Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stuart Williamson, a prisoner at HMP Norwich, on 29 December 2021

A report by the Prisons and Probation Ombudsman

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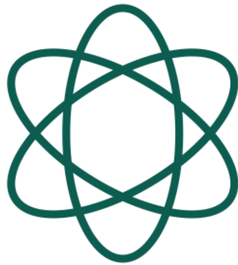
Our vision

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

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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 Stuart Williamson died as a result of blood loss caused by a self-inflicted cut to his neck on 29 December 2021, at HMP Norwich. He was 56 years old. I offer my condolences to Mr Williamson's family and friends.

Staff started suicide and self-harm procedures (known as ACCT) when Mr Williamson arrived at Norwich on 2 November 2021 and continued them until 19 November. Staff managed the ACCT procedures well overall, though there were some issues with observations and recording interactions. I am satisfied that Mr Williamson gave staff no indication that he was at increased risk of suicide in the six weeks before he died.

The clinical reviewer found that the care Mr Williamson received for his mental health was of a good standard.

I am concerned that Mr Williamson's in-cell phone was not working and despite reporting this several times, it was not fixed before he died. Restrictions imposed during the COVID-19 pandemic made it even more important for prisoners to have use of an in-cell phone. Norwich should ensure that in-cell phones are fixed promptly, particularly during periods where COVID-19 restrictions limit the time prisoners spend out of their cell.

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 **July 2022**

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Summary

Events

1. On 2 November 2021, Mr Stuart Williamson was remanded in prison custody, charged with murder, and sent to HMP Norwich.

2. Mr Williamson was supported using Prison Service suicide and self-harm prevention procedures (known as ACCT) from the day he arrived at Norwich until 19 November.

3. At 4.52pm on 29 December, when delivering a meal to his cell, an officer discovered Mr Williamson unresponsive and bleeding heavily from a cut to his neck. Another officer radioed a medical emergency code and prison and healthcare staff attended. They, along with ambulance paramedics, attempted to resuscitate Mr Williamson, but were unsuccessful. At 5.29pm, a doctor pronounced that Mr Williamson had died

Findings

4. We found that staff managed the ACCT well overall. There was a consistent case manager, case reviews were multidisciplinary, and reviews were held frequently. However, we identified that some of the observations and conversations were not always completed or recorded.

5. The clinical reviewer found Mr Williamson received a good standard of clinical care. He was referred and assessed quickly by the mental health team and had a named mental health nurse who he met with regularly. However, the clinical reviewer noted that Mr Williamson did not always receive his prescribed medication.

6. Mr Williamson was unable to telephone his family for nearly two weeks after he arrived at Norwich due to a delay in approving his contact numbers. While we understand the need for security checks to take place to verify telephone numbers, maintaining contact with family can be a protective factor and authorising telephone numbers for someone subject to ACCT measures should not have taken so long. The prison has since reviewed processes so that they prioritise prisoners on an ACCT.

7. Mr Williamson was moved to a cell with a broken telephone socket on 17 November. He reported this several times, but it was not fixed before he died. Although there was a telephone on the wing, access was limited due to the COVID-19 restrictions in place. Mr Williamson did not make any telephone calls after 16 December, and we do not know if this was by choice or due to lack of access.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, and in particular staff should:
  - carry out observations at the agreed frequency and at unpredictable times;
  - write meaningful summaries in the ongoing record and record full details of all conversations; and
  - check the ACCT document carefully when carrying out the Supervisor Daily Check and flag any issues that need attention.

- The Head of Healthcare should review the medication prescribing and administering process to ensure that medication is consistently prescribed and administered.

- The Governor should ensure that:
  - wing staff identify and record if cells do not contain the required equipment, including a working telephone; and
  - staff report problems with telephone sockets at the earliest opportunity.

- The Ministry of Justice should liaise with BT to ensure that they attend prisons to repair broken phones as soon as possible following any issues being reported.

The Investigation Process

8. 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.

