

**Investigation into the circumstances surrounding the
death of a man
at HMP&YOI Norwich in September 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

December 2010

This is the report of an investigation into the circumstances surrounding the death of a man who died unexpectedly at the age of just 27 years in HMP&YOI Norwich. He was received at Norwich on the evening of 3 September 2009 and was found dead in bed the next morning.

The investigation was led by one of my colleagues. One of my family liaison officers contacted the man's family and offered them an opportunity to ask questions about his death. In addition to his parents and siblings, he leaves a partner and children. I offer them, and all those affected by his death, my sincere condolences.

I am grateful to the Commissioning Manager for Planned Care for NHS Norfolk for her work in providing a clinical review of the brief time the man spent in Norwich. I am also grateful to the Safer Custody Manager at Norwich, who provided a high standard of liaison for both the investigator and clinical reviewer.

Although my investigator and the clinical reviewer concluded their interviews in early December 2009, the investigation could not be concluded until the Coroner received the toxicology report. Unfortunately, it was not received until 18 May 2010. This in turn delayed the clinical review which was received in my office on 24 June. Although the significant delay in issuing this report was substantially not of my making, I offer my apologies to the man's family for any additional distress which this may have caused.

Following the findings of the toxicology report, the pathologist concluded that the man died from the combined effects of sedative drugs prescribed for him in prison and sedative drugs that he brought into prison concealed on his person. I have found no evidence that he intended to harm himself by ingesting these drugs.

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

Jane Webb
Acting Prisons and Probation Ombudsman

December 2010

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SUMMARY

In August 2008, the man was sentenced to one year nine months in prison for grievous bodily harm. He was released on licence from HMP Wayland on 16 January 2009. He was recalled to prison on 3 September after breaching the terms of his licence. He arrived at HMP Norwich shortly after 3.00pm. He went through the standard search procedures and first reception health screen. He was allocated a cell on A1 landing.

The man told the reception nurse that he used zopiclone (used to treat insomnia), diazepam (used to treat anxiety) and cannabis in the community. His urine showed that he had taken benzodiazepines (of which diazepam is one) and cannabis. He was prescribed a reducing dose of diazepam and painkillers and zopiclone. The diazepam was administered in the presence of a nurse in his cell. The remaining medication was given to him to hold and take when required.

He appeared to be in good spirits on the night of 3 September. The night nurse checked him twice during the night shift and on each occasion he appeared to be sleeping peacefully in bed.

At about 8.25am, a landing officer opened the man's cell and asked him if he wanted to go out for exercise. When he did not respond, the alarm was raised. Wing staff, health care staff and paramedics attempted to resuscitate him but he was pronounced dead at 8.55am.

A post mortem examination on 5 September found no apparent cause of death. Two packages were found in the man's rectum and four items were removed from his cell for further examination. Subsequent toxicology reports showed that the packages removed from his rectum contained buprenorphine, quetiapine and cannabis and that all these substances were in his system. Based on these findings the pathologist concluded that he died from the combined effects of sedative drugs prescribed to him in prison and sedative drugs that he had brought into prison concealed about his person.

A clinical review of the healthcare received by the man in Norwich concluded that he received appropriate medical care during his brief time in prison.

I conclude that his death could not reasonably have been foreseen or prevented by HMP Norwich. He was properly searched when he arrived at Norwich. His first reception health screen was conducted appropriately and he was prescribed medication consistent with his presentation and the results of his urine test.

I make one recommendation about the location of prisoners needing detoxification and highlight three examples of good practice.

THE INVESTIGATION PROCESS

1. I was notified of the man's death in September 2009. The investigation was allocated to an investigator on 11 September. Notices were issued to staff and prisoners at Norwich telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. No one came forward in response. The investigator wrote to the Coroner and spoke to a Detective Sergeant from Norfolk CID.
2. A clinical review of the man's medical care was commissioned from NHS Norfolk. The Commissioning Manager for Planned Care undertook the review. Her report appears as an annex to this report.
3. The investigator visited Norwich on 17 September and the clinical reviewer accompanied her. Together they met with the Safer Custody Manager. The investigator and clinical reviewer read the man's prison record and took copies of relevant documents. They visited A wing and spoke informally to some of the staff. The investigator spoke to the then Governor on 22 September.
4. The investigator returned to Norwich on 1 December and interviewed four members of staff. She visited the prison's reception area to familiarise herself with the way in which new prisoners are searched for contraband. She spoke at length to the Head of Security about search procedures and the use of drug detection dogs.
5. One of my family liaison officers spoke to the man's mother on the telephone. She explained the nature and purpose of this investigation and offered the family the opportunity to share any concerns they had about his death and raise any questions about his treatment in prison. The man's mother said she wanted to know as much as possible about her son's brief time in prison. She said that the then Governor and the prison chaplain broke the news of her son's death to her in person at home. She said that she and her son's partner subsequently visited the prison and were very well treated. The prison offered to contribute to funeral costs and staff attended the service.
6. A post mortem examination took place on 5 September at hospital. No evidence was found of natural disease that caused or contributed to his death. Blood, urine and tissue samples were sent for examination by a toxicologist. Two packages found in the man's rectum and four other items from his cell were also sent for forensic analysis. The results of these tests were passed to the investigator and the clinical reviewer on 18 May 2010.

