25 minutes before staff could get into Mr Sparrow's cell. The fact that the officer was also unable to find the cell inundation point key, which allows an alternative access view point into the cell, added to the delay. When staff looked through the inundation point, they found

Mr Sparrow hanged in his cell. They radioed a medical emergency code. Staff, including healthcare staff, responded quickly and started cardiopulmonary resuscitation (CPR). Paramedics arrived at Mr Sparrow's cell at 12.07am, took over resuscitation efforts and transferred him to hospital, where he died that evening.

Findings

Assessment of risk

7. We are satisfied that staff appropriately placed Mr Sparrow on ACCT procedures after he self-harmed on 4 June. Given the information available to them at the time, we consider, on balance, that they could not reasonably have foreseen that he was at imminent risk of suicide before his death and that hourly checks were, therefore, sufficient.
8. However, staff failed to monitor him hourly, as they had agreed.

Reception health screen

9. Healthcare staff did not complete Mr Sparrow's initial health screen when he arrived at Norwich in line with the required timeframe. Although he saw a GP, he did not receive his initial health screen for two days. As a result, important information about his previous mental health history was not identified and he was inappropriately discharged from the mental health team's caseload without ever being seen in person.

Recall paperwork

10. Although Mr Sparrow was recalled to prison on 18 May and asked for his recall document, staff did not share it with him before he died. As a result, he did not know how long he would remain in prison.

Roll checks

11. The night duty officer failed to conduct the evening roll check on 4 June as he should have done and failed to check that there was no immediate cause for concern. Although this did not affect the outcome for Mr Sparrow, it is important that local roll check policies are followed.

Emergency response

12. There was a delay of 25 minutes between the OSG finding that Mr Sparrow had blocked his cell door observation panel and staff entering the cell and calling an emergency medical code. Given that Mr Sparrow was being monitored under ACCT procedures at the time, we consider this delay was unacceptable.
13. Following the death of another prisoner in July 2018, Norwich agreed to implement a recommendation to address deficiencies in staff entering cells promptly in an emergency. We are disappointed that we must repeat this recommendation and we escalate our concerns to the Prison Group Director.

Recommendations

- The Governor should ensure that all staff undertake ACCT observations as directed, actively engage with prisoners being monitored and record their engagement promptly.
- The Governor should ensure that recall documents are shared with prisoners in the required timeframe and the date recorded accurately.
- The Governor should ensure that staff understand their responsibilities when completing roll checks and that roll checks are properly carried out in line with local procedures.
- The Governor should commission a fact-finding investigation into the OSG's actions on the night of 4 June with a view to considering whether any further action is appropriate.
- The Governor should ensure that our report is shared with the night duty officer so he is aware of our findings.
- The Governor should ensure that all prison staff:
 - know what action to take if a prisoner being monitored under ACCT covers his observation a panel and does not respond;
 - are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies so that there is no delay in calling a medical emergency code or calling an ambulance;
 - go into cells as quickly as possible in a potentially life-threatening situation subject to a risk assessment; and
 - an inundation point key is readily available on every wing and staff know where to find it.
- The Prison Group Director for Bedfordshire, Cambridgeshire and Norfolk should satisfy himself that Norwich has put effective measures in place to implement this recommendation.
- The Governor and Head of Healthcare should ensure that:
 - all newly arrived prisoners receive an initial health screen in line with PSI 07/2015 and National Institute for Health and Care Excellence (NICE) guidelines; and
 - staff conduct detailed assessments and prioritise prisoners who have not had an initial health screen and induction.

The Investigation Process

14. 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.
15. The investigator visited Norwich on 11 June 2019. He obtained copies of relevant extracts from Mr Sparrow's prison and medical records.
16. NHS England commissioned a clinical reviewer to review Mr Sparrow's clinical care at the prison.
17. The investigator and clinical reviewer jointly interviewed 14 members of staff at HMP Norwich on 29 and 30 July 2019. No prisoners came forward to be interviewed.
18. We informed HM Coroner for Greater Norfolk of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.
19. The Ombudsman's family liaison officer contacted Mr Sparrow's family to explain the investigation and to ask if they had any matters that they wanted us to consider. They said that they wanted to know all the events that led to his death, including whether Mr Sparrow had been prescribed medication; whether he asked for a transfer to another prison because he was being bullied and feared for his safety; was he moved to the prison's vulnerable prisoner's wing; had he collecting his meals and medication; whether he was attending to his personal hygiene needs and what risk factors had staff identified that might contribute to Mr Sparrow harming himself. We have addressed these issues in this report.
20. Mr Sparrow's family received a copy of the draft report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Norwich

