

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

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

November 2009

This is the report of the investigation into the apparently self-inflicted death of a man at HMP & YOI Norwich in January 2009. The man had been identified as posing a risk to himself and was being monitored under the prison's suicide and self harm procedures. He was 48 years old when he died.

During the course of the investigation, my office has had contact with a number of the man's family and friends. I offer my sincere condolences to them.

The investigation was conducted by one of the Ombudsman's investigators on my behalf. She was assisted by another investigator. They received excellent support from the Safer Custody Manager. I would also like to thank the Governor of Norwich and his staff for their co-operation.

The local PCT commissioned the clinical reviewer to undertake a review of the clinical care the man received whilst at Norwich. I am grateful for her thorough review.

The man's family and friends said that he did not find it easy to share his thoughts or concerns with others. Nonetheless, staff on C wing at Norwich, where he spent the majority of his time, worked hard to support him. Their interviews with the investigators revealed how much they knew about the man's personal problems and anxieties and they should be commended for the care they showed to him.

However, whilst at Norwich, the man complained of being bullied and pressured by other prisoners on C wing. The two members of staff he complained to passed on his concerns to the Security Department. My investigation has revealed that the staff who worked with him on a daily basis were unaware of his complaints. As a result I make recommendations about how allegations of bullying are handled at the prison.

I also make recommendations about the management of suicide and self harm procedures in the prison, and about the provision of healthcare services.

The man's was the tenth apparently self-inflicted death to occur at Norwich since the Ombudsman took over responsibility for investigating all deaths in prison custody in 2004. His was the second of three such deaths to occur at the prison in very close succession. However, I have not found there to be any particular similarities between the circumstances of the deaths.

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
Deputy Ombudsman

November 2009

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SUMMARY

The man was arrested by the police in September 2008, and was charged with causing actual bodily harm. He appeared at court the following day and was remanded into the custody of HMP Lincoln. Whilst being placed on the escort van which would take him to Lincoln, he told escort staff that he intended to harm himself whilst in prison. Escort staff opened a Suicide/Self Harm Warning Form and, on his arrival at the prison, staff placed him on an ACCT document. (Assessment, Care in Custody and Teamwork is the process used to support and monitor prisoners who are at risk of suicide or self harm.)

Following his second appearance at court on 16 September, the man was moved to HMP Norwich. He had some health problems that needed further investigation by healthcare staff. In reception, he said that although he was on an open ACCT, he had no intention of harming himself. He told staff that he had previously suffered with depression and had abused alcohol in the past. However, he said he was not currently receiving treatment for either problem.

During his first few weeks at Norwich, the man complained of a number of health problems, including coughing up and vomiting small amounts of blood, being unable to sleep, and nausea and a lack of appetite. He was referred to the local hospital for an urgent chest x-ray, to rule out tuberculosis (a highly contagious disease). The prison did not receive the results of the x-ray until over a month later.

On 7 October, the man was released on bail. However, he breached the conditions of his bail, and was returned to Norwich on 25 October. On his arrival, he told staff that he still had some health problems and repeated that he did not intend to harm himself. Over the next few weeks, he was assessed by a number of different healthcare staff. He complained of insomnia and a lack of appetite, although he said he was not depressed. He was prescribed sleeping tablets and continued to be monitored.

In November, there were indications that the man might be involved in trafficking mobile telephones into the prison, perhaps on behalf of other prisoners. On 10 December, on his return from a court appearance, he became upset. He told reception staff that he was being bullied by another prisoner on C wing, where he was located. He said he did not want to return to C wing. His concerns were reported to the Security Department and he was moved to a different wing.

The man referred himself to the prison's substance misuse service and was assessed on 19 December. He again complained of being bullied and pressured by other prisoners on C wing, and the Security Department were informed once more. However, it appears that C wing staff were not aware of his allegations. He moved back to a single cell on C wing on 22 December.

On Friday 2 January 2009, the man became upset after talking to his wife. He told members of his family and staff at the prison that the marriage had ended. He said that he intended to take his own life, and as a result, was placed on an ACCT. It was decided that staff should check him four times an hour, including overnight.

The following day, a Saturday, the man attended his ACCT case review which was with two members of staff. His primary concern appeared to be safeguarding his finances. Staff agreed to help him arrange this the following Monday. They thought that his mood had improved and he was no longer talking of suicide. As a result, staff decided that he should be checked once in the morning, afternoon and evening, but hourly during the night – when he said his mood was lowest.

Night staff checked the man throughout the night and had no concerns about him. However, during a routine check at 6.30am on 4 January, a member of night staff found him with a ligature around his neck, attached to the window bars in his cell. Staff attempted cardio-pulmonary resuscitation until the paramedics arrived. At about 7.00am, the paramedics pronounced him dead.

This investigation has identified failings in how the prison deals with and records allegations of bullying. It has also revealed omissions in the completion of the man's ACCT document. I make 11 recommendations. The clinical reviewer has also highlighted a number of concerns about the provision of healthcare, particularly mental health care, at Norwich. She has made 23 recommendations of her own, which I endorse. While I have included some of her recommendations within my report, the Governor and Head of Healthcare will wish to note the review in its entirety.

THE INVESTIGATION PROCESS

1. The Ombudsman's office was informed of the death of the man in early January 2009. The investigation was allocated to an investigator the following day. She visited HMP Norwich on 7 January to open the investigation. She met a representative of the local branch of the Prison Officers' Association, and spoke to the member of the Independent Monitoring Board who was on duty on 4 January.
2. The investigator issued notices inviting staff and prisoners to contact her with any information they felt might be relevant to the investigation. Three prisoners wrote to the office about the man's death. They were all interviewed as part of the investigation. The investigator and a colleague carried out interviews with staff and other prisoners at the prison between January and March 2009. The investigator's colleague was conducting an investigation into another apparently self inflicted death which also occurred at the prison in January. As a result four members of staff with strategic responsibilities were interviewed jointly in respect of both deaths. The transcripts of those interviews have been redacted as appropriate and form annexes to both investigation reports.
3. The local PCT appointed a clinical reviewer to undertake a clinical review. The clinical reviewer, the investigator and her colleague conducted several joint interviews with members of the prison's healthcare department.
4. The investigator was provided with relevant documentation covering the man's time in prison, including a copy of his core prison record, his medical record, and the staff incident reports written after his death. She was also provided with transcripts of the telephone calls he made in the days prior to his death. Some significant documents, such as the ACCT document opened on 16 September and the medical record relating to his time at Lincoln, were missing.
5. One of the Ombudsman's Family Liaison Officers made contact with several members of the man's family to invite them to be involved in the investigation process. They raised a number of questions and concerns, which I have summarised below, about the care he received while at Norwich:
 - Why, as he had been identified as being a risk to himself, the man had not been located in a safer cell. (Safer cells are specially designed to offer fewer ligature points.)
 - Why items that he could use to harm himself were not removed from his cell when he was identified as being a risk to himself.
 - Whether, in the light of concerns about him, staff carried out the appropriate assessments and put the appropriate support mechanisms in place.
 - Whether there was any evidence that he was subject to bullying while at Norwich. In particular, whether any bullying was as a result of his previous convictions.
 - Whether prison staff at Norwich knew what was happening in his personal life, and if so, how they responded.
 - Whether he had been refusing to eat and whether staff had taken any action in response.

- Whether prison staff identified his difficulties with reading and writing and offered the appropriate support.
- Members of his family told the Family Liaison Officer that he and his wife were experiencing problems, and were concerned about the impact this might have had on him.

I hope this report helps to answer their questions.

HMP & YOI NORWICH

6. HMP/YOI Norwich is a local training prison, with a separate young offender institution. The adult side of the prison holds male category B and C prisoners on remand and sentenced. It also has an older prisoner unit. The prison can accommodate 536 prisoners. B and C wings (the two main wings holding adult prisoners) opened in 1996.

HM Chief Inspector of Prisons (HMCIP)

7. In November 2006, HMP/YOI Norwich underwent an unannounced follow-up inspection by HMCIP, after a full announced inspection in March 2005. The follow-up inspection found that the prison had attempted to resolve some of the problems identified in 2005, but that national prison population pressures had undermined the prison's achievements.
8. HMCIP reported that their earlier criticisms of the prison's suicide and self-harm procedures had been "fully addressed". Robust systems had been put in place to support and monitor those at risk. However, they reported that the prison had not been able to "concentrate enough on the significant problems of bullying" in the prison. Among adults, bullying was found to be connected to the "poor and unsafe prescribing of medications which could be, and were being, traded". Staff-prisoner relationships were found to be "reasonably good", with prisoners generally speaking well of staff.
9. Health services at the prison were found to have improved since the last inspection, with considerable investment in an electronic clinical management system. Primary mental health provision within the prison (except for those diagnosed with a severe and enduring illness) was, however, found to be poor.

Independent Monitoring Board (IMB)

10. Each prison in England and Wales is also monitored by an Independent Monitoring Board (IMB), consisting of volunteer members of the local community. Members of the IMB have access to each part of the prison and every prisoner held there. The IMB produce annual reports for each establishment. The most recent report available for Norwich covers the period 1 March 2007 to 29 February 2008.
11. The IMB noted the significant population pressures experienced at Norwich, writing that over one third of prisoners shared a cell designed for one person. However, the IMB found the prison to be operating "reasonably well". Healthcare provision, particularly mental health provision, within the prison was criticised. The Board argued that there should be a "proper needs analysis" and that the prison should have a more consistent general practitioner (GP) service. The Board called for the prison mental health team's staffing to be restored to "its previous level" and for prisoners to have consistent access to a GP with mental health experience.

