

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Gabrielle Cosofret, a prisoner at HMP Norwich, on 21 May 2021**

**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 Gabrielle Cosofret died on 21 May 2021, having been found hanging in his cell at HMP Norwich. He was 33 years old. I offer my condolences to Mr Cosofret's family and friends.

I am concerned that there is no evidence that staff had any meaningful contact with Mr Cosofret in the months before his death. Although he continued to have key working sessions because he had been identified as potentially vulnerable, these sessions never went below the surface and staff simply recorded repeatedly that he did not want to engage with them. This lack of engagement meant that staff could not fully assess Mr Cosofret's risk to himself.

The fact that Mr Cosofret, a Romanian national, spoke very limited English and could only communicate at the most basic level, may go a long way to explaining why he did not engage with staff. Despite this, there is no evidence that staff ever used interpreting services to discuss more complex or sensitive subjects with him. Although we cannot say whether this would have encouraged Mr Cosofret to disclose his distress to staff, I am very concerned that he was never given this opportunity.

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

**Kimberley Bingham**  
**Acting Prisons and Probation Ombudsman**

**March 2022**

# Contents

Summary .....	1
The Investigation Process.....	1
Background Information.....	3
Key Events.....	4
Findings .....	6

# Summary

## Events

1. In December 2020, Mr Gabrielle Cosofret was remanded to custody, charged with assault and failing to surrender to bail. He was taken to HMP Norwich.
2. Mr Cosofret was born in Romania and spoke very limited English. He had a history of drug and alcohol misuse and completed an alcohol detoxification on arrival at Norwich.
3. Between 26 December and 15 January 2021, Mr Cosofret was subject to Prison Service suicide and self-harm support measures, known as ACCT. On 22 January, Mr Cosofret was discharged from the mental health team as he had not been diagnosed with any mental health issues.
4. Between December 2020 and May 2021, Mr Cosofret had almost weekly key working sessions. Staff typically recorded that Mr Cosofret did not want to engage, that he had a limited understanding of English and that they had no concerns about him. In March, Mr Cosofret moved landings so that he could be near other Romanian prisoners with whom he had made friends.
5. On 20 May and 21 May, Mr Cosofret was reluctant to leave his cell and sometimes did not collect his meals. Staff and prisoners tried to talk to him about this but he either did not want to engage or reassured them that he was feeling fine.
6. On 21 May at 7.31pm, during a routine roll check, an officer found Mr Cosofret hanging from his bunk bed. She radioed an emergency code and tried to go into the cell. She could not open the door and assumed it had been barricaded from the inside. Another officer who responded two minutes later was able to open the cell. Staff cut Mr Cosofret down and attempted to resuscitate him. At 8.08pm, the prison GP pronounced that Mr Cosofret had died.
7. There were some intelligence reports both before and after Mr Cosofret died that he may have been in debt. Staff and prisoners we spoke to did not believe this was the case.

## Findings

8. We are concerned that there were missed opportunities to engage meaningfully with Mr Cosofret both during key working sessions and through the use of interpreting services. It is impossible to know whether Mr Cosofret would have disclosed his distress or risk to himself if staff had staff used these mechanisms more appropriately.

## Recommendations

- The Governor should ensure that staff have meaningful interaction with prisoners during key working sessions, in line with the published policy.
- The Governor and Head of Healthcare should ensure that staff use appropriate interpretation services to communicate with prisoners with limited English language

skills, especially when discussing sensitive or complex matters, in line with Prison Service Instructions.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and asking anyone with relevant information to contact her.
10. Due to the COVID-19 pandemic, the investigator was unable to visit the prison. She obtained copies of relevant extracts from Mr Cosofret's prison and medical records via post and email.
11. The investigator interviewed nine members of staff and two prisoners. NHS England commissioned a clinical reviewer to review Mr Cosofret's clinical care at the prison. The clinical reviewer and investigator jointly interviewed healthcare staff. The interviews were conducted by video-link and telephone because of the COVID-19 restrictions in place.
12. We informed HM Coroner for Norfolk of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Cosofret's brother, sister-in-law and cousin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked for more information about the circumstances of Mr Cosofret's death.
14. Mr Cosofret's family received a copy of the draft report. They did not make any comments.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

# Background Information

## HMP Norwich

16. HMP Norwich serves the courts of Norfolk and Suffolk and holds a mix of up to 768 remanded and sentenced prisoners and young adults. The main site houses Category B and C prisoners. Another site contains a resettlement unit, holding Category C prisoners and an open resettlement facility, holding Category D prisoners. Virgin Care provides primary healthcare and substance misuse services. Norfolk and Suffolk Foundation Trust provides mental health services.