9. The investigator obtained copies of relevant extracts from Mr Williamson's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Williamson's clinical care at the prison. The investigator and clinical reviewer jointly interviewed six prison and healthcare staff. The investigator also interviewed one officer and received a written response to questions from the Business Hub Manager.

11. 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.

12. The Ombudsman's family liaison officer contacted Mr Williamson's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Williamson's sister asked what information the police shared with the prison about Mr Williamson's mental health and medication; whether he was prescribed antidepressants and did he comply; what support he received and whether he was subject to suicide and self-harm procedures.

13. Mr Williamson's family received a copy of the initial report. They did not identify any factual inaccuracies.

14. The prison also received a copy of the report. They identified a factual inaccuracy relating to ACCT documentation, which has been amended. We have also amended and directed our recommendation to the responsible stakeholder for the BT pin phone contract.

Background Information

HMP Norwich

15. 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. A local discharge unit (LDU) is on another site, housing Category C prisoners and an open resettlement facility, holding Category D prisoners. HCRG Care Group (previously Virgin Care) provides primary healthcare and substance misuse services. Norfolk and Suffolk Foundation Trust provides mental health services.

HM Inspectorate of Prisons

16. 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.

Independent Monitoring Board

17. 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 2021, the IMB noted the adverse impact of COVID-19 upon prisoners due to the severe but mandatory constraints upon activities, education, and time out of cell, and also the impact upon staff. Time out of cell and activities had been very limited and the COVID-19 regimes in place to minimise spread of the virus meant minimal time out of cell.

18. The Board found that planning for safeguarding of more vulnerable prisoners was thorough and there are multi-disciplinary discussions of more complex prisoners at the weekly safety intervention meeting (SIM) which instigate good all-round support. Self-harm in the prison population remained high and increased during lockdown.

19. The Board noted that the mental health team was overstretched, and key workers were diverted to support those prisoners suffering the most during lockdown as the prison focused on supporting the prisoners with the greatest need. COVID-19 restrictions on loss of regime were found to have negatively impacted upon prisoners' wellbeing and mental health.

Previous deaths at HMP Norwich

20. Mr Williamson was the ninth prisoner to die at Norwich since December 2019. Six of the previous deaths were due to natural causes and two were self-inflicted. There are no similarities between our findings from our investigation into Mr Williamson’s death and our investigation findings from the previous deaths

Assessment, Care in Custody and Teamwork

21. 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.

22. Part of the ACCT process involves assessing immediate needs and drawing up support actions 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).

Key worker scheme

23. 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.

24. 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

25. On 2 November 2021, Mr Stuart Williamson was remanded in prison custody, charged with murder, and sent to HMP Norwich. It was his first time in prison.

26. When Mr Williamson arrived at Norwich the reception nurse started suicide and self-harm prevention measures (known as ACCT) due to the nature of his offence, history of suicide attempts and because it was his first time in prison. She referred him for an urgent mental health assessment. A prison GP prescribed antidepressants (not in possession, which meant Mr Williamson had to collect them daily).

27. On 3 November, Mr Williamson appeared at Norwich Crown Court and was told that his plea and directions hearing would be in January, but the date was still to be set. When Mr Williamson returned to Norwich, a member of the chaplaincy team carried out Mr Williamson's ACCT assessment. She noted that Mr Williamson said he felt shocked and was not sleeping but did not feel suicidal. Mr Williamson told her about the serious attempts to take his own life in the weeks after his offence (he twice took an overdose of non-prescribed medication with alcohol and tried to hang himself) but had not made any further attempts. Mr Williamson said he had good support from his sister, read books and used mindfulness techniques as a way of coping.

28. A Supervising Officer (SO) chaired the first ACCT review. A nurse from the mental health team and Mr Williamson attended. Mr Williamson said he had not yet received his antidepressants and did not have a telephone in his cell. The nurse told Mr Williamson his medication would soon be dispensed, and the SO said he would report the issue with the in-cell telephone. The SO reduced observations from four an hour to one an hour and scheduled the next ACCT review for 8 November.