KEY EVENTS

12. In September 2008, the man was arrested by Norfolk Police and was taken to Kings Lynn Police Station and charged with actual bodily harm. He was held at the police station overnight to appear at court the following morning.
13. A Prisoner Escort Record (PER) was completed by a police officer in the custody suite. (The PER is designed to highlight the risks the escorted prisoner may pose to themselves and to others. The initial page of the PER (Part A) is completed by the police or the prison, depending where the prisoner leaves from. The PER Part B serves as an ongoing record of the prisoner's time whilst being escorted and should be updated by escort staff during the day.) The man's PER recorded that he posed a risk to others due to the nature of his previous offences. The police officer completed the form to indicate that there were no known risks concerning either his medical history or any risk to himself.
14. The man appeared at Kings Lynn Magistrates' Court the following day and was remanded into the custody of HMP Lincoln until his next court appearance. At 12.45pm, he was placed in the escort van. Escort staff recorded on the PER Part B that at this point, he "was making comments about wanting to kill himself and that when he got to HMP [Lincoln] he would seriously hurt himself". He told the escort staff that he would not be at court the following week. Staff wrote that he was very reluctant to get on the van. As a result of his comments, escort staff opened a Suicide/Self Harm Warning Form. He was to be observed at regular intervals until the van arrived at Lincoln.
15. The escort van arrived at Lincoln at 2.40pm. Escort staff passed the Suicide/Self Harm Warning Form to prison staff in reception. As a result of the concerns about the man, prison staff opened an ACCT document. (Unfortunately, when he was released from court on bail in October 2008, the ACCT book was lost at court and was not available to the investigator.)
16. On his arrival at Lincoln, the man would have been assessed by a nurse who carried out the first reception healthscreen. The purpose of the first reception healthscreen is to identify any immediate physical or mental health concerns and make appropriate referrals to medical staff or other agencies. (When he was transferred to HMP Norwich three days later, his medical records from Lincoln were transferred with him. Unfortunately, healthcare staff at Norwich have not been able to locate the records. As a result, it has not been possible to identify his health needs on arrival at Lincoln or any medical treatment he might have received during his short time there.)
17. The man also underwent a Cell Sharing Risk Assessment (CSRA), which assesses the risk a prisoner poses to other prisoners, and therefore their suitability for sharing a cell. The prison officer assessing him noted that he had been considered a risk to himself during his last prison sentence, two years earlier. The officer also recorded that he had come into the prison that day on a Suicide/Self Harm Warning Form. He wrote that the man's long term partner had died two years before and he had suicidal thoughts then. He was assessed as posing a low risk to other prisoners and suitable for sharing a cell.

18. On 16 September, the man was due to appear at Kings Lynn Magistrates' Court again. The PER that accompanied him noted that he was on an open ACCT and might pose a risk to himself. He arrived at court at 10.19am. At 10.22am, a prisoner custody officer (PCO) recorded that a second Suicide/Self Harm Warning Form had been opened because the man had said he wanted to harm himself before he appeared in court.
19. During a routine check at 1.05pm, a member of escort staff recorded that the man had been coughing a lot and was now coughing up blood. As a result, an ambulance was called and he was taken to the local hospital for treatment. (There is no further information in his Norwich medical records about the treatment he received at the hospital that day, or the probable cause of his symptoms.) In his absence, the judge remanded him into the custody of HMP Norwich until the following day. He was discharged from hospital at 6.10pm and was escorted to Norwich.
20. At 8.40pm, the man underwent a first reception healthscreen with a nurse. He told the nurse that he had been assessed at Kings Lynn Hospital two or three weeks previously because he was short of breath. The nurse recorded that he had been "monitored and told he had an abnormality". There is no evidence in his medical record to indicate that healthcare staff sought any further information about this. The nurse recorded that the man had no concerns about his physical health and that, other than a "few scratches on his head", he appeared well. He told the nurse that his wife had "beaten him up".
21. The nurse recorded that the man had arrived at the prison on an ACCT "because of his previous behaviour", she continued "he has told me he has no intention of harming himself, he just wants to get home". He told the nurse that he was "alright". The nurse was interviewed as part of this investigation. She told the investigators she had got to know him a little during his time at the prison. She explained that they had got on well. They had chatted on several occasions, when she saw him as she completed her duties across the prison. She described him as an "anxious man", although he did not discuss his anxieties with her, and said she had tried to reassure him.
22. The nurse remembered that during his reception healthscreen the man had seemed worried about being in prison, but not upset. He told her that he thought the victim was going to withdraw the charges at his next court appearance. The nurse told the investigators that he gave her no cause to worry although she knew he had come into the prison on an ACCT document. She said that she would probably have seen the ACCT document when she assessed him, although she could not recall whether this was definitely the case and could not remember any details of it.
23. An officer then undertook the CSRA with the man. He noted that the man had previously abused alcohol, but was not currently dependent on any substances. He recorded that he was on an open ACCT document but considered him to pose a low risk to other prisoners, and therefore suitable for sharing a cell. The nurse completed the healthcare aspect of the form, although she did not record whether

he posed a low, medium or high risk to others. She indicated that, following the self harm assessment, she had no concerns about him. He was placed in a double cell on E wing, the induction unit.

24. Later that evening, the man was seen by an officer on E wing who completed the first night interview. The officer recorded that the man was on an open ACCT document but currently had no thoughts of harming himself. He told the officer that he had suffered from depression in the past but was not prescribed any medication. The officer recorded that the man had difficulties reading and writing. The first night interview document instructs that any such problems should trigger a referral to the Disability Liaison Officer. There is no indication in the man's file that such a referral was made or that he received any specific assistance with or advice about his difficulties. The E wing officer concluded that there were no concerns about where he should be located in the prison.
25. Early the following morning, the man left Norwich for Kings Lynn Magistrates' Court. He was once more remanded into the custody of HMP Norwich, to appear at Norwich Crown Court in October. At 1.52pm, he was placed on the escort van to return to Norwich. At 2.28pm, the escort staff recorded on the PER that they could not get a response from him and had pulled into a layby to await an ambulance. A member of healthcare staff made an entry on his medical records at 3.20pm, noting that he had received a telephone call from the paramedics who had treated him in the escort van. The member of healthcare staff recorded that the man had been found "slumped in the vehicle, but was instantly rousable". He wrote that the man had vomited, and this had contained "a very small amount" of blood and that he was complaining of painful ribs. It was recorded that the man would continue his journey to Norwich and would be assessed by medical staff on his arrival.
26. At 4.38pm, a doctor made an entry in the man's medical record. He noted that the man was complaining of chest pain. He wrote that the man had been in a fight with his wife and had been hit in the chest. The doctor noted that the man had experienced pain when breathing during the journey to the prison, had fainted and been sick. He was now fully conscious, but was complaining of sore ribs. The doctor carried out an electro-cardiogram (ECG) which indicated no problems with the man's heart. (An ECG is a test that looks at the rhythm and electrical activity of the heart.) The doctor recorded that the man's chest was tender with some bruising. He prescribed co-codamol (a painkiller), herbal remedy sleeping tablets and capsules to treat indigestion. The doctor recorded that the man should undergo an urgent chest x-ray.
27. On 18 September, the man underwent a secondary healthscreen with a nurse. The nurse recorded that the man had not been eating for a couple of days. She wrote that she was unable to obtain a urine sample from him. The nurse carried out a nutritional assessment with him, which indicated that he currently posed a "minimum risk". She concluded that he should be assessed each week.
28. Five days later, on 23 September, the doctor examined the man once more, as he was complaining of nausea and vomiting. He told the doctor that he was still noticing small amounts of blood in his vomit. The man complained of being unable

to eat. He told the doctor that he might be released from prison the following week as the charges against him had been dropped. The doctor prescribed an anti-nausea medicine. He noted that the man's chest x-ray results were not due until the following week. He recorded that, if he was released from court, the man's doctor in the community should be advised to carry out a blood test to identify the cause of his symptoms.

29. On 1 October, the man was assessed by a second doctor, as he was complaining of insomnia. He told the second doctor that the herbal remedy was not helping. The second doctor prescribed zopiclone (sleeping tablets) for one week. Two days later, a nurse recorded that she had seen the man on E wing while dispensing medication to prisoners. She wrote that he was complaining of coughing up blood. This nurse recorded that she had asked him to provide a sample of sputum and that she had asked for an appointment with a doctor that day.
30. The second doctor examined the man at 10.52am later that morning. He recorded that he was complaining of having had a cough for two or three weeks and coughing up a "light red blood". The second doctor recorded that the man had undergone a chest x-ray at the hospital but that the results had still not been received. Upon examination, the doctor found no signs of pneumonia or problems with his lungs. He concluded that he was probably suffering with pharyngitis (inflammation of the throat), caused by a bacterial infection. He prescribed antibiotics and arranged to assess him in a week's time.
31. The man appeared at Norwich Crown Court on 7 October and was granted bail. There is no entry in his medical file to confirm that healthcare staff were aware that he had been discharged from court. Similarly, there is no evidence that, on his release, medical staff either gave him advice about his health concerns or contacted his doctor in the community, either in respect of the chest x-ray (the result of which was still outstanding) or his continuing symptoms.
32. On 24 October, Norfolk Police re-arrested the man as he had breached the conditions of his bail. Whilst in police custody, he underwent a risk assessment which identified that he was currently taking painkillers for internal bleeding. The risk assessment did not identify that he posed a risk to himself. He was kept in police custody overnight, to appear at Kings Lynn Magistrates' Court the following morning. The PER completed by the police recorded that he had a stomach complaint, might pose a risk due to the nature of his previous offences and was vulnerable (no further information about this risk was provided).
33. At court on 25 October, the man was remanded into the custody of HMP Norwich until 29 October. At 10.17am, he was placed in the escort van to begin the journey to Norwich. During the journey, the escort staff found him slumped forward in his seat and recorded on the PER that his posture gave the "impression that he had fainted". On checking him further, staff could not get a response from him. The escort staff stopped the vehicle and made further attempts to rouse him. After successfully doing so, the escort staff decided that, as they were very close to the prison, they would continue the journey.