## HM Inspectorate of Prisons

17. The most recent inspection of HMP Norwich was in November 2019. Inspectors reported that since their previous inspection, Norwich was less safe, with increased levels of violence and improvements needed in the processes to challenge and reduce this violence. They found weaknesses in ACCT management, although the prisoners being supported under ACCT said they felt well cared for.
18. Inspectors reported positive engagement between staff and prisoners but the high level of inexperience among staff led to considerable frustration among prisoners. They noted that much low-level poor behaviour was unchallenged. Inspectors found that all prisoners had been allocated a key worker. Engagement had initially been good, but staff shortages had meant that too few sessions took place for the scheme to be effective
19. Inspectors reported that eight per cent of prisoners were foreign nationals. They noted that there was useful translated information available in reception and the induction unit. There were no records available to determine how often prison staff used interpreting services.

## Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2020, the IMB reported that Norwich was not adequately staffed, with many staff being inexperienced. They also noted that some officers did not challenge poor behaviour robustly.
21. The IMB found that the key worker scheme had been very constructive for some prisoners but, as it was time consuming, it had affected routine officer work. They noted that levels of violence were high, and the quality of ACCT documents was inconsistent.

## Previous deaths at HMP Norwich

22. Mr Cosofret was the tenth prisoner to die at Norwich since May 2019. Eight of these previous deaths were due to natural causes and one was self-inflicted. Previous investigations have raised no issues relevant to this investigation. Two prisoners have died at Norwich since Mr Cosofret, one of whom killed himself and the other prisoner died of natural causes.

## Assessment, Care in Custody and Teamwork

23. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.
24. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

## The key worker scheme

25. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS's *Manage the Custodial Sentence Policy Framework*. This says:
  - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
  - Key workers must have completed the required training.
  - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
  - Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.
26. During the pandemic, key working was suspended across the prison estate under the Exceptional Delivery Model (EDM), except for those prisoners considered most at risk.

## Key Events

27. On 22 December 2020, Mr Gabrielle Cosofret appeared at court and was remanded to custody, charged with assault and failing to surrender to bail. He was taken to HMP Norwich. Mr Cosofret was assessed as a high risk to share a cell due to previously starting a fire in his prison cell in October 2020. He had been released from prison in November, after spending one month in prison. That had been his first time in prison in this country, although he had served prison sentences in Romania, where he was born.
28. A nurse noted that Mr Cosofret spoke and understood English, that he was answering questions appropriately and was calm and polite. Mr Cosofret said he had no thoughts of suicide or self-harm. He told the nurse that he had a history of heroin, crack cocaine, cannabis and alcohol misuse. The nurse assessed his alcohol withdrawal symptoms, which were moderate, and he was prescribed medication to lessen these symptoms. Healthcare staff offered him methadone (a heroin substitute) to manage his withdrawal from heroin, but he declined this.
29. On 26 December 2020, Mr Cosofret started a fire in his cell. Mr Cosofret refused to be assessed by healthcare or prison staff afterwards and said that he did not think he should be in prison. Staff started Prison Service suicide and self-harm support measures, known as ACCT. Over the following two weeks, Mr Cosofret displayed very limited engagement with ACCT reviews and checks and did not comply with his detox observations and assessments. He also did not attend a scheduled mental health assessment.
30. On 12 January 2021, an officer conducted a welfare check on Mr Cosofret. He recorded that it was difficult to conduct ACCT checks because Mr Cosofret blocked his observation panel and did not respond to staff. Although the obstructions were removed each time, Mr Cosofret continued to re-block the observation panel. The officer also recorded that staff received constant verbal abuse from Mr Cosofret when they tried to interact with him and had been told to “fuck off” multiple times when they took his lunchtime meal to him. The officer noted that Mr Cosofret was an “overly unpleasant man to deal with currently”.
31. On 15 January, staff held an ACCT review. It was recorded that Mr Cosofret engaged well and said he had no current thoughts of suicide and self-harm. Staff closed the ACCT and scheduled the post closure review for 22 January. A nurse noted that Mr Cosofret had no diagnosis of any mental health issues, so he was discharged from the mental health team. Mr Cosofret appeared happy with this. He did not engage with the ACCT post-closure review.
32. The prison’s Head of Safety told the investigator that after the ACCT was closed, Mr Cosofret continued to have key working sessions because he was considered to be in a priority group under the EDM as he was struggling to engage with staff on the wing.
33. Between 31 December 2020 and 7 May 2021, Mr Cosofret had 17 key worker sessions. All of these were with different members of staff, who typically noted Mr Cosofret’s lack of engagement with staff and limited understanding of English. No concerns were identified at any of the sessions.