HMP&YOI NORWICH

7. Norwich is a local prison serving the courts of East Anglia. It holds remand and sentenced adult men and young offenders. The buildings are a mixture of Victorian, twentieth and twenty first century builds on different sites. The adult men and young offenders were integrated in 2009 and the young offender institution was converted into a resettlement unit for low risk category C prisoners. There is also a separate category D (open) prison.
8. A Wing is a newly built wing that opened in late August 2009. The new A wing and activities block consists of the first night centre, induction unit and integrated drug treatment system (IDTS) stabilisation and maintenance landings. A2 landing is designed for prisoners requiring detoxification. Accordingly the cells have large hatches in the doors allowing nurses to observe the prisoners more clearly and to pass them medication and drinks during the period when they are undergoing withdrawal. A wing has cells for 180 prisoners but since opening 30 cells have been doubled and it now accommodates 210 prisoners.
9. The Norwich Independent Monitoring Board (the IMB comprises independent volunteers who monitor day-to-day life in prisons) report 2009/10 commented that A wing was opened on schedule, the building was pleasantly light and airy and the transfer of prisoners into it was well planned and effected efficiently. A number of teething problems became apparent when the wing was first occupied – the radio signal was poor or non-existent and the protective glass in the wing offices meant it was impossible for staff inside them to communicate orally with staff outside them (when my investigator visited A wing in September 2009 staff were banging on the windows or gesticulating to attract the attention of colleagues). These problems have since been rectified.

KEY EVENTS

10. In August 2008, the man was sentenced to one year and nine months imprisonment for grievous bodily harm. He served his sentence at HMP Wayland and was released on licence on 16 January 2009.
11. On 3 September, he was arrested by police and charged with possession of a category B drug (cannabis), possession of a category C drug (Subutex), using threatening words or behaviour, resisting arrest and obstructing a police officer. His family told my family liaison officer that he went willingly with the police when arrested.
12. His probation officer notified the public protection casework section at the National Offender Management Service the same day that the man had breached the terms of his licence. He appeared before magistrates and was remanded to custody pending a hearing on 15 September. He was taken to HMP&YOI Norwich, arriving in reception there at 3.09pm.
13. The man went through each stage of the standard search procedure in order to identify whether he was carrying any contraband such as drugs or mobile telephones. He was strip searched, which meant that his clothes were removed in turn to preserve his dignity. He was also checked with a hand held metal detector and then walked through the x-ray portal. As a known drug user, he was also searched using a drug detection dog. The dog gave a positive indication that the man had come into contact with drugs recently. (A positive indication from a drug detection dog can mean that the person has drugs on their person or that they have used them or otherwise come into contact with them recently.) He told reception staff that he had, "had a spliff recently". He then sat on the BOSS chair (body orifice security scanner – a device for searching for metal objects concealed internally). This did not indicate that he was concealing any metal object.
14. Following the search procedure, Nurse A completed the man's first reception health screen. It included testing his urine and the results showed positive for cannabinoids and benzodiazepines (a group of psychoactive sedative drugs used to treat insomnia, muscle spasms and anxiety). He told the nurse that he had recently been involved in a car accident and was taking painkillers for whiplash and zopiclone (usually prescribed for insomnia). He also told her that he was taking unprescribed diazepam (a benzodiazepine used to treat anxiety) daily and used cannabis regularly. At interview the nurse told the clinical reviewer that he appeared "fidgety" consistent with someone withdrawing from benzodiazepines.
15. Nurse A concluded that the man needed diazepam detoxification. She prescribed diazepam (in a reducing dose consistent with detoxification), paracetamol, ibuprofen and zopiclone (a single tablet). The first dose of detoxification medication is usually given in reception.