34. The man arrived at Norwich shortly before midday. It appears that, on his arrival, he was wrongly given a new prison number. Each newly arrived prisoner at a prison is given a unique identifying number. This number is noted on all documentation relating to that prisoner. As he was being returned to prison in relation to the original offence of actual bodily harm, he should have remained with the same prison number. It is not possible to know whether this had any impact on how he was assessed on his arrival at the prison, but may account for why no mention is made of him having been on an ACCT throughout his last stay at Norwich.
35. In reception, the man underwent a CSRA with a third officer. He told the officer that he had been on an ACCT previously but had no thoughts of harming himself now. The officer considered him to pose a low risk to other prisoners and thought he was suitable for sharing a cell. A nurse completed the healthcare aspect of the form. She recorded that there was insufficient evidence to determine the level of risk he posed to others. She recorded that, following the self harm assessment, she had no concerns about the risk he posed to himself.
36. The nurse also carried out the first reception healthscreen. The man told her that he was waiting for an appointment to investigate the cause of his internal bleeding. The nurse recorded that the man was being prescribed painkillers and medication for his stomach, although he did not know their names. She also recorded that he was asthmatic and did not have any inhalers with him. The man said that he would like to see the doctor about his stomach and to be prescribed painkillers. The nurse made no notes in his medical record to indicate that she was aware that he may have fainted during the journey to the prison. There is no evidence to suggest that he received any specific healthcare intervention or assessment as a result of the escort staffs' concerns.
37. The nurse recorded that the man was "upset" but that he said he was "ok, worrying about [his] wife". He said he had no thoughts of harming himself and that he had never tried to harm himself in the past. He told the nurse that he suffered from panic attacks and took sleeping tablets.
38. The nurse who carried out the first reception healthscreen on 25 October was interviewed by the investigators as part of the investigation. She said that she had been working at the prison on a full-time basis for about four years, although she was employed by an agency. She remembered that the man had appeared somewhat angry and impatient during the reception process, but she thought his most pressing concern had been getting an inhaler for his asthma. She checked whether the correct inhaler was available but did not find one. She also checked the emergency supplies but the inhaler was out of stock there too. She said that she told him she would get an inhaler for him but that it might take some time, as it was a Saturday and she was working alone.
39. At 6.02pm, the nurse who had carried out the first reception healthscreen earlier that day recorded that she had been asked to see the man as he might be having an asthma attack. She contacted Medicom to request a prescription for an inhaler. (Medicom is the out of hours service used at Norwich when there are no doctors on site. The service is accessed by telephone, and Medicom doctors can provide

prescriptions following discussion with the nurse.) The Medicom doctor returned her call at 6.15pm and prescribed an inhaler. The man was given the inhaler and the nurse recorded that he became calm and his breathing “immediately improved”.

40. The man was allocated a cell on E wing, where he was seen by a fourth officer who completed the first night interview with him. The officer again recorded that the man had problems reading and writing. Once more, there is no indication that a referral was made to the Disability Liaison Officer, as directed, or that he received any specialist support. In response to a routine question, the man told the officer that he had no thoughts of harming himself.

41. On 27 October, the man was assessed by a third doctor to arrange prescriptions for painkillers and his asthma inhaler. The doctor noted that he had been in Norwich three weeks earlier. She made the following entry:

“In fact, it does not appear to be a stomach problem he has. Says never had a problem there and has never vomited. In fact, it is on coughing that he brings up a bit of blood and he has done this since he was attacked by his wife and beaten up around the chest. This is why he is on painkillers ... He apparently had an x-ray here two weeks ago but no result available on this file or his old one ... To contact x-ray urgently.”

42. The third doctor continued the entry, noting that she had contacted healthcare about the x-ray results and was told they had not received them yet. She recorded that she had “informed them that this is urgent” as the man might be suffering with tuberculosis, a highly contagious illness. Later that day, the doctor recorded that she had left a telephone message for the x-ray department at the hospital requesting the results and asking that he undergo a second chest x-ray that week. Neither his medical record nor his prison record indicates when he went to the hospital for the second chest x-ray. The third doctor also recorded that the hospital had faxed the results of his first chest x-ray to her, and that there were no indications of any problems.

43. The following day, 28 October, the man moved from the induction wing to B wing, one of the two main wings in the prison. On 29 October, he appeared at Kings Lynn Magistrates’ Court where he was remanded into custody until 12 November. (On that date, he was once more remanded into custody until 26 November.) The following day he moved from B wing to the ground floor of C wing.

44. The man went to the asthma clinic on 3 November and was assessed by the nurse running the clinic. He told the nurse that he had just given up smoking. He said he was anxious about his wife and baby daughter and was not sleeping well, despite being prescribed sleeping tablets. (His family have told the investigator that he did not have any children. Over the course of his time at Norwich, he told various members of staff that he did have children. Continuing to have contact with them appeared to be a source of concern for him.) The nurse reassured him and explained that he should be reviewed in the next few weeks.

45. The man was treated by the first doctor on 7 November, after complaining of nose bleeds. He was examined by another doctor a week later on 14 November, complaining of sleeplessness. The fourth doctor gave him a further prescription for zopiclone.
46. On 22 November, a Security Information Report (SIR) was raised in relation to the man. (Any information which potentially compromises the security of the prison or the safety of those in the prison must be recorded on an SIR, which is then passed to the Security Department. The SIR records the nature of the information and what action has been taken in response.) The SIR indicated that during a telephone conversation, the man and his wife had discussed her bringing prohibited items (mobile telephones) into the prison on her next visit. The information suggested that he might be trafficking the items for other prisoners, or in collaboration with them. The security manager decided that he and his cell should be searched. There is no information in his prison file to indicate whether this search took place, or whether any prohibited items were found. The SIR recorded that two C wing managers, a senior officer (SO) and a principal officer (then a senior officer), were informed of the allegation on 26 November. Both officers were interviewed as part of this investigation. The principal officer (PO) said he could not recall being told that the man may be involved in trafficking mobile telephones into the prison. Neither could recall having received any information from the Security Department that he was being bullied or pressured by other prisoners.
47. Two days later, the man was taken from the prison to Thetford Police Station. The reason is not recorded, although it appears that he was charged with additional offences whilst he was at Norwich. The PER which accompanied him indicated that he was suffering with an unspecified medical condition and had some medication with him. It was also recorded that he might be involved in trafficking prohibited items into the prison. Later that day, he was returned to the prison.
48. On 26 November the man appeared at Kings Lynn Magistrates' Court. His case was committed to Norwich Crown Court for trial and he was remanded into custody again until 10 December. The PER that accompanied him to court indicated that he had substance use issues (although the only prior mention of this in his file is on the CSRA completed on 16 September). The following day, however, he referred himself to CARATs. (Counselling, Assessment, Referral, Advice and Throughcare service which provides support to prisoners who have substance use problems.) He wrote on the referral form (although it appears that the form may have been completed on his behalf) that he was an alcoholic and used to abuse drugs. He wanted to speak to CARATs about "this and other things". He wanted to enrol on the RAPt programme (Rehabilitation of Addicted Prisoners trust) once he had been convicted. (The date stamp on the referral form indicates that CARATs received it on 10 December.)
49. The asthma clinic nurse saw the man again at the asthma clinic on 27 November. He told her that he had started smoking again, because he had been charged with additional offences. (There is no record of these additional charges in his prison file.) He said that his asthma worsened when he felt anxious. The nurse gave advice on stopping smoking and arranged a review in a month's time.

50. On 1 December, the man was assessed by another nurse, as he was still complaining of having trouble sleeping. The nurse recorded that he had “many concerns re: wife – losing hair, court case, etc”. He wrote that he was “not getting any sleep at all” and was complaining of a poor appetite. The man said that his mood was “up and down” although he said he was not suicidal and had no thoughts of harming himself. He told the nurse that he was not depressed. The nurse recorded that he was still receiving co-codamal (for pain relief). He noted that he had advised him that zopiclone was for short term use only.
51. The man appeared at Norwich Crown Court on 10 December. The PER indicated that he had been issued with medication and the escort staff had also been given medication to hold for him. No other risks were noted on the form. He was remanded into custody until 17 December. He arrived back at the prison at about 11.00am.
52. On his return to prison, the man was processed through reception. Whilst there, he became upset and said that he wanted to go to the Segregation Unit (where prisoners are held in basic, single cells apart from other prisoners, often as a form of punishment). The officer who had completed the man’s first CSRA on 16 September was on duty in reception and recorded the information on an SIR. He wrote that the man complained that another prisoner on C wing was pressuring him to get his wife to bring drugs into the prison. He said he did not want to return to C wing.
53. The officer was interviewed as part of this investigation. An officer with 13 years experience, he had been based in reception for about five years. He remembered that the man had returned to the prison on 10 December “very agitated, very angry about, on the face of it, what was happening to him at court”. The officer said that the man demanded to be taken to the Segregation Unit. However, the officer explained that he felt there was “something not right” about the way he was behaving. He told the investigators that he had put his arm around the man’s shoulders and taken him to a separate room in reception for a chat. The officer said that he had told him “not to be stupid”. He offered him a cup of tea and tried to help him to calm down. At this point, the officer recalled that a prisoner working in reception had come to speak to the man to find out why he was upset.
54. The prisoner had been transferred to another prison and so the investigator and a fellow investigator interviewed him there. The prisoner said he had been at Norwich between June 2008 and January 2009. During his sentence, the prisoner had undergone the training to become a Listener. (Listeners are prisoners trained by the Samaritans to provide confidential support to other prisoners. A member of the Samaritans was present during the prisoner’s interview with the investigators to offer support.) He explained that he was based in reception almost every day, to offer support to newly arrived prisoners. The prisoner was also an Insider, located on E wing (the Induction Unit) where newly arrived prisoners spend their first few days. (Insiders are prisoners who provide information about prison life to other prisoners. It is not a confidential service.)