34. Mr Cosofret did not want to engage further with substance misuse services after his detox from alcohol, so, on 24 January 2021, he was discharged. On 26 and 28 January, Mr Cosofret flooded his cell and the landing with water. Staff tried to speak to him about his behaviour, but he would not engage with them. He took his clothes off and tried to give them to staff but they told him he needed to remain dressed. Mr Cosofret refused to engage with staff and covered his observation panel with toothpaste.
35. On 3 February, Mr Cosofret was sentenced to 28 months imprisonment. The earliest he could be released was 7 October. He was moved to the third floor of B Wing.
36. On 26 February, an officer submitted an intelligence report that another prisoner was seen threatening to punch Mr Cosofret if he did not pay off his debt. Wing staff were notified, and the behaviour of the other prisoner was monitored. No further concerning behaviour was observed.
37. On 3 March, a member of the safer custody team carried out a routine welfare check to see how Mr Cosofret was. Mr Cosofret said he was feeling good, but the officer noted that he struggled to describe his mood in detail due to the language barrier. Mr Cosofret said he would like to move to the first floor as there were more Romanian prisoners located there who would help him communicate. On 8 March, he was moved to the first floor.
38. On 7 April, staff submitted an intelligence report about concerns that a Romanian gang was starting to form on the first floor of B Wing. Mr Cosofret was named as one of the prisoners involved.
39. On 17 April, an intelligence report recorded that a bottle containing what appeared to be fermenting liquid (illicitly produced alcohol) was confiscated from Mr Cosofret after he had been given it by another prisoner.
40. On 19 April, an officer tried to engage Mr Cosofret in a key worker session. Mr Cosofret said he was 'fine' and then walked away from the officer who noted that Mr Cosofret had some difficulty speaking English and might need help to understand the language. (The officer had no further key working sessions with Mr Cosofret.)
41. On 7 May, the prison's offender manager, assessed Mr Cosofret. Mr Cosofret said he could not read or write. She recommended that Mr Cosofret did a course to improve his English. She said she had no concerns that Mr Cosofret was a risk to himself.
42. On 11 May, Mr Cosofret refused to attend the English course. He asked to see a dentist, as he said it was painful when he ate. He was referred to the dentist, who typically had around a two-week waiting list. On 18 May, an officer noted that she could not have a key worker session with Mr Cosofret because his wing was locked down.
43. The Head of Residence told the investigator that, on 19 May, Mr Cosofret told a Supervising Officer (SO) that he did not want to go to work in the kitchen, but that staff had no further concerns about him. She believed that he had gone back to work over the next few days. His records indicate that he did not miss any sessions of employment.