29. On 4 November, a SO held an ACCT review as there had been developments linked to Mr Williamson's offence. A mental health nurse, an officer and Mr Williamson attended. Mr Williamson said he was relieved that the remains of his victim had been found and the information was now in the public domain. Mr Williamson said he was eating a little better, but his sleep was still disturbed (he had collected his antidepressant medication). The ACCT panel agreed that Mr Williamson's risk had not changed and kept observations at one an hour. The SO recorded on the care plan that the mental health team would continue to review and assess Mr Williamson, for staff to continue supporting him with his adjustment to being in prison for the first time and have contact with his wider family when he felt more able to. The SO scheduled the next ACCT review for 10 November.

30. After the ACCT review, the nurse carried out a further mental health assessment with Mr Williamson. She concluded that Mr Williamson's mood was stable. Mr Williamson (who was a psychiatric mental health nurse) said he thought his prescribed medication was sufficient, was grateful for the support he had received and was told how to ask for extra support if required. She recommended the allocation of a case manager from the mental health team to provide consistent support. (Another nurse was allocated to Mr Williamson on 9 November 2021.)

31. The next day, an officer contacted Mr Williamson on his in-cell telephone for a key work session. Mr Williamson said that he felt more settled, spent time watching the television and asked when he could expect to get his PIN in order to make calls. The officer said he would try to sort this out.

32. On 7 November, a SO held an ACCT review (earlier than scheduled due to a change in the wing regime). A nurse and Mr Williamson attended. The SO recorded that Mr Williamson had started to adjust to being in prison but was concerned he did not have his PIN number, so he was unable to contact his sister. The SO agreed to contact the Business Hub Manager about the PIN number. Mr Williamson told the nurse he had not been given two doses of his antidepressant medication but was unsure why. The review panel reduced observations to two each morning, afternoon, and evening, and five observations during the night. The SO scheduled the next ACCT review for 16 November.

33. On 9 November, an officer met with Mr Williamson in the evening for a key work session. Mr Williamson said he still did not have access to his PIN phone and was waiting for credit to be added. The officer contacted Mr Williamson's sister after the key work session to update her on his wellbeing.

34. On 16 November, a SO held an ACCT review. A nurse and Mr Williamson attended. The SO encouraged Mr Williamson to apply for work or education, and he agreed this would give structure to his day. Mr Williamson told staff that he now had access to his PIN phone, had spoken to his sister, written to his parents and that he had a video link with his legal representative on 19 November. Mr Williamson said he had to attend court on 22 December, and he spoke to staff in detail about his offence. He did not raise any other issues. The nurse told Mr Williamson that he would continue to be supported by the mental health team and his next mental health review was scheduled for 1 December. The ACCT review panel considered Mr Williamson's risk remained unchanged and scheduled the next ACCT review for 19 November, after the meeting with his legal representative. They kept the same level of observations.

35. Later, an officer met with Mr Williamson for a key work session. He noted that he seemed relaxed, had no issues, and understood the ACCT process and the additional support offered. Mr Williamson said his family and solicitor provided him with support and he wanted to get a job to keep himself busy. The next day, Mr Williamson moved to a different cell on the same wing as he had completed his time on the Reverse Cohorting Unit (RCU – where newly arrived prisoners were kept for 14 days, separate from the main prison, to limit the spread of COVID-19).

36. On 19 November, a SO held an ACCT review. A mental health nurse and Mr Williamson attended. Mr Williamson said it was noisy on the wing. The SO suggested he should make an application to move to a quieter wing. Mr Williamson said he was worried when he arrived at Norwich, but now felt settled and got on well with staff and other prisoners. He said he no longer had difficulty sleeping, was in regular contact with his sister and just wanted the court hearing to begin. The ACCT review panel agreed to close the ACCT. The SO told Mr Williamson that he would continue to be supported by wing staff and the mental health team. He scheduled an ACCT post-closure review for 26 November.