55. Whilst an Insider on E wing, the prisoner said he had spoken to the man several times. He described him as “an emotional person” and said that he had also seen him in his capacity as a Listener. On 10 December, the prisoner was working as a Listener in reception. He told the investigators that the man had returned from court “very, very agitated” and he had become abusive towards staff. The prisoner said that the Officer had asked him to speak to the man as a Listener.
56. The prisoner explained that, whilst the Listener service was generally confidential, there were times when it was appropriate to involve members of staff, with the individual’s consent. He explained that this was sometimes necessary if the individual wanted action to be taken on his behalf. The prisoner said that
- “... because of certain aspects of the [conversation], I said to the man that ... for anything to happen from now on in, we’d have to include a member of staff and that’s what released me from the confidential side because I needed to speak to staff about it, and he said that I could.”
57. According to the prisoner, the man was being placed under considerable pressure from other prisoners on C wing, some of whom were from his local area. The prisoner told the investigators that the man was being pressured into taking subutex (a prescription medication prescribed to those dependent on heroin). The prisoner also said that the man’s wife was being placed under pressure by other prisoners to bring drugs into the prison. The man was “quite stressed” by this and wanted to move away from the prisoners who were bullying him. The prisoner told the investigators that in such circumstances prisoners were sometimes offered Rule 45 status. (Rule 45 status is reserved for vulnerable prisoners or those who need additional protection for their own safety. They are located in separate accommodation, away from the general prison population and may have a slightly different daily regime.) The man told the prisoner that he did not want to take Rule 45 status, but would like to be located on the Induction Unit where he felt safe.
58. The officer said that the prisoner then asked him to talk to the man again. The man told the officer that he was being pressured by another prisoner on C wing, whom he did not name. The officer said that he showed him some photographs of other prisoners on C wing and he was able to identify the prisoner that he said was pressuring him. The man told the officer that he and the other prisoner were from the same local area. He told the officer that the prisoner was putting pressure on his wife to bring drugs into the prison. The officer told the investigators that he thought it would be sensible to locate the man on E wing while the situation was investigated. He telephoned the duty principal officer to discuss his concerns. The PO agreed that the man should be located on E wing. The officer then made a telephone call to both E wing and C wing to inform them of the decision. Later that day, the man was located on E wing.
59. On 17 December, the man appeared in court and was convicted of actual bodily harm. He was remanded into custody to await sentencing. Two days later, following his self-referral, he was assessed by a CARATs worker. The CARATs worker completed a Drug Intervention Record (DIR). The man told her that his main problem was with alcohol but he had used cannabis on a daily basis in the past. He said that prior to being remanded into custody he had been drinking

about ten units of alcohol two or three times a week. He told the CARATs worker that he had never sought treatment before but he wanted to access support in the community when he was released. He said that he had no financial or accommodation concerns and owned his own business. The CARATs worker agreed to identify suitable community support for him and provide further information on managing his substance use.

60. During the appointment, the man told the CARATs worker that while he had been located on C wing his cellmate had been taking and dealing subutex. He said that an associate of his cellmate knew his wife and had approached her to bring subutex into the prison. The man did not want to move back to B or C wing because he “feared there would be repercussions”. As a result of this information, the CARATs worker completed an SIR. She noted on the SIR that she made a telephone call to E wing to pass on the information. The investigator spoke to the CARATs worker by telephone. She said that the man had appeared calm during their appointment. He said that he and his wife had discussed the situation and he had told her not to bring the drugs into the prison. The CARATs worker said she had telephoned E wing, but could not remember which member of staff she had spoken to. She received an email acknowledgement from the Security Department to confirm receipt of the SIR but was not contacted again and did not, nor expect to, hear any more about the SIR.
61. The investigator asked the CARATs worker whether the man mentioned having been pressured into using subutex himself. She said he had not told her this, although he had said that he had tried subutex once while at Norwich. It had made him feel very unwell and he would not take it again. The investigator asked whether the CARATs worker had had any concerns about the man. She said that she had not and that, had she been concerned about him, she would have opened an ACCT document immediately. The CARATs worker said that all CARATs staff were ACCT trained and confident about opening the documents as necessary. She said that she had been very shocked to learn that the man had died.
62. The investigators spoke to a number of fellow prisoners on C wing. Some had known the man before coming to prison, and others met him on the wing. When he first moved to C wing, he was located on the ground floor. In December, he moved to C3 landing (actually, the second floor landing). The prisoners were asked whether he mentioned being bullied or pressured by other prisoners on C wing, or if they had heard from other prisoners that this was happening. None of the prisoners interviewed (with the exception of the first prisoner, whose evidence is discussed above) were aware that he was subject to any bullying whilst on the ground floor of C wing. However, one prisoner who knew him from the community, said that when the man was moved to C3 landing, he was storing and trading his prescribed co-codamol. This prisoner said that he thought the man was being bullied by other prisoners for his medication.
63. Staff working on C wing were asked if they had been aware that the man was being bullied or pressured by other prisoners. They were also asked if they had known, or been told, that he was trading his medication. None of the staff interviewed had any knowledge of these claims.

64. During the course of the investigation the then Head of Healthcare was interviewed. She was asked how prescribed medication was normally distributed to prisoners. The former Head of Healthcare explained that some medications were suitable to be held “in possession” by prisoners and some were “in sight” medications. (Prisoners with “in possession” medication are encouraged to take responsibility for their own medication, and therefore, keep it in their cells. “In sight” medication is distributed on a dose by dose basis, and must be consumed immediately, in the presence of healthcare staff.) She said that all medications are risk assessed. Those deemed dangerous if wrongly taken or particularly likely to be traded amongst prisoners or lead to bullying, are “in sight” only medications. She explained that co-codamol had been risk assessed and was considered suitable for “in possession” medication.
65. As part of the investigation, the investigator also spoke to the Governor responsible for security. The Governor was shown the three SIRs relating to the man and was asked whether wing staff would normally be briefed on the contents of SIRs, and how this would be done. She explained that as the CARATs worker had recorded on the SIR of 19 December that she had informed E wing staff of the man’s concerns, the Security Department would not have taken any additional action to inform them. If the CARATs worker had not indicated that she had spoken to E wing staff, security staff would have done so.
66. The Governor said that, in relation to the two other SIRs, she would have expected security staff to indicate that the relevant Wing Observation Book had been updated. (Each wing has a Wing Observation Book which is used to record information about events that occur on the wing. It is a useful way of updating staff who work shifts. The Wing Observation Book should be checked regularly by wing staff.) The SIR contains a tick box section which details a number of possible actions to be taken by the security office. Security staff should tick once relevant actions have been taken, and sign and date the form. Amongst the options are ‘Wing manager/Head of Unit advised’, ‘Anti Bullying Co-ordinator [advised]’ (now known as the Violence Reduction Co-ordinator) and ‘Suicide Prevention Co-ordinator [advised]’. A second section details the relevant records that may need updating as a result of the SIR, including the Wing/Area Observation Book. None of the three SIRs resulted in an entry being made in the relevant wing observation book. Additionally, none of the forms indicated that either the Violence Reduction Co-ordinator or the Suicide Prevention Co-ordinator had been advised.
67. The Violence Reduction Co-ordinator was also interviewed during the investigation. The Co-ordinator explained that she checked Wing Observation Books every week to look for mention of bullying. She otherwise relied on the Security Department forwarding any SIRs relating to bullying. The Governor said that security staff would pass information about bullying directly to the Co-ordinator. The Co-ordinator was asked if she had been aware that the man had complained of being bullied. She said she had not been aware of this and had never seen any of the three SIRs.
68. On 19 December, an officer who was working on E wing made an entry on the man’s wing file, writing:

“Refused to locate to C1. After further discussion says he will move to C1 after refusing Rule 45 status. Is not happy about moving but has refused alternatives.”

69. The E wing officer spoke to the investigators. He recalled that on that day, the man was behaving “strangely”, although he said that he found his behaviour generally to be somewhat “eccentric”. The E wing officer said that the man had not given any reason for refusing to move back to C wing. He told the investigators that prisoners often preferred to stay on E wing, which only holds 35 prisoners and is, therefore, relatively quiet and calm. He offered him Rule 45 status, which would have meant he would not move to C wing but he refused the offer. The E wing officer explained that there was some stigma attached to Rule 45. He said it could be used for those who had committed sexual offences, but was also used with prisoners who needed protection for other reasons, or who were considered to be vulnerable. The E wing officer explained to the man that he had three choices, move to C wing, take Rule 45 status or be located in the Segregation Unit and face adjudication. (Prisoners face adjudications for rule breaking or bad behaviour. They can result in punishments such as loss of earnings or a period of solitary confinement.) In fact, the man did not move from E wing to C wing until three days later, on 22 December.
70. The investigators asked the E wing officer whether he was aware that the man complained of being pressured by another prisoner. He said he had a “very vague memory”, but could not remember there being any specific information. He said that, generally, when prisoners complained of being pressured or bullied an SIR would be raised. If the prisoner named a specific individual as the perpetrator, the name would be recorded in the prisoner’s wing file, so that staff were aware. The man’s wing file does not contain any information about him feeling pressured and the name of the prisoner he identified to the officer on 10 December was not recorded in his file.
71. The E wing officer was asked whether he had ever had any concerns about the man or had been aware of concerns about him. He said that quite a long time before he died, after what appeared to be a difficult telephone conversation with his wife, he had said he would kill himself. The E wing officer had not taken him seriously when he said this, describing him as someone who reacted strongly to situations. He too had been surprised that he had died.
72. During the course of the investigation, the investigator spoke with a friend of the man, who lived next door to him in the community. She said that some weeks before he died, she had spoken to him by telephone, and had become concerned about some of the things he was saying. The man’s friend said she had telephoned the prison to share her concerns. An officer who was based on C wing and was interviewed by the investigators recalled learning of her concerns and speaking to the man about them. The officer said that he and a colleague had been asked to check him at about 7.30pm one night. (Unfortunately, neither the man’s friend nor the C wing officer could remember when this had happened, and no mention is made in his prison file or the Wing Observation Book.) The man reassured the officers that it had been a misunderstanding. Both officers were satisfied that he did not pose a risk to himself.