44. Prisoner A, a Polish prisoner, was interviewed by the investigator with the assistance of an interpreter. He said that Mr Cosofret was “always happy”, and he had no concerns about him. He said he sometimes gave Mr Cosofret vape capsules if he ran out. He did not think Mr Cosofret was in debt to other prisoners.
45. Prisoner B, a Romanian prisoner, was located in the cell next to Mr Cosofret. He said that Mr Cosofret was upset and angry about being in prison as he thought he had been given bad advice by his solicitor and said he was not guilty of the offence he had been convicted of. He said that Mr Cosofret was also upset that he did not have any contact with his family. He told the investigator that Mr Cosofret tried to hide his true feelings from other prisoners and staff so that he appeared happy. He said he had asked Mr Cosofret if he wanted to end his life, but Mr Cosofret had said that he did not. He had tried to reassure him that there was support available for him from staff and other prisoners.
46. Prisoner B said that Mr Cosofret’s understanding of English was not very good and staff used him and another Romanian prisoner to interpret when they needed to communicate with Mr Cosofret.
47. Prisoner B said that on 20 May, Mr Cosofret refused to come out of his cell or collect his meals. He spoke to him through his observation panel and encouraged Mr Cosofret to come out and talk, but he refused. He told the investigator that officers also encouraged Mr Cosofret to come out of his cell and asked if there was anything wrong with him. He did not know the names of these officers.
48. Officer A told the investigator that Mr Cosofret sometimes did not collect his meals when he was on B Wing. He said he challenged this when Mr Cosofret first moved onto the wing, but it came to be considered as normal behaviour for Mr Cosofret. He said that he did not know if Mr Cosofret supplemented his food intake from his own or other prisoners’ canteen spends (purchases at the prison shop) but that he did not appear underweight. Other officers said that Mr Cosofret was a quiet prisoner, with limited English. No one we spoke to said that they had any concerns about Mr Cosofret.

### **Events of 21 May**

49. Prisoner B said that on the afternoon of 21 May, Mr Cosofret did not want to leave his cell for association. He tried to encourage him to come out, but Mr Cosofret refused. He asked him if anything was wrong, but Mr Cosofret said that he was ‘okay’, and he would see him tomorrow and talk to him then. He said that this was around 3.45pm. It was the last time he saw Mr Cosofret.
50. Officer A remembered that Mr Cosofret did not want to come out of his cell that afternoon but said that this was not unusual for prisoners. He said that he had no concerns about Mr Cosofret but asked his friends if he was okay anyway. They said that they thought he was. He thought that Mr Cosofret had been coming out of his cell for association in the days before 21 May. He told the investigator that he did not have any concerns that Mr Cosofret was a risk to himself.
51. At 5.10pm, Officer B went to unlock Mr Cosofret’s cell for dinner. She could not open it as she believed it was blocked, perhaps with his foot. She asked Mr Cosofret if he wanted dinner through his observation panel. He was sitting in his

cell and declined dinner without giving a reason. She noted that he seemed “normal”.

52. Officer B then spoke to Officer A, who told her that he was a bit concerned about Mr Cosofret who had not been the same lately. (Officer A could not recall this conversation when asked by the investigator.) Officer B returned to Mr Cosofret’s cell to try and speak to him, but he indicated that he did not want to talk. She planned to go back to speak to him later that evening when the wing was quieter.
53. Around 5.45pm, Officer A did a roll check of the landing. He could not remember specifically checking Mr Cosofret but said he must have and that he did not raise any concerns.
54. At 6.45pm, another officer did another roll count of the landing. He told the investigator that when he does a roll check, he checks that the prisoner is in their cell and there are no obvious issues. He said he checked every cell but could not remember what Mr Cosofret was doing. Once he had done the check, he walked across to the communications room who told him that they needed to do a recount on B Wing. Staff telephoned B Wing and, at around 7.25pm, Officer B began a second roll check.
55. When Officer B got to Mr Cosofret’s cell, she looked through his observation panel and saw Mr Cosofret suspended by a ligature from his bunk bed. The officer radioed a code blue (an emergency code which indicates a prisoner is unresponsive or having difficulty breathing) at 7.31pm and requested immediate staff assistance. Staff in the communications room requested an ambulance. She unlocked the cell and tried to push the door open but could not as the cell seemed to be barricaded from the inside. She continued to try to get into Mr Cosofret’s cell.
56. At 7.33pm, an officer got to Mr Cosofret’s cell and managed to open the door. He supported Mr Cosofret’s weight whilst Officer B cut the blanket Mr Cosofret had used as a ligature using her anti-ligature knife. They checked for signs of life but found none. They moved Mr Cosofret onto the landing where there was more space, and the officer began chest compressions. Other officers arrived and helped.
57. At 7.36pm, a nurse got to Mr Cosofret’s cell. He checked for signs of life while officers continued chest compressions. The nurse attached the defibrillator, inserted an airway and administered oxygen. Paramedics arrived at 7.45pm and took over Mr Cosofret’s treatment. At 8.08pm, the prison GP pronounced that Mr Cosofret had died.
58. A SO submitted an intelligence report the day after Mr Cosofret died indicating that he had been feeling low for a couple of days, but that he had been out of his cell and had collected some things he had ordered from the prison shop.
59. Another intelligence report suggested that Mr Cosofret paid off his debts with vape capsules on the day that he died. The investigator asked Prisoner B about this. He said that another prisoner had helped Mr Cosofret by giving him vape capsules when he did not have any. He said the other prisoner had acted as a friend and did not expect anything in return, but Mr Cosofret wanted to repay the capsules and gave them to staff on 21 May to give to the other prisoner. Records show that Mr