21. HMP Norwich serves the courts of Norfolk and Suffolk and holds a mix of up to 769 remanded and sentenced prisoners and young adults. The main site houses Category B and C prisoners. A local discharge unit (LDU) is on another site, housing Category C prisoners. Virgin Care provides healthcare services, including mental health services.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Norwich was in October 2019 but has not yet been published.
23. The previous inspection took place in September 2016. Inspectors reported that provision for prisoners at risk of suicide and 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 the mental health team provided a good response to prisoners with urgent needs, including contributing to ACCT procedures.
24. They concluded that arrangements for supporting newly arrived prisoners had improved, and that this was particularly the case for those with substance misuse issues. However, inspectors observed a slightly chaotic reception process during one day of their inspection and they noted that the position needed to be monitored to ensure arrangements on arrival were adequate.

Independent Monitoring Board

25. 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 2019, the IMB reported that there was a significant increase in self-harm across all areas of the prison in November and December 2018. They noted that the safer custody team had identified bullying, feeling under threat and debt issues as potential triggers of self-harm.

Previous deaths at HMP Norwich

26. Mr Sparrow was the fourth prisoner at Norwich to take his own life since June 2017. Following the death of a prisoner in July 2018, Norwich agreed to implement a recommendation we made to address the failure of staff to go into a cell as quickly as possible in a potentially life-threatening situation. We repeat that recommendation in this case.

Assessment, Care in Custody and Teamwork

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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. There should be regular multidisciplinary review meetings involving the prisoner.

28. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. 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. HMP Norwich is a pilot site for a revised version of the ACCT process.

Key Events

29. In October 2015, Mr David Sparrow was sentenced to four years and six months in prison for robbery and attempted robbery. He was released early from prison but was then recalled to custody on several occasions. He was last released from HMP Thameside on 21 January 2019.
30. Mr Sparrow had a history of mental health and substance misuse problems, and he had been diagnosed with anti-social personality disorder and alcohol dependency syndrome. He had been admitted to mental health hospitals under the Mental Health Act in 2009 and 2016.

HMP Norwich

31. On 18 May 2019, Mr Sparrow was charged with assault and was recalled to HMP Norwich.
32. His person escort record (PER, the record that travels with prisoners) noted that he was an alcoholic and had a personality disorder.
33. During his reception interview, Mr Sparrow identified his next of kin. Staff raised no concerns about Mr Sparrow but assessed his risk of sharing a cell as high so decided to allocate him a single cell. Mr Sparrow said that he had no thoughts of suicide or self-harm.
34. Newly arrived prisoners should receive an initial health screen, but Mr Sparrow did not receive one. The nurse who was on duty in Reception, told us that there were nursing and prison staffing issues. She said that Mr Sparrow arrived on a Saturday afternoon and she could not see him because she had other duties to perform. She said that Reception closed at 6.00pm on a Saturday – three hours earlier than on a weekday.
35. The nurse said that she ensured that a prison GP saw Mr Sparrow (and two other newly arrived prisoners) so that they could be prescribed any medication they needed.
36. There is a section on the cell sharing risk assessment form which a reception nurse must complete to assess if a prisoner has any health risks. The form indicates that the nurse signed the form to confirm that Mr Sparrow had no additional risks. However, she told the investigator that she had not assessed Mr Sparrow and had not therefore signed the form. She said the signature on the form had been falsely entered and was not hers.
37. A prison GP saw Mr Sparrow after his reception interview. She noted his history of alcohol dependency and that he had withdrawal symptoms. She prescribed him olanzapine (an antipsychotic) and a five-day course of alcohol detoxification medications.
38. Mr Sparrow was sent to A Wing, the First Night Centre.
39. The nurse told us that she expected that Mr Sparrow's initial health screen would be completed on 19 May. However, it did not take place then due to staffing issues.