73. On 22 December, the man moved to a single cell on the second floor of C wing. He was assessed the same day by the nurse he had seen on 1 December. He told the nurse that his asthma felt “much better”. The nurse noted that he had been in the Segregation Unit after refusing to stay on C wing due to the “availability of drugs”. (There is no record of him actually spending any time in the Segregation Unit. This may relate to his previous request to be taken there rather than to C wing.) The nurse recorded that the man felt he was being pressured to take drugs by other prisoners and was not interested. He told the nurse that the victim of his offence had dropped the charges against him (it appears that this was not true). He said he was angry that he would be in prison over the Christmas period. He still had trouble sleeping, and could only sleep when he took the sleeping tablets.
74. Over the Christmas period (from 25 December 2008 until 2 January 2009), the prison regime was reduced. Prisoners interviewed as part of the investigation said that they had spent much more time locked in their cells. They either had a period of association in the morning or in the afternoon, but activities such as work or education did not take place. (Association is the period of the day when prisoners are unlocked and have free time on the wing.) During this period, staff did not record any concerns about him.
75. Whilst prisoners are held in prison their telephone calls are recorded and may be monitored by prison staff if there is reason to do so. Telephone calls made by individual prisoners are logged. The investigator was provided with the log of telephone calls the man made in the days before his death. On 2 January, he tried to call his wife 15 times between 9.04am and 11.37am. He also made two calls to his neighbour and one to the brother of his previous partner (with whom he was still close and who he referred to as his brother in law).
76. The prison provided the investigator with transcripts of the telephone calls he made on 2 and 3 January. At 9.41am on 2 January, he spoke to his wife. The transcript indicates that they had a tense conversation as she said she would not be able to visit him over the weekend because she was unwell. Several minutes later, he called his brother in law and left a message on his answerphone, indicating that his marriage had ended. He then left a message on his neighbour’s answerphone. During the message, he talked about who should receive his money and possessions if he did “anything stupid”. Later that morning, he spoke to his wife once more and the transcript of the call indicates that it was another difficult conversation. Transcripts of other calls he made to his brother in law and neighbour that morning indicate that he was becoming anxious about his finances and wanted to prevent his wife from accessing his bank accounts.
77. The investigator spoke to a fellow prisoner who knew the man from the community. He said that, a few days before the man’s death, he had been asked to witness a document for him. The prisoner said that he did not know what he was being asked to witness, but later found out that it was his will. He said another prison had written the will on the man’s behalf, but he did not know the name of this prisoner.

78. At 12.30pm on 2 January, the C wing officer completed a Concern and Keep Safe Form (the first stage of the ACCT process) for the man. He wrote that the man “had had a difficult morning on the phone with his wife, who has now finished the relationship”. The C wing officer recorded that the man’s wife had told him he would not see his daughter again. He continued that he had “stated to me that he might as well end it all. Refuses to say when or how, only that it is his business”. The C wing officer recorded that the man was refusing to eat and was very agitated.
79. The C wing officer told the investigators he had six years experience as a prison officer, four of which were at Norwich. He said that he was normally based on B and C wings on the adult side of the prison, and usually on C3 landing (where the man lived). He told the investigators that the nature of his responsibilities meant that he had a lot of interaction with prisoners on the wings. The officer said that he first met the man when he was on C wing in October 2008 and that over time he had got to know him a little. He described him as “blowing hot and cold”, sometimes polite and sometimes “a bit moody”. He said that he seemed to get on with other prisoners and, although some years older than many on the wing, was not a “loner”. The officer said he was not aware that he had complained of being bullied whilst on C wing.
80. The investigator asked the C wing officer about the ACCT training he had received. The officer said that he had received training in the last four years and felt confident to open a document when a prisoner caused concern. He explained that on 2 January, he had talked to the man and become concerned about him when he said that he had “nothing left to live for”. The officer said that, as he was based on C3 landing, he knew that the man was not coming out of his cell or eating. He said that he had opened an ACCT document as a result of what the man said.
81. At 1.40pm, the PO (then SO), the C wing officer and the man met and the next stage of the ACCT document, the Immediate Action Plan, was completed. The PO recorded that he should remain on C3 landing and should be observed once an hour until he had undergone the assessment interview, the third stage of the ACCT process. He was given normal access to the telephones and reminded of the Listener service.
82. Shortly after the Immediate Action Plan was completed, the man asked to see a Listener, which was arranged. At 3.30pm, an officer carried out the assessment interview with him. She recorded that his wife had ended the relationship and had told him he would not be able to see his daughter again. (As mentioned previously, staff told the investigator that the man said he had a child, or sometimes children. His family have confirmed that, to their knowledge, he had no children, and certainly none with his new wife.) The officer conducting the assessment wrote that he felt he had “nothing to live for” and wanted to “end it all”. The man told the officer that the anniversaries of the deaths of his unborn child and his long term partner would take place within the next week. He said that his wife was due to visit him the following day, 3 January, but he did not think she would come. The officer recorded these three significant dates in the section of

the ACCT document which lists any potential triggers that might lead the individual to harm themselves.

83. The officer recorded that the man had not attempted to harm himself but she wrote that he was “adamant that now is his time to go to a better place (his words). He is adamant he will kill himself...” The officer recorded that he was “extremely tearful and emotional” during the interview, and had talked at length to her about his life. She wrote about his current suicidal thoughts:

“The man told me he wants to be dead and he has made his own decision to do so. He spoke a lot about killing himself now but refused to discuss how and when. He told me that razors were taken out of his cell by staff, but said ‘that won’t stop me’. He states he has written to his solicitor and posted it this morning changing his will. He also handed me a letter for his wife to be given to her after his death (his words).”

84. The investigators interviewed the officer who conducted the assessment as part of the investigation. She said that she had been an officer at Norwich for three years, and had undergone the ACCT assessor training in January 2008. The officer said that she had not met the man before undertaking the assessment interview. She remembered that initially, when she arrived on C3 landing, he refused to talk to her. The officer said that he did eventually begin to talk, quickly becoming upset and starting to cry. At this point she had suggested that they move to his cell so they could talk in private. Once in his cell, the officer described the interview as “very, very emotional, very intense”. She said that when she went into his cell she noticed that he had packed all his belongings into a bag. The officer asked him if he was “living out of a bag” and he replied that he had packed his belongings so that no one else would have to. She remembered that, at this point, he had given her a letter he wanted passed to his wife after his death. The investigators asked the officer if she believed that he intended to harm himself in some way. She replied:

“Yes, yes I did, yes. I mean, throughout the assessment obviously questions like that come up ... I did say to him ‘do you want to be dead?’ and all he kept saying was that he wanted to go to a better place, that he’d done everything here that he could do and he wanted to go to a better place. So yes, I was under no doubt whatsoever that he was going to attempt [to harm himself] ...”

85. The officer said that after the assessment interview, which took about an hour and ten minutes, she discussed the assessment with the PO. The officer told the PO about the extent of her concerns and that, as a result, the man should be observed four or five times per hour. The officer explained that this was the highest level of observations possible, without someone being constantly observed. (Constant observations require a member of staff to sit outside the prisoner’s cell and interact with and observe them at all times.) She explained that the level of observations reflected the extent of her concern about him.

86. At 5.00pm, the officer who conducted the assessment, the PO and the man met and the first case review took place. The PO recorded that he was very emotional and remained adamant that he would “go to a better place”. The PO noted that “to

our knowledge he has never attempted suicide but all present express concern". It was decided that he should be observed four times per hour and the situation should be reviewed the following day, after his wife was supposed to visit.

87. Prior to his promotion, the PO had been one of the wing managers on C wing. He had got to know the man a little during that time. The PO told the investigators that he often worried about his marriage and would sometimes discuss his concerns with wing staff. The PO remembered that he frequently had difficulty contacting his wife by telephone and staff had sometimes given additional telephone calls to help reassure him.
88. The investigators asked the PO when he had ACCT training. He said that he received his initial ACCT training about three years ago. However, since the man's death the prison had arranged refresher training, which he had attended and found useful. The PO said he did not clearly remember conducting the ACCT case review with the officer and the man. However, he said that he did remember that the man had been very concerned that his wife would not visit as planned the following day. The PO explained that he thought the man's ACCT document should be reviewed the next day, when staff would know if his wife had visited or not and therefore what level of support he needed.
89. The PO indicated on the case review form that the man should be referred for a routine mental health assessment. The PO explained to the investigator that staff with serious concerns about the mental health of an ACCT prisoner could make an urgent referral to the doctor, who would refer the prisoner to the mental health team. If staff thought that the prisoner would benefit from seeing the doctor, but did not need to be assessed urgently, they could make a routine referral. The PO explained that, where a routine referral was made, staff might not make an appointment for the prisoner but might encourage the prisoner to make an appointment for himself. He could not recall, in the man's case, whether he had told him to make an appointment for himself, or whether he had contacted healthcare staff to arrange this on his behalf. There is no evidence in the man's medical record that a doctor's appointment was requested.
90. Following the first case review, a Caremap should be completed. This sets out the prisoner's issues or concerns, and actions that need to be taken to achieve the agreed goals. It indicates who is responsible for each action, and when it should be completed by. The Caremap in the man's ACCT document had not been completed and the PO was asked about this. He said that he should have completed the Caremap following the case review. The PO told the investigators that he had thought it might be more useful to complete it after the visits session the following day, when staff would know if his wife had been to see him. He accepted that he should have recorded this decision on the Caremap.
91. Staff on C wing made entries in the Ongoing Record in the man's ACCT document, where staff record interactions with the prisoner. At 5.15pm, a member of staff recorded that he was refusing to collect his tea and his mood seemed "very low". He was noticed that evening writing in his cell. At 7.40pm, a landing officer recorded that the man had told him "he wants a razor blade to cut his own throat". The officer wrote that he was "intent on killing himself".