She did not have the required medication at that time so she telephoned A wing and asked Nurse B to make sure the man received it on the wing. He was taken to cell A1-24 on A wing. As a prisoner detoxifying from illicit drugs, he should have been located on A2 landing but appears to have been placed on A1 either in error or because A2 was full.

16. Nurse B told the clinical reviewer at interview that A wing had only recently opened when the man arrived at Norwich. She said there was a lot of confusion in the early days that led to prisoners on detoxification sometimes being incorrectly located on other landings. This made it harder for staff to make sure they were receiving appropriate care. She said that she found out where he was located and went to his cell. She said he appeared to be settling in well and was in good spirits. He was playing his music loudly and she asked him to turn it down. She spoke to him at some length about what medication he was allowed. She watched him take his dose of diazepam and gave him his doses of paracetamol, ibuprofen and zopiclone for that night in possession so that he could take them if and when he needed to.
17. Nurse C was the substance misuse nurse on duty on A wing during the night of 3/4 September. Her role is to look after the prisoners who are detoxifying on A2 landing. She was told at handover that the man had been put on A1 landing in error. She said at interview that she remembered speaking to him when she came on duty that night. It was her practice to introduce herself to all new prisoners undergoing detoxification. She said he was pleasant and appreciative of her visit. She remembered that his music was on very loud and an officer told him to turn it down.
18. Nurse C said that she is not required to check prisoners who are detoxifying, unless they are very unwell. However, it is her practice to check them for her own peace of mind. She decided to check the man partly because he was located on a different landing. As mentioned previously all the cells on A2 have large observation hatches in the door allowing the nurses a good view of the prisoner and enable them to pass medication or drinks at night. Because he was located on A1, his cell door had a standard observation flap, making it more difficult to observe him. She remembered checking on him twice during the night and said he looked to be asleep in bed on both occasions. She last looked at him before going off duty at about 7.45am. She said she did not notice anything untoward about his appearance.
19. At about 8.25am on 4 September, Officer A began unlocking the cells on A2 landing. He opened the man's door and asked him if he wanted to go out for exercise. He got no response and, on looking more closely, saw that he was blue in colour. He called to Officer B for assistance. Officer B said she went into the cell with Officer A and they tried to wake him by calling his name and touching him. She said he

looked to be asleep under his blankets. The bedding had not been disturbed. He did not respond so Officer B used her radio to call a code blue emergency (signifying that a prisoner is unconscious or having breathing problems). Because of difficulties with the radio signal on the wing she also ran to the wing office and banged on the glass to attract the attention of other staff.

20. Officer C was also on duty on A wing. He heard Officer A say to a prisoner, "exercise fella" and then call to Officer B for assistance. He realised that something was wrong and went to the man's cell. He saw both officers trying to wake him. Officer B left the cell and Officer C said he and Officer A turned the man over on the bed. As they did so they heard a gurgling sound and took this as an indication that he was still breathing. They moved him on to the floor and placed him in the recovery position. At this point Officer D and a Principal Officer (PO) entered the cell.
21. Officer D checked the man for signs of life but could find none. The officers placed him on his back and Officers D and A began cardio pulmonary resuscitation. The PO asked a Senior Officer (SO) to call for an ambulance and to get emergency response nursing staff. However, the emergency response nursing staff arrived shortly afterwards because they had received the radio message from Officer B.
22. Two nurses and a Healthcare Assistant (HCA) heard the emergency code blue on the radio and immediately made their way to A wing. Due to poor radio reception they thought that the emergency was on A4 landing but when they got to A wing they were told the emergency was in cell A1-24. The HCA was asked to collect the emergency bag containing a defibrillator from A5 landing.
23. The HCA said he attached the defibrillator to the man and no shock was advised. (If there is no electrical activity in the heart the defibrillator will advise not to shock but to continue CPR.) He continued CPR and the nurses set up a bag and mask to give him oxygen. After one cycle of CPR the defibrillator analysed him and again advised no shock. The healthcare staff continued CPR until the paramedics arrived at about 8.40am. The paramedics continued CPR. They also attached a 12 lead electro cardiogram (ECG) machine to him and it showed a flat line (indicating that there was no electrical activity in his heart). At 8.55am the paramedics pronounced that he had died.
24. The prison's death in custody contingency plan was followed. Four items were removed from the man's cell by the police and given to the Coroner's pathologist. They were a paper cup containing tablets, a torn Somerfield bag and two plastic wrappings. All the prisoners who were subject to monitoring under the Assessment, Care in Custody and Teamwork procedures (ACCT - the National Offender Management Service's process for monitoring prisoners thought to be at risk of

harming themselves) were reviewed. An officer in Safer Custody visited a friend of the man who was subject to ACCT. The then Governor and the chaplain visited his parents to break the news of their son's death.