40. On 20 May, a nurse completed an initial and secondary health screen for Mr Sparrow. He noted that Mr Sparrow had a history of mental health issues (a personality disorder) and had been prescribed antipsychotic medication. Mr Sparrow had alcohol withdrawal symptoms. He referred Mr Sparrow to the mental health team but told us that he had not identified that Mr Sparrow had previously been admitted to a mental health hospital under the Mental Health Act. He said that he did not have access to Mr Sparrow's PER as the health screen was completed 48 hours after Mr Sparrow arrived.
41. That day, a Mental Healthcare Manager completed a desktop mental health assessment for Mr Sparrow. He told us that he reviewed Mr Sparrow's medical record and identified that he had a personality disorder. However, he concluded that Mr Sparrow had no identifiable mental health problem and did not record that he had previously been admitted to psychiatric hospitals nor that he had been prescribed antipsychotic medication. He concluded that there was no clinical rationale for Mr Sparrow to be assessed by mental health services.
42. Mr Sparrow continued to take his antipsychotics and alcohol detoxification medication and received support from the substance misuse team.
43. On 21 May, an administrative clerk in the Offender Management Unit (OMU) noted in Mr Sparrow's prison records that he had received Mr Sparrow's licence recall paperwork from the National Offender Management Public Protection Casework Section and had shared it with him that day. There is no evidence that the recall paperwork was shared with Mr Sparrow. The clerk told the investigator that he had not in fact shared the recall paperwork with Mr Sparrow himself but had followed standard practice and sent it to the wing with the expectation that wing or probation staff would pass it to him.
44. On 22 May, a member of the resettlement team saw Mr Sparrow and completed a basic custody screening interview. They discussed Mr Sparrow's recall to prison, his living accommodation, working in prison, his substance misuse and his physical and mental health problems. Mr Sparrow said that he had a personality disorder, was taking olanzapine and was on an alcohol detoxification programme. He said that he had been in care as a child and had been detained under the Mental Health Act about a year ago. He said that he had issues with prisoners on B Wing and did not want to live there. Mr Sparrow said that he had not received his recall paperwork. He said that he had a court hearing in June 2019 and suggested that he might be released from prison after 30 days. The team member noted that he would ask Mr Sparrow's offender manager about his release date.
45. That day, a key worker completed a first key worker session with Mr Sparrow. (The key worker scheme is designed to give each prisoner a regular point of contact and support.) Mr Sparrow said that he felt safe on A Wing and did not want to move to B Wing where there were rival gang members who would assault him. Mr Sparrow applied to participate in education classes.
46. On the morning of 23 May, a member of the substance misuse team saw Mr Sparrow and noted that he had completed his five-day detoxification programme. Mr Sparrow said that he had no withdrawal symptoms and felt well. It was noted that the substance misuse team would review him every two weeks.

47. Later that day, Mr Sparrow submitted an application form to ask for his recall paperwork as he had not received it or seen anyone from the probation team.
48. On 27 May, an officer noted that Mr Sparrow's next of kin had contacted the prison as she was concerned that he had not contacted her and may have forgotten her telephone number. This information was passed to his key worker.
49. On 29 May, the key worker spoke to Mr Sparrow in his cell. Mr Sparrow said that he was scared to leave his cell for fear of being attacked by other prisoners who believed that he was a sex offender. The key worker told Mr Sparrow that his next of kin was concerned that he had not contacted her. Mr Sparrow explained that he had not called her because he felt it was unsafe to leave his cell. The key worker noted that he arranged for a wing officer to unlock Mr Sparrow that afternoon when no other prisoners were out of their cells so that he could use the phone, if he wished. He told his supervisor and recorded his concerns about Mr Sparrow in the wing observation book.
50. An entry in the wing observation book that day noted that a prisoner had told wing staff that he was concerned about Mr Sparrow. The prisoner said that Mr Sparrow was refusing to leave his cell, was not collecting his meals, had stopped taking his medication and was talking to himself in his cell.
51. In the afternoon, an administrative clerk in OMU replied in writing to Mr Sparrow's application which asked about his recall paperwork. She said that Mr Sparrow's recall pack was sent to him on 21 May and that he should ask wing staff about it. She added that Mr Sparrow would soon be allocated an offender supervisor.
52. On 31 May, a member of the substance misuse team reviewed Mr Sparrow. He told her that he felt well and had no withdrawal symptoms. He said that he was due to appear in court on 11 June and there was a possibility that he might be released. She planned to review Mr Sparrow in 14 days.
53. On 3 June, a Custodial Manager (CM) recorded in Mr Sparrow's prison records that his next of kin had phoned the prison again as she was concerned about his safety. The CM noted that he had spoken to a Supervising Officer (SO), who worked on A Wing. The SO said that staff had spoken to Mr Sparrow but he had not told them why or who had allegedly threatened him. Mr Sparrow said that his situation might have been the result of mistaken identity and that someone had thought he was a sex offender. The CM said that staff had taken Mr Sparrow's meals to him in his cell twice a day and had unlocked him outside of the usual regime for prisoners. He noted that staff needed to consider moving Mr Sparrow to G Wing, which was on the Category C side of the prison.
54. The SO recorded that he had implemented the prison's self-isolating policy and log for Mr Sparrow and arranged for him to be moved to G Wing on 4 June.