Cosofret had ordered double the amount of vape capsules he usually did in his last canteen order, perhaps with this in mind.

### **Contact with Mr Cosofret's family**

60. Mr Cosofret had refused to give any details of a next of kin when he arrived at Norwich. After his death, staff tried to identify a next of kin from Mr Cosofret's records but were unable to do so. A Performance and Assurance manager was appointed as the prison's family liaison officer. She contacted the Romanian Embassy in London and was given the details of Mr Cosofret's brother and sister-in-law. She spoke to his sister-in-law, as his brother did not speak much English. She stayed in contact with his family and offered a contribution to repatriation and funeral expenses, in line with Prison Service policy. Mr Cosofret's family visited the prison and spoke to some of the prisoners who knew him.

### **Support for prisoners and staff**

61. After Mr Cosofret's death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
62. The prison posted notices informing other prisoners of Mr Cosofret'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 Cosofret's death.
63. Officer B said she had been deeply affected by finding Mr Cosofret hanging. She had been referred for external formal support, but she had not been offered an appointment until 21 July due to an external administrative error. The investigator highlighted this issue to the prison after she interviewed Officer B on 21 May. The prison said they were already aware of it and would do what they could to escalate the issue.

### **Post-mortem report**

64. The pathologist concluded that the cause of Mr Cosofret's death was hanging. No drugs or alcohol were detected in his system.

# Findings

## Assessment of risk of suicide and self-harm

65. Between 26 December 2020 and 15 January 2021, Mr Cosofret had been subject to ACCT procedures. After that time, he had not been considered a risk to himself or to require ACCT support.
66. On 21 May, when Mr Cosofret refused his evening meal, Officer B went back to speak to him to check how he was feeling but Mr Cosofret did not want to speak to her. Staff said that it was not unusual for prisoners, including Mr Cosofret, to miss meals, and although she was not overly concerned about him, she planned to return later that evening to try to talk to him. In the circumstances, and without the benefit of hindsight, we are satisfied that this was a conscientious and reasonable approach.
67. It appears that Mr Cosofret hid the extent of his distress from staff and prisoners. One prisoner we spoke to, who had a closer relationship with Mr Cosofret, said that Mr Cosofret ensured he looked happy even when he was not. This prisoner said that Mr Cosofret was angry as he felt he had been wrongfully imprisoned and upset because he did not have any contact with his family. Staff were unaware of this.
68. Staff typically described Mr Cosofret as a quiet prisoner who did not engage with them much but said they had no concerns that he was a risk to himself. Some staff and a prisoner said that Mr Cosofret was more reluctant to come out of his cell in the two days before he died and that he had been feeling 'low', although this was not recorded in his prison records at the time.
69. There was no evidence at the time that Mr Cosofret was having thoughts of suicide or self-harm. However, as we discuss below, we are concerned that the lack of any meaningful interaction with Mr Cosofret reduced his opportunity to speak to staff about how he was feeling and made it difficult for them to make an informed assessment about his risk to himself.

## Meaningful contact

70. The key worker scheme provides for a dedicated member of staff to establish a relationship with a prisoner and should therefore provide opportunities to identify any concerns a prisoner may have and help to put support in place.
71. Although key working was suspended for most prisoners during the pandemic, Mr Cosofret was, exceptionally, considered to require ongoing key working sessions as there were concerns that he was not engaging with staff on the wing. That being the case, we would have expected to see staff make more effort to engage with Mr Cosofret during the key work sessions.
72. Between 31 December 2020 and 7 May 2021, Mr Cosofret had seventeen key worker sessions. All were with different members of staff. None of the sessions identified any concerns. On 18 May, three days before his death, an officer tried to see Mr Cosofret for another key work session but was unable to see him due to the wing being locked down.