37. On 22 November, an officer met Mr Williamson for a key work session. He told her that he was settled on the wing, but said he was unable to speak to his parents as their number had not been added to his PIN phone and the in-cell phone was broken, which he had reported to wing staff. The same day, a pharmacy technician referred Mr Williamson to the nurse prescriber as he had not been collecting his antidepressants.

38. On 25 November, a nurse met with Mr Williamson and he told her that he no longer wanted to take antidepressants. After discussion, she agreed to stop the prescription and noted that she would typically have started a reduction plan, but Mr Williamson had not been prescribed the medication for long enough. She referred Mr Williamson to the mental health team for a review.

39. On 28 November, a SO held the ACCT post-closure review, two days after it was scheduled (no reason is given for the delay). The SO recorded that Mr Williamson had no issues and had no thoughts of suicide or self-harm.

40. On 1 December, a nurse met with Mr Williamson to review his mental health. Mr Williamson said that he had felt very well supported by the ACCT process, was sleeping better, and continued to use coping strategies to reduce his stress. He said that he got on well with prison staff and a select few prisoners. Mr Williamson said he had decided to stop taking antidepressants because he no longer felt the same level of anxiety, now that his offence had been discovered and was relieved people knew. The nurse noted that there were no identifiable suicide or self-harm risks at the time of assessment and scheduled a mental health review for 23 December (the day after Mr Williamson's next court appearance).

41. On 10 December, an officer from the Safer Custody Team went to see Mr Williamson for a wellbeing check. They had received an email which said Mr Williamson had arranged for his sister to be his power of attorney. Mr Williamson said this was simply to allow his sister to manage his account while he was in prison and that he had no intention of ending his life. Mr Williamson told the officer that he was not struggling with his mental health, had started education, and was reading books sent by his sister.

42. When he had access to his PIN phone, Mr Williamson maintained contact with his family and twice spoke to his partner. All prisoners' telephone calls, except those that are legally privileged, are recorded and prison staff listen to a random sample. The investigator was provided with a recording of the calls made by Mr Williamson between 15 November and 16 December.

43. During the calls to his family Mr Williamson spoke about the daily frustrations of being in prison (not having clothes that had been sent in, access to newspapers, the noise on the wing etc) and gave them information about when he thought he was next due in court. During a conversation with his partner on 5 December, they agreed not to speak about his offence or the court case, but she said she was going to have to give evidence as a prosecution witness. Mr Williamson apologised several times for the situation and told her that he would try and find a way that meant she did not have to be a witness but did not elaborate. There was nothing to suggest that Mr Williamson was in crisis during any of the calls.

44. On 17 December, due to an outbreak of COVID-19, a restricted regime was implemented to try and reduce the spread of the virus at Norwich.

45. On 22 December, an officer met with Mr Williamson for a key work session. Mr Williamson said he was managing the lockdown regime well but asked when he would have access to a shower. The officer said that wing staff were awaiting guidance from prison management, which Mr Williamson accepted. Mr Williamson told the officer that he was unable to contact his family as his in-cell phone had been broken by the previous occupant, which he had reported numerous times over the preceding weeks.

46. The next day, a nurse twice tried to contact Mr Williamson on his in-cell telephone but received no reply. He went to Mr Williamson's cell, as he wanted to check on his welfare, but had to speak to him through the door due to the COVID-19 restrictions. Mr Williamson said he had not appeared in court the previous day but was unsure why. He told the nurse that he was passing time by watching television, reading, and writing letters to his family, but had not had a shower for six days due to the COVID-19 restrictions (he had a sink in his cell). Mr Williamson told him that his in-cell telephone was not working, and he agreed to speak to the wing manager about the broken phone. The nurse planned to see Mr Williamson again on 7 January 2022.