Events of 4 June 2019

55. Mr Sparrow's birthday was 4 June. Staff were not aware of this and Mr Sparrow did not tell them.
56. In the morning, the Deputy Governor chaired the prison's weekly Safety Intervention Meeting (SIM). The minutes for this meeting noted that Mr Sparrow

was isolating himself because he felt under threat from other prisoners because he was a sex offender. Staff had started to apply the local self-isolating policy and started to monitor Mr Sparrow's wellbeing.

57. That morning, staff recorded in the wing observation book that Mr Sparrow had pressed his emergency cell bell and said that he was under threat as prisoners were calling him a sex offender.
58. At 1.45pm, Mr Sparrow was moved to G Wing.
59. Shortly after moving to G Wing, Mr Sparrow pressed his cell bell. An officer responded and found that Mr Sparrow had made cuts to his forearm. The officer told us that Mr Sparrow appeared paranoid and made a number of strange statements. Mr Sparrow said he believed that prisoners were going to press the fire alarm and that he would be stabbed as everyone tried to leave the building. The officer started suicide and self-harm procedures, known as ACCT, and asked for healthcare staff to attend immediately.
60. When a nurse arrived at Mr Sparrow's cell, he had a towel wrapped around his left forearm. He said that he had cut himself and his arm was bleeding. She noted Mr Sparrow appeared anxious and refused to show her his injury. He repeatedly said that he had not committed a sex offence but that other prisoners were "out to get him". Mr Sparrow eventually agreed to be treated and she cleaned and dressed his wounds. She noted that Mr Sparrow had made superficial cuts.
61. A SO spoke to Mr Sparrow and completed the ACCT immediate action plan. He referred Mr Sparrow urgently to the mental health team and placed him on hourly observations until the first ACCT review. He reminded Mr Sparrow of the prison's support services. Mr Sparrow said that the whole wing was after him because they believed he was a sex offender.
62. At 4.00pm, a mental health nurse and a nurse saw Mr Sparrow to complete an initial assessment and find out his issues before the first ACCT case review. She told us that Mr Sparrow complained that he was under threat from other prisoners, that other prisoners thought that he was a paedophile and that he was going to be attacked and raped. She noted that Mr Sparrow presented as paranoid. He believed that prison staff were involved in a conspiracy against him and he was also suspicious of healthcare staff. Mr Sparrow believed that weapons had been hidden in the showers and that he would be attacked and stabbed when he showered.
63. The mental health nurse said that to ease Mr Sparrow's fears, she and an officer took him to inspect the shower area to reassure him that there were no weapons there and he would be safe. She told us that this appeared to reassure Mr Sparrow to a degree. Mr Sparrow said that he wanted to kill himself but was too scared to do this, "was not brave enough" and denied that he would try to harm himself again. She noted that the mental health team would review Mr Sparrow and she agreed to attend the first ACCT case review. She ensured that his olanzapine prescription medication had been transferred from the main prison to the Category C site.