92. During the night, the man was checked once an hour. This is not in line with the PO's direction that he should be checked four times per hour. Moreover, between 8.40pm and 3.40am, it appears that night staff conducting the checks did so at the same time each hour. It is good practice for staff to vary the times when they make ACCT observations. Doing so means that the prisoner cannot predict when staff will make their next check.
93. On Saturday 3 January, the C wing officer recorded that the man was unlocked for breakfast at 8.45am. He recorded that, at 9.00am, he told him that he was not eating and the officer should "piss off". The officer wrote that the man was "very angry in mood" and remained in bed. He stayed in bed until 12.00pm.
94. At 12.00pm, the C wing officer wrote that the man refused to collect lunch and said he was not going to eat. The officer noted that he was "very tearful", saying he knew he "had lost his wife and daughter" and believed he would never see them again. The officer wrote that the man's wife was due to visit that afternoon, but that he did not expect her to come. He suggested that the man speak to a Listener or use the Samaritans telephone, but he did not want to. The officer concluded the entry writing "told him to use cell bell if problems over lunch. Understands that staff will be checking on him."
95. Over the lunch time period, the entries in the man's ACCT record that he remained lying on his bed. At 2.05pm, the C wing officer wrote that prisoners were unlocked for afternoon association, and he had come out of his cell. At 2.30pm, the officer noted that the man was using the telephone, but was unable to make contact with his wife. At 2.41pm, he left a message for his wife on an answerphone. The prison provided the investigator with a transcript of that telephone call. The man said that, if the relationship was over, his life was also over. He said that people in the prison were concerned about him, and were "keeping an eye on him". He said that he wanted to kill himself.
96. The man then made a number of telephone calls to his brother in law and neighbour, expressing further concern about his wife's access to his property and bank account. The C wing officer told the investigator that, when he saw the man was on the telephone, he contacted the prison's communications office to find out who he was speaking to. They confirmed that he was not speaking to his wife. He recorded in the ACCT document that in between telephone calls the man remained on the landing watching other prisoners playing pool. He noted that he "appears calm at this time, has been seen smiling".
97. The C wing officer told the investigators that staff feared that the man's wife would not turn up for her booked visit. They felt that he was likely to be upset if she did not come. The officer explained that normally prisoners who had visits booked would be escorted to the visits hall to wait for their visitors to arrive. Because of staff concerns about him, it was decided that he would be held on the wing until his wife arrived, to save any potential embarrassment if she did not. His wife did not arrive for the visit that afternoon.

98. While the man remained on the wing, he talked to the C wing officer about his anxieties. The officer recorded their conversation in the Ongoing Record, writing that he “made good eye contact” and appeared “much calmer and more relaxed and is dealing better with the issue”. The officer noted that the man now appeared to be most concerned about “safeguarding his interests”. He recorded that he had not mentioned suicide again.

99. During his interview with the investigators, the C wing officer explained that he spoke at length with the man that afternoon. His concerns focussed on protecting his finances from his wife. The officer offered to help him by telephoning his bank the following Monday. The investigators asked the officer how the man seemed that afternoon, he explained:

“Well, I felt that because I’d known him previously and I know he’s a bit up and down, I decided that ... we’ve crossed the hill, the peaks ... he’s looking ahead. He was convinced that ... it’s all ended, his relationship, but he wasn’t, I don’t think he was talking about ending his life anymore.”

100. At 4.10pm, another wing manager (the SO who was interviewed during the investigation), the C wing officer and the man met for the second ACCT case review. The SO, who was the case manager, recorded that the man was in a “more positive frame of mind than yesterday”. The man “stated he had no intention of killing himself”, although the SO recorded that he was still tearful at times. He wrote “the man stated that he felt lowest during the night period”. The SO recorded that the level of risk he posed to himself was now low (the other options being raised or high). He wrote that they had agreed that the ACCT should remain open but that the observations should be reduced to once in the morning, afternoon and evening, and once an hour during the night. The next case review was set for 8 January. No entries were made on the Caremap in the man’s ACCT document.

101. Both the SO and C wing officer were asked about the case review during interviews with the investigators. The SO said that he had received ACCT case manager training since arriving at Norwich three years earlier. He had also attended the refresher training, organised at the prison after the man’s death. He said that he had never received any mental health awareness training, but thought that this would be useful.

102. The SO explained that the case manager convening the case review would normally try to make sure that someone who knew the prisoner was present. He said, however, that case reviews held in the evening or at the weekend (as in this case) limit the availability of other agencies, such as CARATs and healthcare. The SO said that whilst staff were able to invite representatives from healthcare or the mental health in-reach team to a case review, in his experience, it was rare for them to attend.

103. The investigators asked the SO how the man had seemed during the case review, he explained:

“He seemed to have improved a little bit. The C wing officer had been speaking to him a lot throughout the day and he had improved a lot through the day ... His concern was, well, financial issues on the outside. He desperately wanted to speak to his bank. And that was what he was focusing on; we’d agreed to speak to his bank on the Monday morning and use my senior officer PIN, because he couldn’t obviously phone the bank with his PIN code, and everything was looking, we were looking at Monday morning to get him onto the phone to try and stop any issues with his finances, which was his focus.”

104. The SO was asked about the decision to reduce the level of ACCT observations. He said that staff make decisions based on what they are “being presented with”. He explained that the man presented as someone who was upset about his personal problems, but was looking forward and focussing on resolving some of those concerns. The SO said that he had asked the man directly if he intended to kill himself, and he had said that he did not. The SO said that, had he remained concerned that he might try to harm himself, he could have suggested that he should be placed under constant observation. He said this was something he was confident and comfortable with suggesting, where it was necessary.
105. The C wing officer told the investigators that he agreed that the level of observations the man was subject to should be reduced. Both officers said that hourly observations overnight were fairly standard, but that if they had been more concerned about him, the observations could have remained at four per hour.
106. After the case review finished, the man remained on the wing during association. At 5.00pm, the C wing officer recorded in the Ongoing Record that the man had collected his tea and was “in better spirits”, eating and watching television. Fifty minutes later, he used the Samaritans telephone on C wing for five minutes. This was recorded on the Cordless Phone Monitoring Log. The guidance on the Log notes that “use of the cordless phone must be recorded in the prisoner’s ACCT, if one is open”. The information was not recorded in the man’s ACCT document. At 7.00pm, staff recorded that he was talking with a Listener in his cell.
107. In most prisons, staffing levels are reduced once prisoners have been locked in their cells for the night. During the night at Norwich, the prison is normally managed by the Night Orderly Officer, with ten officers and eight Operational Support Grade (OSG) staff. Normally, two officers are based on B and C wing, assisted by an OSG. On 3 January, an SO was the Night Orderly Officer. He was interviewed as part of the investigation. The Night Orderly Officer explained that during the night of 3 January a prisoner had to be taken to hospital and was escorted by an officer. As a result the Night Orderly Officer supervised B and C wings, assisted by two OSGs.
108. The two OSGs were also interviewed by the investigators. The first OSG had been working as an OSG at Norwich for about ten years and the second had been employed as an OSG for four years. Both were employed to work night shifts. The second OSG said that the night shift began at 8.45pm and ended at 7.30am, although the first OSG said that night staff usually came on duty at about 8.30pm. The Night Orderly Officer explained that their main responsibilities were to carry out patrols of the landings on their wings and make ACCT observations. On that

particular night in January, there were 12 ACCT documents open on B and C wing, with varying levels of observations.

109. Between 8.15pm and 6.00am all ACCT observation entries in the man's ACCT document were made by either the two OSGs. The second OSG said that he had last received formal ACCT training in April 2009. Prior to that he received ongoing training and updates in ACCT procedures, either informally via senior colleagues or formally through training sessions. The first OSG said that he had ACCT training some time ago, but also had informal training from senior colleagues. The first OSG told the investigator that he had been due to attend an ACCT training session arranged after the man's death, but that it had been postponed.
110. Both OSGs were asked how an ACCT observation should be carried out during the night. The second OSG explained that, as cells were often dark during the night, he carried a torch, and would also switch on the cell light if necessary (which could be operated by a switch outside the cell). He said that, during the observation, staff had to see movement in the prisoner. The first OSG also carried a torch to help him conduct observations at night. However, he did not think that staff had to see the prisoner move during an ACCT check. He explained that he would usually wait for a little while to see if the prisoner moved, but that he did not wait indefinitely.
111. The second OSG told the investigator that, as they patrolled the wings, night staff would check prisoners with open ACCT documents. He explained that this meant that prisoners would normally be checked more frequently than the instructions on the ACCT document (the number of observations required is recorded on the front of each ACCT document). The second OSG said that staff made the checks at irregular times and varied the time, so that prisoners could not predict when they would next be checked. However, with two exceptions, it appears that the man was checked at almost the same time every hour throughout the night.
112. Neither OSGs recorded any concerns about the man during the night. It appears that he was asleep for the majority of the night. Neither could recollect having any conversations with him, and they did not remember him pressing his cell bell during the night. (Each cell at Norwich is fitted with a cell bell, which is used to attract staff attention. Cell bells are intended for emergency use. Norwich does not have a system for recording when cell bells have been used. Prisoners interviewed as part of this investigation said that all prisoners knew how to use their cell bells.)
113. At 5.15am, the first OSG checked the man and recorded that he had seen movement. He checked again at 6.00am. The first OSG told the investigator that, at about 6.35am, he made ACCT observations of two prisoners who had to be checked four or five times an hour and who had cells near to the man. He decided that, as he was close by, he would check him once more. On looking through the observation panel in the cell door, he saw that he was not in bed. He noticed him sitting on the floor, under the cell window. He had a ligature around his neck, which was tied to the window bars above. The first OSG said that he was carrying a radio and he tried to use it to alert staff. On trying the radio, he found it was not

working. The first OSG knew that the Night Orderly Officer was in the wing office on the ground floor, and so ran down the stairs to him.