73. The officers who spoke to Mr Cosofret do not appear to have understood why he was considered to require key working sessions and we are concerned that no meaningful interaction seems to have taken place during these sessions. We have seen no evidence that officers completed the prison's Key Worker Guidance Note Sheet which was supposed to guide staff about the topics to be covered in key worker sessions during the pandemic. Staff entries typically refer to Mr Cosofret not wanting to engage or having a limited understanding of English and raised doubts about whether he really understood what was being said or whether he was able to communicate at anything but a very basic level.
74. As these were precisely the concerns that had led to him being identified as needing key work sessions, we are surprised and disappointed that no action was taken in response. The fact that a different officer saw him every time would have made it difficult for any one officer to form a relationship with him or to see the bigger picture. In addition, the quality assurance process, under which only around 9 out of every 100 key work entries are reviewed by a custodial manager or a senior manager, meant that no one else was in a position to identify the bigger picture or to see that the key work sessions were not achieving their apparent aim of improving Mr Cosofret's engagement with staff. We make the following recommendation:

**The Governor should ensure that staff have meaningful interaction with prisoners during key working sessions, in line with the published policy.**

#### **Use of interpretation services**

75. We recognise that some prisoners will never want to engage with staff or to open up about their concerns and feelings. However, we consider that one reason why staff found it impossible to engage with Mr Cosofret was that his poor English prevented him having anything but a very basic conversation. Mr Cosofret was located on a wing to be close to other prisoners who spoke Romanian and were also able to assist him interpreting what staff said. During our interviews, the consensus was that Mr Cosofret spoke limited English but, sometimes with the assistance of his friends, it was enough to communicate on a day-to-day basis. However, there are also numerous entries on Mr Cosofret's record indicating that staff were unsure whether he had understood what they said.
76. The Prison Service's policy on foreign national prisoners says,
- "Language barriers obviously make all other problems worse. Staff should not assume that prisoners with some comprehension of English have completely understood what is being said to them. Poor communication between staff and prisoners may have implications for things like risk of self-harm and good order and discipline."
77. PSI 64/2011 says,
- "All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and/or during the risk management process."
78. We are therefore concerned that there is no evidence that staff ever used the interpreting and translation services available at Norwich or considered contacting the two Romanian members of staff available to interpret. We consider that an

interpreter should have been used when having more complex discussions such as key working sessions, medical assessments or ACCT assessments and reviews.

79. We consider that the failure to use the interpreting services was a missed opportunity to engage with Mr Cosofret. While we cannot be sure that he would have opened up to staff about the extent of his distress, it would have provided him with the means to do so if he had wanted to.
80. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff use appropriate interpretation services to communicate with prisoners with limited English language skills, especially when discussing sensitive or complex matters, in line with Prison Service Instructions.**

### Clinical care

81. The clinical reviewer concluded that Mr Cosofret's clinical care was of a good standard and equivalent to that he could have expected to have received in the community.

### Intelligence about Mr Cosofret

82. In February, staff submitted an intelligence report that another prisoner had threatened to punch Mr Cosofret if he did not repay his debt. As a result, the other prisoner's behaviour was monitored, and wing staff were informed. No further related incidents were reported. In April, staff submitted an intelligence report that they were concerned a Romanian gang was forming on B wing. After Mr Cosofret died, there was intelligence that he had repaid his debt in vape capsules earlier that day.
83. We spoke to staff and prisoners about this intelligence. None believed that Mr Cosofret was in significant debt or that he was being bullied. The Head of Residence said that she did not think a "gang" had formed on B Wing but that there was simply a group of prisoners who spoke the same language and helped each other. She understood Mr Cosofret's "debt" to be a few borrowed vape capsules between friends and said that this was a common occurrence in the prison. Prisoners we spoke to also gave the same impression. On the evidence available to the investigation, we are satisfied that staff acted appropriately and there was no reason to believe that Mr Cosofret was in significant debt or under threat when he died.

**Prisons &  
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