64. The mental health nurse told the investigator that that Mr Sparrow appeared distressed, but it was unclear whether he was psychotic, and there was no evidence that he was hearing voices.
65. CCTV footage shows that wing staff visited Mr Sparrow regularly that evening. Most prisoners were locked in their cells by 5.24pm. The few prisoners who remained on the landing were mostly cleaners.
66. At 6.00pm, an officer recorded in the ACCT log that Mr Sparrow had earlier pressed his cell bell and made “very bizarre, rambling” statements about how staff were going to let other prisoners assault him.
67. CCTV footage shows that at 6.59pm, an unidentified prisoner was standing at Mr Sparrow’s cell door, apparently talking to him.
68. At 7.15pm, a nurse and an officer visited Mr Sparrow to check on his dressing after his earlier self-harm. The nurse spoke to Mr Sparrow through the cell door observation panel and noted that he was acting strangely. As the prison was in patrol state with only one officer present, they agreed not to open his cell door. Mr Sparrow continued to express ideas that he was under threat and was not safe. They reassured Mr Sparrow that he was safe and that all prisoners were now locked up for the night. Mr Sparrow thanked the nurse for caring and allowed her to view and assess his bandaging by lifting his arm up to the observation panel. She noted the bandage dressing was still in place. The officer noted this contact in the ACCT observation record.
69. CCTV footage shows an officer completed the evening roll check at 7.30pm, noting that all prisoners were locked in their cells and okay. She raised no concerns when she opened Mr Sparrow’s observation panel to check on him.
70. The assistant night orderly officer for F and G wings started his night duty around 7.55pm. The officer’s duty finished at 8.00pm. The officer recorded in the ACCT log that Mr Sparrow had continued to say that he feared for his safety. An Operational Support Grade (OSG) started his night duty at 8.00pm.
71. CCTV footage shows at 8.04pm, the assistant night orderly officer conducted the night roll check of the wing landing. He checked that each cell door was locked but did not look through any of the cell observation panels. He completed the night roll check of the wing noting that all prisoners were locked in their cells and okay.
72. CCTV footage shows the OSG walking down the wing landing at 8.59pm. At 9.15pm, he completed an ACCT check on Mr Sparrow. Despite staff agreeing to monitor Mr Sparrow hourly under ACCT procedures, one hour and 45 minutes had passed since he or any other member of prison staff had last checked on Mr Sparrow. He opened Mr Sparrow’s cell observation panel and shone his torch into the cell to check on his wellbeing. He told the investigator that he could not recall what Mr Sparrow was doing in his cell at the time but he had no concerns about him.
73. At 10.25pm, the OSG completed an ACCT check of Mr Sparrow and raised no concerns.

74. At 11.25pm, when the OSG tried to complete an ACCT check for Mr Sparrow, he found that the observation panel was blocked with what appeared to be a towel. He looked through the side gap of the cell door but could not see Mr Sparrow and could not get a response from him when he knocked on his door and called his name. He went to the office and telephoned the assistant night orderly officer to raise concerns about Mr Sparrow. However, the officer had just left the gate area office and did not answer the phone.
75. The OSG returned to Mr Sparrow's cell but was still unable to get a response from him. He then went upstairs to complete an ACCT check on another prisoner, after which he returned once more to check on Mr Sparrow. By 11.37pm, Mr Sparrow had still not responded to the OSG and his observation panel was still blocked. The OSG left Mr Sparrow's cell after about a minute, went to check on another prisoner who was subject to ACCT procedures, after which he tried to telephone the gate office again. On this occasion, he spoke to an officer, who was with the assistant night orderly officer in the gate area office. The officer told the OSG to use the cell door inundation point to attempt to see Mr Sparrow.
76. At about 11.48pm, the OSG looked for the inundation point key, but it was not in its usual place near Mr Sparrow's cell. He tried the supervising officer's office, but it was not there either. He eventually found an inundation point key on F Wing, returned to G Wing and used it to unlock the inundation point.
77. When the OSG looked through the inundation point, he saw Mr Sparrow hanging from a ligature tied to the light fitting. He immediately radioed a medical emergency code blue (to indicate that a prisoner is unconscious or has difficulty breathing). Staff in the control room recorded that this occurred at 11.50pm and immediately called an ambulance and requested staff assistance. He did not enter the cell. He had not had any recent first aid training.
78. Within one minute, the assistant night orderly officer and an officer arrived at Mr Sparrow's cell. The assistant night orderly officer unlocked the door and went in, followed by the officer. The assistant night orderly officer said that Mr Sparrow was pale in colour and clammy. The officer checked Mr Sparrow for signs of life but found none. The assistant night orderly officer immediately started cardiopulmonary resuscitation (CPR) and the officer conducted chest compressions.
79. Two nurses responded to the code blue and arrived at Mr Sparrow's cell at 11.53pm. The nurses took over Mr Sparrow's care using emergency equipment, and a defibrillator (a device that monitors heart rhythm and delivers a shock if required) advised them to continue with CPR.
80. Paramedics arrived at Mr Sparrow's cell at 12.04am and took over resuscitation efforts. An ambulance air crew and an ambulance arrived shortly afterwards to offer support. The paramedics obtained a pulse and Mr Sparrow was transferred to hospital at 1.03am on 5 June. Mr Sparrow died later that day at 7.36pm.