114. Security restrictions in most prisons mean that night staff do not carry full sets of keys, and this is also the case at Norwich. The Night Orderly Officer is the only member of staff to carry a full set of keys. However, he explained that staff working on the wings have access to a sealed pouch which contains a cell key. The Night Orderly Officer explained that in an emergency staff could break the seal and use the cell key. Before going into a cell, staff must either inform the communications office or the Night Orderly Officer must be present. The first OSG told the investigators that on the night of 3 January he was carrying the pouch for B and C wing. Because his radio was faulty he could not inform the communications office and, therefore, could not go into the man's cell.
115. The Night Orderly Officer told the investigators that at about 6.35am, the first OSG had come to him in the wing office and told him there was a 'Code Blue' on C3. (Code Blue is the emergency code used at Norwich to alert staff to a medical emergency where someone is not breathing.) As he ran up the stairs, the Night Orderly Officer used his radio to call for healthcare assistance. The first OSG accompanied him to the man's cell.
116. When he arrived at the cell, the Night Orderly Officer looked through the observation panel and realised that it was a "serious situation". He used his cell key to open the man's cell. All staff at Norwich carry anti-ligature knives (which are designed to safely cut ligatures), and the Night Orderly Officer used his to cut the ligature from around the man's neck. He checked whether the man had a pulse but could not find one. He described him as appearing grey in colour. At this point, the Night Orderly Officer said that he used his radio to request an ambulance. He gave the second OSG his set of keys and asked him escort the ambulance through the prison to C wing. The Night Orderly Officer began to carry out cardio-pulmonary resuscitation (CPR). He told the investigators that although his first aid training was out of date, he felt confident beginning CPR. Neither of the OSGs were first aid trained.
117. A night nurse was on duty in healthcare. He was interviewed as part of the investigation. The night nurse said that there were usually three members of healthcare staff on duty overnight, one nurse on the adult side of the prison, one in healthcare and a healthcare assistant based on the Nelson Unit (which houses elderly prisoners). The nurse explained that, between 10.00pm and 6.00am, nurses on duty do not carry keys and relied on the orderly officer if they have to move around the prison. However after 6.00am, nurses carry a 'pass set' of keys, which allow them to move freely about the prison, but do not contain a cell key.
118. At about 6.30am, whilst in the treatment room on A wing, the night nurse heard the Code Blue call over his radio. He explained that bags containing emergency medical equipment are located on A wing, in the treatment room on B wing and in the healthcare centre. On his way to C wing, the night nurse collected the emergency bag from the B wing treatment room. He was asked about the location of defibrillators (a machine which can deliver electric shocks to help restart the heart) in the prison. He was not sure where they were located and said that, in

any case, they did not form part of the emergency equipment taken to a Code Blue. He told the investigators that the emergency bag was already heavy and awkward to carry and he would not have been able to carry a defibrillator as well, even if he had thought it might be useful.

119. On his arrival at the cell, the night nurse saw the man lying on the cell floor and the Night Orderly Officer carrying out CPR. The Night Orderly Officer told the nurse that the man had been found with a ligature around his neck. The nurse told the investigators that as soon as he arrived at the cell, he used his radio to call for an ambulance (although the Night Orderly Officer had already done so). He checked for a pulse and tried unsuccessfully to insert an airway. He and the Night Orderly Officer continued to carry out CPR until the paramedics arrived at the cell at about 6.45am. The paramedics continued trying to resuscitate the man but without success. At 7.00am, they pronounced that he had died.

Contact with the man's family

120. Shortly after the man's death, the Governor of Norwich appointed another Governor as the Family Liaison Officer. The Governor and the Family Liaison Officer travelled to the man's home to break the news of his death to his wife. As she was not there, they contacted her by telephone. His wife did not wish to meet the Governor and the Family Liaison Officer in person, and so was told of her husband's death by telephone. She asked them to contact the man's brother in law. The Governor and the Family Liaison Officer met the man's brother in law and his wife and offered support.

121. The man's wife was offered financial assistance with the funeral costs. She was also offered the opportunity to visit the prison and to see his cell, but did not wish to do so.

122. Several months after the man's death, his cousin contacted the Ombudsman's Family Liaison Officer and asked to visit the prison and see his cell, which the prison arranged.

Support for prisoners

123. Prisoners on C wing were invited to go to a wing meeting, where they were told that the man had died. A member of the chaplaincy team was present and led a prayer and two minute silence. Prisoners interviewed by the investigators said that they felt well supported by wing staff after his death. Other prisoners in the establishment were informed of his death by way of a notice from the Governor placed under their cell doors. Case reviews were arranged for all the prisoners on open ACCT documents.

Support for staff

124. The staff who were involved when the man was found and provided the emergency response were invited to a hot debrief, led by the Governor. (A hot debrief is a meeting held very shortly after a serious incident. It provides the opportunity to talk about what happened, and immediate lessons can be identified.

It is also an opportunity for staff involved to be offered the appropriate support. Holding a hot debrief is a requirement of Prison Service Order 2750, Follow up to a death in custody.) Members of the prison's Care and Welfare Team contacted all the staff involved and offered support. All the staff interviewed as part of this investigation said that they felt well supported by senior managers and colleagues.

ISSUES IDENTIFIED DURING THE INVESTIGATION

Clinical care

125. As noted previously, the man's death was one of three apparently self-inflicted deaths to occur at Norwich within a very short space of time. As a result, the local PCT commissioned the clinical reviewer to review the clinical care all three received at Norwich. The review of the clinical care the man received is attached as annex 1. The review looks broadly at the provision and management of healthcare services generally within the prison, and more narrowly, at the particular standard of care he received. It is a very detailed review which makes a number of recommendations. I have included the recommendations which are relevant to the circumstances of his death and I endorse them all. The Governor and Head of Healthcare will wish to take notice of all of the recommendations made.
126. This investigation has identified failings with the first reception health screen procedures. Whilst none of the issues are directly linked to the man's death, they are of concern. He arrived at Norwich on 16 September having been transferred from Lincoln. Concerns about his frame of mind had prompted staff there to open an ACCT. Although he arrived at Norwich on an ACCT, there is no evidence to suggest that a more detailed assessment of his mental health was undertaken. No referral was made for a more in depth mental health assessment.
127. On 16 September 2008, after coughing up blood whilst at court, escort staff took the man to hospital for treatment. Later that same day he arrived at Norwich. Healthcare staff who assessed him in reception made no mention of his earlier ill health, or his hospital treatment. On 25 October, he appeared to faint whilst being escorted from court to Norwich. Again, no mention was made in his medical record. On both occasions, escort staff detailed their concerns in the PER which accompanied him to Norwich. The clinical reviewer makes the following recommendation:

The Head of Healthcare should ensure that all reception healthcare staff are competent to undertake reception screening. Competencies must include an understanding of the ACCT procedures, mental health and substance misuse, use of the PER and the importance of obtaining previous medical information.

128. When the man was returned to Norwich on 25 October 2008, after breaching his bail conditions, he said he suffered from asthma. He was anxious to be prescribed the necessary medication. The nurse who assessed him in reception said that there were no inhalers in stock in the pharmacy. The man was moved to his cell on the wing without an inhaler and, later that evening, suffered an asthma attack. The clinical reviewer makes the following recommendation:

The Head of Healthcare should ensure that medication is available out of hours as well as during the day.

129. On 17 September, the man was examined by a prison doctor. The GP believed that he may have been suffering from tuberculosis and so ordered an urgent chest x-ray. The x-ray was undertaken at the local hospital on 23 September but the prison had not received the results before he was bailed from court on 7 October. In fact, the prison received the results of the original chest x-ray on 27 October. The clinical reviewer concludes that this was an unacceptable delay for an urgent x-ray. Her review identified that the process for x-ray reporting is not clear. A service specification between the prison and the local hospital was not available. Additionally, there is no evidence to suggest that the man, or his community GP, received any information or advice relating to the possible cause of his symptoms on his discharge on 7 October. The clinical reviewer makes the following recommendation:

The Head of Healthcare should ensure there is a clear agreement with the local hospital for the response to urgent requests for x-rays. An administrative process to ensure that x-ray requests and reports are followed up should be established.

130. The clinical reviewer's review identifies

“ ... [an] inadequacy of provision of mental health services ... which is difficult to understand given the national developments in this element of prison healthcare over the past few years and the mental health needs of the prison population”.

There were four registered mental health nurses in the healthcare team at the time of the review. None of whom was employed to undertake specific mental health work. There was no primary mental health service, other than some GP prescribing for anxiety and depression.