29 December

47. On 29 December at 10.51am, an officer met with Mr Williamson for a key work session. The officer recorded that they had a long conversation about his court case and Mr Williamson said he was 'feeling good' and had no issues, other than looking forward to a shower when he was out of isolation. [Prison Service Instruction 75/2011 - *Residential Services*, states that a prisoner can expect access to a shower at least weekly & facilities in-cell for ablutions. However, there may be circumstances, such as those brought about by the global pandemic, which mean that individual prisons are not able to deliver that.]

48. At 4.52pm, an officer went to Mr Williamson's cell to deliver his evening meal. She unlocked the door and saw Mr Williamson sitting on his bed, but he did not respond to her. She noticed blood, shouted for help and her colleague radioed a code red (an emergency code which indicates a potentially life-threatening incident involving blood loss). Staff in the communications room immediately called for an ambulance. Other officers responded to the emergency and they used towels to stop the bleeding, moved Mr Williamson to the landing floor and started cardiopulmonary resuscitation (CPR). They attached a defibrillator, which advised there was no shockable rhythm.

49. A nurse also responded to the emergency. She checked for signs of life while officers continued chest compressions. She inserted an airway and was joined by three other healthcare staff and resuscitation continued until paramedics arrived at 5.13pm and took over Mr Williamson's treatment. Paramedics recorded that staff were performing CPR to a high standard. At 5.29pm, the air ambulance doctor pronounced that Mr Williamson had died.

50. Staff found two razor blades tied together and a plastic fork, covered in blood. They also found a note in Mr Williamson's cell addressed to his partner. He wrote that he

had been on remand for nine weeks, which had felt like nine months, and that a life without a future, happiness, choice and freedom was not a life.

Contact with Mr Williamson's family

51. The prison appointed a family liaison officer (FLO). Under normal circumstances next of kin should, wherever possible, be informed of a death in person by a FLO. However, contact by telephone was permitted during the COVID-19 pandemic. The FLO therefore informed Mr Williamson's sister of his death by telephone and offered ongoing support. The prison contributed towards the costs of Mr Williamson's funeral in line with national policy

Support for prisoners and staff

52. After Mr Williamson's death, the duty governor debriefed all staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff support team and the TRiM manager (trauma risk management) also contacted prison staff.

53. The prison posted notices informing other prisoners of Mr Williamson'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 Williamson's death.

Post-mortem report

54. The pathologist concluded that the cause of Mr Williamson's death was hypovolemic shock (severe blood loss which means the heart is unable to pump enough blood to the body) due to a self-inflicted cut to his neck

Findings

Assessment of risk of suicide and self-harm

55. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)* sets out the procedures that staff must follow when they identify that a prisoner is at risk of suicide and self-harm. It lists risk factors and potential triggers for suicide and self-harm.

56. Mr Williamson arrived at Norwich with a number of these risk factors: it was his first time in custody; he was charged with the murder of his ex-partner and faced a life sentence if found guilty, and he had previously tried to take his own life. Staff correctly started ACCT procedures and Mr Williamson was supported until the ACCT was closed on 19 November.

57. We found that the overall management of Mr Williamson's ACCT was good. There was a thorough assessment, a care plan that reflected his needs, case reviews were comprehensive and completed when there was a change in his circumstances and all reviews were multidisciplinary with a mental health nurse at each one.

58. However, we did identify some deficiencies in the daily management of the ACCT. Some observations were missed on 3 November and at other times some observations were late or at predictable times. Staff did not always complete the summary sections in the ongoing record and the records of conversations were not sufficiently detailed. We are also concerned that the Supervisor Daily Check did not always identify the issues with the observations and summaries. While we acknowledge it was over five weeks after the ACCT was closed that Mr Williamson took his own life, it is important that staff monitor prisoners in line with their ACCT plan and demonstrate that they have had meaningful interactions with them. We therefore recommend:

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

    - **carry out observations at the agreed frequency and at unpredictable times;**
    - **write meaningful summaries in the ongoing record and record full details of all conversations; and**
    - **check the ACCT document carefully when carrying out the Supervisor Daily Check and flag any issues that need attention.**

Clinical care

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

Mental health

60. The clinical reviewer found that Mr Williamson was well supported by the mental health team. He was referred when he arrived at Norwich, was quickly assessed

and was allocated a named mental health nurse who was proactive in engaging Mr Williamson.