Contact with Mr Sparrow's family

81. At 9.00am on 5 June, the prison family liaison officer and a prison manager visited Mr Sparrow's next of kin at home to break the news that he had been taken to hospital after a serious suicide attempt. They accompanied her to the hospital so that she could see him. She informed other family members, who met them at the hospital. She was with him when he died. The family liaison officer and prison manager stayed in regular touch with her and other members of Mr Sparrow's family until his funeral. The prison contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

82. After Mr Sparrow's death, a CM and the duty governor debriefed the staff involved in the emergency response to offer support and ensure that they had the opportunity to discuss any issues arising. The staff care team also offered support.
83. The prison posted notices informing prisoners of Mr Sparrow'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 Sparrow's death.

Post-mortem report

84. The post-mortem examination established that Mr Sparrow died from hanging. Post-mortem toxicology results confirmed the presence of Mr Sparrow's prescribed medication, olanzapine, in his system at a level consistent with therapeutic use.

Findings

Concerns about Mr Sparrow's safety

85. Although Mr Sparrow repeatedly said that he was concerned about his safety, there was no intelligence or evidence to suggest that this was true or that his safety had been jeopardised. Nonetheless, staff took his concerns and allegations seriously and moved him from a busy induction wing to a quieter location on the Category C site to reduce his anxiety. Staff also began monitoring Mr Sparrow under Norwich's self-isolating procedures which ensured that he was offered time out of his cell to attend to his personal and hygiene needs. This was good practice.

Recall paperwork

86. Mr Sparrow was recalled to custody four months after he had been released from prison. The length of time the prisoner must spend in prison after recall depends on the type of recall to which they are subject: a fixed term recall lasts for 28 days, while a standard recall means the prisoner will remain in prison to serve the remainder of their sentence unless they are released earlier by the Parole Board.
87. Being recalled to prison is a vulnerable time for prisoners and it is important that the system works effectively so that prisoners are told the details of their recall as quickly as possible. HMPPS's Recall, Review and Re-Release of Recalled Prisoners Policy Framework (April 2019) states that all recalled prisoners must be provided with a copy of their recall dossier and a copy of the recall information leaflet within one working day of receipt from the Public Protection Casework Section, and that a member of staff must explain the documents in the recall dossier to the recalled prisoner.
88. Mr Sparrow asked about his recall paperwork on more than one occasion, and on 22 May an officer told him he would ask about his release date. OMU apparently sent Mr Sparrow's recall pack to his wing on 21 May so that probation or wing staff could share it with him, but OMU staff could not confirm that he had received his recall paperwork before his death. We have seen no evidence that Mr Sparrow received the recall paperwork in the 17 days before he died or that he knew how long he would have to spend in prison. It seems very possible that this uncertainty contributed to Mr Sparrow's distress and put him at increased risk of suicide.
89. Staff told us that the probation team were short-staffed at the time and this might have led to Mr Sparrow not receiving his recall pack. Whatever the reason, the delay was unacceptable. We make the following recommendation:

The Governor should ensure that recall documents are shared with prisoners within the required timeframe and the date recorded accurately.

Management of risk of suicide and self-harm

90. Prison Service Instruction (PSI) 64/2011 on safer custody and PSI 07/2015 on early days in custody list risk factors and potential triggers for suicide and self-

harm. When Mr Sparrow arrived at Norwich, staff appropriately identified that he had a number of these risk factors. He had a history of mental health issues, he had been recalled and he was an alcoholic. He did not express any thoughts of suicide or self-harm and staff were not concerned that he was at risk of suicide or self-harm at the time. Mr Sparrow had no significant concerns apart from alcohol withdrawal symptoms which staff immediately treated.

91. Approximately ten days later, Mr Sparrow started to isolate himself because he feared for his safety but did not give staff any details about why or which prisoners he thought were threatening him. We found no evidence that his fears for his safety had any foundation in reality.
92. Staff appropriately started ACCT procedures when Mr Sparrow harmed himself on the afternoon of 4 June. When a mental health nurse initially assessed Mr Sparrow, he noted that he displayed paranoia and tried to reassure him that he was safe. Mr Sparrow denied that he would try to harm himself again and did not express any thoughts of suicide or self-harm to the staff with whom he came into contact in the hours before he was found hanged in his cell.
93. Although Mr Sparrow's earlier self-harm indicated mental distress, it had not been life-threatening. Given this and given the information available to them at the time, we do not consider that staff could reasonably have predicted that Mr Sparrow was at imminent risk of suicide or that they should necessarily have placed him on more frequent ACCT checks. It is unfortunate that healthcare staff did not know that Mr Sparrow had previously been sectioned under the Mental Health Act as it is possible that this would have affected their assessment of the risk he posed to himself.
94. Mr Sparrow took his life before staff completed his ACCT assessment and first case review, both of which are required to be completed within the first 24 hours of the start of ACCT procedures. These would have given staff the opportunity to have explored the reasons for Mr Sparrow's distress in more detail and to have put a caremap in place to address them.