25. A post mortem (PM) examination was completed at hospital on 5 September. The pathologist found no evidence of natural disease that caused or contributed to the man's death. Neither did he find any injuries or evidence of assault or restraint. Two packages were found in his rectum and sent for forensic analysis along with the four items removed from his cell with samples of his blood, urine and other tissues.
26. The first of the packages discovered in the man's rectum was found to contain one whole, one half and one fragment of 8mg buprenorphine (Subutex – an opioid used to treat opioid addiction) tablets and small amounts of cannabis in three different forms. The package was dry and therefore the examining chemist concluded that it was unlikely that any of the contents had leaked into his body. The second package was found to contain 12 buprenorphine tablets, 8.95g of cannabis in flowering form and 6.4g of cannabis in resin form. Although this package was damp, the chemist concluded that the contents had not leaked out into his body.
27. The paper cup removed from the man's cell contained the paracetamol and ibuprofen given to him at the prison as part of his detoxification regime. The cup also contained part of a blister pack containing two Seroquel tablets. (Seroquel is the brand name of a preparation containing quetiapine. It is used to treat schizophrenia, bipolar disorder and anxiety disorders and was not prescribed to him.) The examining chemist concluded that the Somerfield bag and the two wrappings removed from the cell had at one point been part of the packages found in his rectum.
28. Forensic analysis of the man's blood and urine samples showed that he had consumed buprenorphine, cannabis, paracetamol, ibuprofen, zopiclone, quetiapine and diazepam. Based on the findings of the toxicologist, the pathologist concluded that he died as a result of the combined effects of the sedative drugs found in his system, with buprenorphine likely to have made a major contribution.

ISSUES CONSIDERED

Clinical care

29. The clinical review at annex 1 contains a complete account of the medical treatment received by the man during his brief time in Norwich. I consider that the reception health screen and first night prescribing for him were appropriate. There was no evidence to suggest that he had recently taken any opioid substance (such as buprenorphine) that would combine fatally with the benzodiazepines in his system and those prescribed for detoxification. His urine showed positive for the presence of benzodiazepines and cannabis, which was consistent with the information about his drug use that he gave to Nurse A.
30. As has been explained previously, A wing was a newly opened wing. One of its functions is to provide an integrated drug treatment service (IDTS) for prisoners needing detoxification. The dedicated detoxification landing is A2. In order to implement an IDTS, a prison must complete a planning tool kit. One of the three main factors in respect of safer custody in the planning toolkit for local prisons is that there must be unrestricted observation through large observation hatches on cell doors.
31. Because the man incorrectly was given a cell on A1 his door only had a regulation observation panel. However, the clinical review concludes that his location away from the detoxification landing, though not ideal, did not impact negatively on the care he received because nursing staff made sure it did not. Nurse B made a point of explaining to him that he was not located where he should have been and advised him to ring his cell bell if he needed anything during the night. She also introduced him to Nurse C which was good practice. Nurse C decided to make regular checks on him even though she was not required to. This is another example of good practice.
32. At interview with the clinical reviewer, nursing staff expressed frustration at the number of times that prisoners requiring detoxification were inappropriately located away from A2. Prisoners are especially vulnerable in the early stages of detoxification and the ability of staff to observe them unrestrictedly is crucial. I know that senior managers at Norwich were aware of this problem at the time and it was regarded as one of the teething troubles associated with opening a new wing. However I consider it sensible that checks are made to ensure that the problem has been resolved.

I recommend that the Governor satisfies himself that prisoners needing detoxification are now routinely located on A2.

The prison accepted this recommendation at draft report stage and commented:

“Prisoners needing detoxification are now routinely located on A2, however due to increased numbers of prisoners requiring detox this may not always be possible. When prisoners are located on other landings within the “A” Wing complex” protocols have been put in place by healthcare that the prisoners are given the same amount of care/checks.”

33. As soon as he realised that the man was not responding Officer A tried to establish if he was still breathing. While turning him over the officer heard a gurgling sound which he took as evidence that he was breathing. He and Officer C therefore moved him into the recovery position on the floor. Officer D then checked for signs of life and when he could find none, CPR was started. This is the correct procedure to follow when finding a person unconscious. Ascertaining whether an unconscious person is breathing is not always straightforward. I am satisfied that staff reacted appropriately and started CPR as soon as possible. From the statements made by the staff concerned, it appears that the man was already dead when he was discovered.