61. Mr Williamson was prescribed an antidepressant (sertraline) on 2 November but missed the first dose. Mr Williamson also missed two doses on 5 and 6 November, but it is not clear from the medical record why he had not received his medication. While this may not have had a significant clinical effect on his mental state, prescribed medication should be given consistently. We therefore recommend:

The Head of Healthcare should review the medication prescribing and administering process to ensure that medication is consistently prescribed and administered.

Access to PIN phone

62. PSI 49/2011, *Prisoner Communication Services*, sets out the requirements for all prisoner communication, including telephone use. The PSI says, 'The checking of social numbers must be proportionate to risk and checked as necessary in accordance with the NSF [National Security Framework] and as set out in the local security strategy [LSS]'.

63. Mr Williamson's records are clear that contact with his family was a protective factor. However, he was unable to make any telephone calls until 15 November, 13 days after he arrived. The Head of Safety told the investigator that because Mr Williamson arrived with restrictions on who he could contact (due to the nature of his offence), staff needed to verify his telephone numbers as set out in PSI 49/2011. He said that at the time Mr Williamson was at Norwich, due to the competing demands of staff time, verifying telephone numbers could take up to two weeks.

64. The Business Hub Manager said that staff processing PIN phone applications were not always aware when a prisoner was subject to ACCT measures and she had now introduced a new process to ensure all staff within the unit know who is subject to ACCT, and they would be prioritised.

65. The Head of Safety said that since Mr Williamson's death, the Safer Custody Team now had two dedicated SOs, who would take responsibility for checking and verifying telephone numbers for those prisoners with restrictions and/or subject to ACCT measures, if staff detailed to PIN phone checks were redeployed to other duties, to reduce the waiting time.

66. We are satisfied that Norwich has responded to the concerns about the length of time taken to authorise PIN numbers and so we make no recommendation.

Access to in-cell telephone

67. When staff completed the Immediate Action Plan for Mr Williamson's ACCT on 2 November, they noted that Mr Williamson was aware of the in-cell phone and how to use it. However, Mr Williamson did not have a telephone handset in his cell at the time. He raised this the next day and it was identified during a management check on 4 November. Staff should check that cells have all the necessary equipment in them before prisoners are placed in them.

68. When Mr Williamson moved cells on 17 November, he was moved to a cell with a broken telephone socket. This meant Mr Williamson was only able to use the telephones located on the wing landing when out of his cell, which was limited due to the COVID-19 restrictions. The last telephone call Mr Williamson made was on 16 December, 13 days before he died. We were unable to establish if this was his choice, or the lack of access to the PIN telephone on the wing due to the restricted regime. Mr Williamson reported the broken telephone socket several times to both prison and healthcare staff, but it was not fixed before he died.

69. The Head of Safety told the investigator that the current contract with British Telecom (BT) states that they will not attend to fix broken sockets until there are at least ten across the prison. He said this had been flagged as a concern and the project manager for the contract was trying to address the issue. He said that cells remained in use even if the in-cell phone was not working, as there was still access to telephones on the wing landing.

70. While we understand the constraints of the BT contract and the difficulties providing a normal regime during the COVID-19 pandemic, Norwich must ensure that prisoners have reasonable access to a telephone to maintain contact with their family. We make the following recommendation:

The Governor should ensure that:

- **wing staff identify and record if cells do not contain the required equipment, including a telephone; and**
- **staff report problems with telephone sockets at the earliest opportunity.**

The Ministry of Justice should liaise with BT to ensure that they attend prisons to repair broken phones as soon as possible following any issues being reported.

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