ACCT checks

95. Although we are satisfied that it was reasonable to agree that Mr Sparrow would be checked every hour, we are concerned that Mr Sparrow was not checked hourly under ACCT procedures for a period that evening.
96. An officer recorded that he had completed an ACCT check on Mr Sparrow at 7.15pm and another officer completed a roll check shortly afterwards at 7.30pm. The OSG started duty at 8.00pm and told us that one of his first tasks was to check on prisoners subjected to ACCT procedures, but it had been a busy evening on the wings. CCTV confirmed that he did not check on Mr Sparrow until 9.15pm. The ACCT observation sheet was also left blank for the period from 8.00pm to 9.00pm, which indicates that staff did not complete an ACCT check as they should have done. This meant that no one had checked on Mr Sparrow for nearly two hours. Although we know that Mr Sparrow was alive when the OSG next checked him at 10.25pm, it is not acceptable that staff allowed this length of time to have passed while he was subject to ACCT hourly observations.

97. ACCT observations are intended to ensure the wellbeing of prisoners and offer them support, as needed. Staff should comply with the agreed level of observations in line with a prisoner's level of risk. PSI 64/2011 states that ACCT conversations and observations must be recorded immediately or as soon as possible afterwards. We make the following recommendation:

The Governor should ensure that all staff undertake ACCT observations as directed, actively engage with prisoners being monitored and record their engagement promptly.

Roll checks

98. Roll checks are carried out to ensure the security and integrity of the prison and enable staff to check on prisoners' welfare. The assistant night orderly officer signed a formal document to confirm that he had completed the roll check on the night of 4 June. However, CCTV footage shows that he had not done so and failed to check upon the welfare of prisoners.
99. While the failure to conduct the roll check on this occasion had no impact on the outcome for Mr Sparrow, it might be critical in other circumstances. We therefore make the following recommendation:

The Governor should ensure that staff understand their responsibilities when completing roll checks and that roll checks are properly carried out in line with local procedures.

Emergency response

100. 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".
101. Mr Sparrow was subject to ACCT monitoring and had covered his observation panel. This should have been a cause for immediate concern. We are concerned that when the OSG could not get a response from Mr Sparrow at 11.25pm on 4 June, he did not act with sufficient urgency.
102. We recognise that the OSG could not see what was happening in the cell and may not have felt it would be safe for him to enter the cell on his own to check on Mr Sparrow, and we do not criticise him for not doing so. However, we are very concerned that there was a delay of more than 15 minutes while he checked other prisoners and tried to contact the assistant night orderly officer by phone. The OSG was carrying a radio and should have used it to contact the assistant night orderly officer immediately to raise his concerns about Mr Sparrow. It is very difficult to understand why he did not do so.
103. There was an additional delay because the OSG could not find the inundation point key. He said that the key was not in its usual place and he had to find one from another wing.
104. In all, it took the OSG 25 minutes from the time he found that Mr Sparrow had blocked his observation panel until he opened the inundation access point, saw

Mr Sparrow hanging in his cell and called a code blue. This delay was unacceptable.

105. We are also concerned that the assistant night orderly officer showed a lack of urgency when the OSG finally contacted him. By this point, Mr Sparrow had been unseen and unresponsive for over 20 minutes. We consider that the assistant night orderly officer should have recognised that this was a potential emergency involving a prisoner under an ACCT and should have gone to the wing himself rather than leaving the OSG to deal with the situation.
106. We cannot say whether the very lengthy delay affected the outcome for Mr Sparrow, but it is important that prison staff respond immediately if it might save someone's life. We recommend:

The Governor should commission a fact-finding investigation into the OSG's actions on the night of 4 June with a view to considering whether any further action is appropriate.

The Governor should ensure that our report is shared with the assistant night orderly officer so he is aware of our findings.