The prison’s response to the man’s death

34. A wing became operational on 31 August 2009. It is a new building and in the few days between the wing opening and the man’s death a number of problems became apparent. The radio signal on A wing was poor and the nature of the glass and design of the wing offices (known as ‘bubbles’) meant staff inside the offices could not hear what was going on outside and vice versa. At interview staff said that they were not all supplied with radios. Radios were allocated according to role. This meant that theoretically a landing might have no staff carrying a radio. This, in combination with the fact that the new landing offices were not equipped with telephones, gave rise to concerns about safety of staff and prisoners and the ability of staff to respond in an emergency.
35. In this case the emergency response healthcare staff did hear the emergency call on the radio. Although they understood the emergency was on A4 landing they were pointed to the correct location as soon as they got to the wing.
36. My investigator spoke to the then Governor about these issues in September 2009. He said that a new aerial was due to be put up nearer the wing which would improve the radio signal. He also said that more staff radios were on order. My investigator confirmed that a new aerial went up in February 2010 and that the issues with the signal and radios have since been resolved. I have therefore decided not to make a recommendation about the radio system.
37. I am pleased that the then Governor and the prison chaplain went in person to break the news of the man’s death to his parents. It is properly the responsibility of the prison to break the news of a death in

their custody. His mother said the family were treated well and sensitively by the prison. All the staff interviewed reported that they too had felt well supported.

38. In the hours immediately following the man's death, staff raised concerns about a prisoner on A wing who was on an open ACCT document and who had been friends with him. The prisoner was visited by a member of the Safer Custody Team and arrangements were made for him to see a nurse and have an ACCT review. This is another example of good practice.

Searching and drug detection

39. Prison staff do not have the power to conduct intimate searches of prisoners. During the mandatory strip search if staff have a strong suspicion that a prisoner has concealed an item on their person, they are only allowed to ask the prisoner to squat or bend over.
40. The Head of Security explained to my investigator that prisoners are not routinely searched using drug detection dogs but they are used in reception when possible. The dog handler will usually be able to tell whether the dog is certain that drugs are concealed on the prisoner or whether it is more hesitant. A hesitant indication might indicate that a person has come into contact with or taken drugs relatively recently. If a dog gives a positive indication then security staff 'flag' the prisoner for a later cell search. The ability of a drug detection dog to detect whether a prisoner has drugs concealed on his person depends on how carefully the drugs have been handled.
41. The problem of drugs and other contraband being brought into prison is unfortunately common. Prisoners, like the man, who are recalled from licence may know in advance that they are likely to return to prison and they have the opportunity to 'prepare' by concealing drugs before they appear at court. I am pleased to see that staff in Reception at Norwich recognised him as someone who was known to use drugs and searched him additionally using a drug detection dog. Had he lived beyond his first night in custody, I would have expected the positive indication given by the drug detection dog to have resulted in a search of his cell and a mandatory drug test during his first days in custody. In the circumstances of this case I do not consider that staff could reasonably have been expected to do more at the time of his reception, to find out whether he had brought drugs in with him.

CONCLUSION

42. This is a sad story. The man was a young man with a young family. I do not know whether he was expecting to return to prison on 3 September 2009. The contents and nature of the packages concealed about his person suggests that he was. He appears to have made a determined attempt to bring contraband into Norwich and to conceal those drugs in a way that made it unlikely staff would find them during the reception process.
43. I have found no evidence that he was aware of the risk in combining the drugs prescribed for him and those he brought into the prison. There is no evidence that he intended to harm himself and no evidence of third party involvement in his death. I do not believe that his death could have been reasonably foreseen or prevented by staff at Norwich.

RECOMMENDATIONS

1. I recommend that the Governor satisfies himself that prisoners needing detoxification are now routinely located on A2.

The prison accepted this recommendation at draft report stage and commented:

“Prisoners needing detoxification are now routinely located on A2, however due to increased numbers of prisoners requiring detox this may not always be possible. When prisoners are located on other landings within the “A” Wing complex” protocols have been put in place by healthcare that the prisoners are given the same amount of care/checks.”

Good practice

1. When Nurse B realised the man had not been given a cell on the detoxification landing, she made a point of explaining to him that he was not where he should be and advised him to ring his cell bell if he needed anything during the night. She also introduced him to Nurse C. This is good practice.
2. The decision by Nurse C to make regular checks on him because he was not located on the detoxification landing was good practice.
3. The visit by the Safer Custody Officer to the man’s friend was good practice.