107. Disappointingly, this is the second time in the last twelve months that we have found deficiencies in the way staff at Norwich have responded to medical emergencies. We therefore repeat the following recommendation and also escalate our concerns to the Prison Group Director:

The Governor should ensure that all prison staff:

- **know what action to take if a prisoner being monitored under ACCT covers his observation panel and does not respond;**
- **are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies so that there is no delay in calling a medical emergency code or calling an ambulance;**
- **go into cells as quickly as possible in a potentially life-threatening situation subject to a risk assessment; and**
- **an inundation point key is readily available on every wing and staff know where to find it.**

The Prison Group Director for Bedfordshire, Cambridgeshire and Norfolk should satisfy himself that Norwich has put effective measures in place to implement this recommendation.

Clinical care

108. The clinical reviewer found that, overall, the care that Mr Sparrow received was of a mixed standard and not wholly equivalent to that which he could have expected to receive in the wider community. He made a number of recommendations, which the Head of Healthcare will need to address.

Reception screening

109. PSI 07/2015 on early days in custody is clear that staff should examine all newly arrived prisoners on their arrival and share, review and act on information, including person escort records, where necessary. NICE guidelines state that initial health screens in reception should ensure continuity of care for people transferring from one custodial setting (including courts) to another by accessing relevant information from the patient clinical record, person escort record and cell sharing risk assessments, and checking medicines and any outstanding medical appointments.
110. Mr Sparrow arrived at Norwich on 18 May and his first reception screen was not completed until 20 May, three days after his arrival. As the screening did not take place on arrival at the prison, healthcare staff had no access to reception documents such as his person escort record.
111. The Head of Healthcare told us that the delay in conducting Mr Sparrow's first health screen was the result of staff resourcing in the reception area at weekends, which sometimes prevented healthcare staff from completing initial health screens for prisoners in the required timescales. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **all newly arrived prisoners receive an initial health screen in line with PSI 07/2015 and NICE guidelines; and**
 - **staff conduct detailed assessments and prioritise prisoners who have not completed their reception screening and induction.**
112. We are concerned that a signature for a member of healthcare team had been falsified on Mr Sparrow's cell sharing risk assessment form, a document that is initially completed as part of the reception process. Falsifying documents is a serious disciplinary matter. While this had no direct impact on Mr Sparrow's death, it adds to our concerns about the reception screening process at Norwich. We understand that Virgin Healthcare and HMP Norwich are investigating this matter and we therefore make no recommendation.

Mental healthcare

113. The clinical reviewer noted that Mr Sparrow had a lengthy history of involvement with mental health services and had previously been detained as an inpatient in a mental health hospital under the Mental Health Act. We share his concern that the severity and complexity of Mr Sparrow's condition were not identified by healthcare staff at Norwich.
114. A nurse appropriately referred Mr Sparrow to the mental health team during his initial health screen on 20 May. Mr Sparrow was prescribed his antipsychotic medication and was placed on a waiting list for routine physical healthcare monitoring to take place, in line with NICE clinical guidelines.
115. A Mental Health Team Manager completed a desktop triage that day but failed to identify that Mr Sparrow had had previously been detained under the Mental

Health Act, that he had been recalled to prison (a risk factor for self-harm) or that he had a prescription of antipsychotic medication which required monitoring for side effects. He then discharged Mr Sparrow from the mental health team's caseload despite having incomplete historical information and not assessing Mr Sparrow in person.

116. The Mental Health Team Manager told us that the desktop assessment was routinely used at Norwich to prioritise prisoners who had clearly identified mental health needs and to manage the demand into mental health services. However, we are concerned that this process was clearly flawed as it missed Mr Sparrow's risks and history and vital information was not obtained from the desktop process. He accepted that he had not identified Mr Sparrow's risk factors and that he should have referred him for a mental health assessment.
117. The Mental Health Team Manager said that as a consequence of Mr Sparrow's death, the practice of desktop assessment had now stopped and all newly arrived prisoners referred to the mental health team now received a face-to-face assessment. We do not therefore make a recommendation.
118. We agree with the clinical reviewer's view that there was evidence of good practice from the mental health nurse in seeing Mr Sparrow before the first ACCT case review to ensure that an initial assessment was completed to inform the ACCT process and formulate an effective care plan.

Substance misuse care

119. Mr Sparrow was appropriately reviewed and treated for alcohol dependence. He completed an alcohol detoxification programme and the substance misuse team had made plans for long-term monitoring.

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