131. During his time at Norwich, the man told several members of healthcare staff that he could not sleep and had no appetite. Both are identified in the prison's own mental health referral guidelines as basic symptoms of depression. There was some evidence that he might have suffered from depression in the past. Nevertheless, he was not referred for a mental health assessment by any member of healthcare staff. The PO made a routine referral to mental health as part of the ACCT process, but the man had not been assessed prior to his death. According to PSO 2700, any prisoner at risk of suicide should be urgently referred for a mental health review. The clinical reviewer makes the following recommendations:

The Governor and Head of Healthcare should ensure that a primary mental health service is established as a matter of urgency. Nurses with a mental health qualification should undertake primary mental healthcare sessions.

The Head of Healthcare should develop a programme of mental health training for all healthcare staff. The training should cover the mental health issues of adults, young people and older adults and should include elements of mental health promotion.

The man's literacy difficulties

132. On both occasions when the man arrived at Norwich, he told staff that he could not read or write well. On 16 September, the officer recorded on the 'First Night Interview' form that the man had problems reading and writing. The form directs that any such problems should result in a referral to the Disability Liaison Officer. On 25 October, another officer completed a second 'First Night Interview' form, and noted that he was unable to read and write. There is no evidence to suggest that, on either occasion, a referral was made to the Disability Liaison Officer. If such a referral was made, there is no evidence to indicate that the man received any further assessment of his difficulties or any support.
133. The man's medical record contains an undated 'In Possession Medication Patient Agreement'. (This form sets out the basis on which a prisoner may be prescribed in possession medication. The prisoner must sign the form to indicate agreement with the terms.) It appears that this form was completed when the man arrived at Norwich in September. The member of staff completing the form noted that he had refused to sign it "because he can't read it". Healthcare staff interviewed as part of this investigation were asked whether there were any mechanisms in place to help prisoners who could not read or write understand the provision of healthcare services in the prison. No staff identified any particular support that would be offered to such a prisoner. (It is worth noting, however, that he did sign a second In Possession Medication Patient Agreement, completed when he was returned to custody in October 2008.)

The Governor and Head of Healthcare should ensure that prisoners with literacy problems are referred to the Disability Liaison Officer and receive the appropriate support.

Allegations of bullying

134. Information gathered from a variety of sources during this investigation indicates that the man was the subject of bullying while on C wing. On two separate occasions, he told members of staff that he was being bullied. A fellow prisoner who knew him from the community told the investigator that he thought the man was being pressured by other prisoners on the wing for his pain medication. Information gathered by the Security Department suggested that the man might be involved in trafficking mobile telephones into the prison, possibly in association with, or on behalf of other prisoners. However, the investigator found no indications that he was being bullied as a result of offences he had committed in the past.
135. When the man told staff that he was being bullied, both members of staff appropriately raised SIRs. An officer helped him identify the prisoner he said was bullying him. The Governor responsible for security told the investigator that either the person raising the SIR or a member of security staff should have informed the appropriate wing managers of the claims. The CARATs worker, who completed one of the SIRs, said that she had told wing staff about his concerns. The officer who completed the other SIR did not record on the SIR that he had contacted the relevant wing staff, and so security staff should have done so. The Governor also

said that security staff should have indicated that the relevant Wing Observation Books were to be updated.

136. The investigators interviewed a number of staff based on C wing, and appeared to know the man well. They were unaware that he was being bullied and appeared to have no knowledge of the SIRs. There were no entries either in his prison file, or in the Wing Observation Book to record that he might be being bullied. The name of the prisoner the man said was bullying him was not recorded either. Self-evidently, staff working on C wing, where he was living and where he felt vulnerable, were best placed to monitor the situation. I appreciate that, in certain circumstances, it is not appropriate to share the contents of an SIR widely. However, much of Norwich's Violence Reduction Strategy (dated 2008, but introduced in January 2009) and the relevant PSO 2750: Violence Reduction relies on wing staff monitoring and supporting both the victims and perpetrators of bullying.
137. The Violence Reduction Co-ordinator was also interviewed. Her role is to check that the Violence Reduction Policy is correctly implemented across the prison. This involves monitoring the steps taken to support victims and manage perpetrators of bullying. The co-ordinator told the investigators that, whilst she was aware that security staff were supposed to pass information about bullying to her, this does not routinely happen.
138. The co-ordinator told the investigators that a new system for supporting the victims and managing the perpetrators of bullying came into effect in January 2009. The system in place prior to that was less formal but very similar. There is very little information in the man's prison file to indicate how he was supported after he said he was being bullied. On several occasions, he told staff that he did not wish to be on C wing because of the bullying. Information in his prison file indicates that he was offered two alternatives: taking Rule 45 status or being located in the Segregation Unit. Ultimately, having rejected the alternatives, he was located on C wing. There is no evidence in his file, or from interviews with staff, that he was offered any additional support once he moved back to C wing. I hope that the system introduced in January, which includes the 'Protecting Individual Prisoners Plan' (or PIPP), provides victims of bullying with greater support. The Governor will wish to assure himself of this.

The Governor should put in place procedures to ensure that when allegations of bullying are made:

- **relevant wing staff and the Violence Reduction Co-ordinator are informed, and**
- **relevant Wing Observation Books and prisoners' files are updated.**

139. This investigation has revealed that record keeping across the prison is poor. Whilst I do not intend to make a recommendation, the Governor may wish to consider whether any steps should be taken to improve the general standard of record keeping.

The ACCT process

140. On Friday 2 January, after a number of seemingly difficult conversations with his wife, the man believed their relationship to have ended. Staff and prisoners on C wing told the investigator that he began to talk openly about his intention to take his life. After such a conversation with the C wing officer, he was placed on an ACCT document. I am pleased to learn that an ACCT document was quickly opened when staff became concerned about him.
141. All the members of staff involved with the early stages of the ACCT process agreed that the man's behaviour was cause for great concern. The ACCT assessor on 2 January was quite sure that he would attempt to harm himself. She identified three events taking place within the next two weeks which might increase the risk. Also, the man packed his belongings and wrote a letter to his wife, which he asked the ACCT assessor to pass on after his death. During the ACCT case review that day, the PO, the ACCT assessor and the man agreed that he should be checked four times an hour until the case review the following day.
142. The following day, the ACCT case review was held by the SO, with the man and the C wing officer present. It was agreed that his mood had improved. He was still sure his marriage had ended, but the officers told the investigator that they agreed to help him protect his finances, which seemed to be his primary concern. Both the SO and the C wing officer agreed that he no longer talked of suicide but focussed on plans to contact his bank the following Monday. The man said he felt lowest during the night. They decided that the risk he posed to himself was low and the level of observations should be reduced to once in the morning, afternoon and evening, with hourly checks overnight. I have considered whether, in the light of the available evidence, the decision to reduce the levels of observations was reasonable.
143. I was impressed by how well members of C wing staff, and in particular the C wing officer, appeared to know the man, and I commend them for this. The Governor will wish to pass on my recognition of the support they gave to him. The C wing officer (and to a lesser extent the PO and the SO) clearly spent some considerable time talking to him, and as a result knew a lot about his personal life and problems. Given this, I think it was reasonable that the SO and the C wing officer decided the level of observations could be reduced. However, I think it would have been prudent to have reduced the observations more gradually. The man had caused great concern the previous day and was described as 'tearful' that lunchtime. Moreover, two of the triggers identified by the ACCT assessor were to occur within the following two weeks. It is worth noting, however, that more frequent checks were to be made overnight when he said he felt lowest, and when, in fact, he apparently took his life.
144. The investigator reviewed the ACCT document and found that the Caremap had not been completed. The PO acknowledged that he should have completed it after the first case review. The SO, as case manager the following day, could also have completed it. The investigator also identified that, during the night of 2 January, the man was only checked once every hour, rather than four times an hour as instructed by the PO. Staff completing checks overnight on both 2 and 3

January, appeared to do so at about the same time every hour. It is good practice for ACCT checks to be made at irregular intervals.

145. The first OSG, who works permanent nights and undertook the ACCT checks on the relevant night, appeared unsure about how the checks should be made. He told the investigator that he did not always wait to see movement in the prisoner when checking them during the night. I am pleased that ACCT refresher training was organised after the man's death. Some members of staff interviewed had already attended and said they found it useful. The Governor will wish to ensure that all relevant staff have now completed that training. Moreover he may wish to ensure that any remaining training needs have been identified.

The Governor should:

- **ensure that all relevant staff have now completed the ACCT refresher training, and**
- **undertake an audit of recent ACCT documents to ensure all training needs have been met.**

146. The ACCT process is intended to be a multi-disciplinary one, involving discipline staff and anyone else who knows the prisoner or who might usefully contribute. The man's ACCT document was opened on a Friday. I appreciate that over a weekend, the likelihood of staff from other agencies, including healthcare, being available is very limited. However, whilst at the prison in March 2009, the investigators reviewed eight recently closed ACCT documents and found that healthcare had not participated in any.

147. The clinical reviewer highlights that the Norwich Safer Custody Policy Agreement 2008 does not appear to have had any strategic healthcare contribution. Healthcare staff interviewed during the course of this investigation were vague about their involvement in the ACCT process. Not all of them had undertaken ACCT training – and this was true of both permanent and agency staff. Discipline staff interviewed said that, while they knew they could invite healthcare staff to ACCT case reviews, they rarely did so. The clinical reviewer makes the following recommendation:

The Governor and Head of Healthcare should ensure that healthcare are involved in updating the prison's Safer Custody Policy to ensure that the role of healthcare is embedded in the ACCT process. All healthcare staff, including agency staff who regularly work at the prison, should undergo ACCT training as a matter of urgency.

Staff response to finding the man

148. In general, the staff response, once alerted to the emergency, was efficient. However, the SO who was the Night Orderly Officer and the first to attend to the man did not have up to date first aid training. Neither of the two OSGs were first aid trained. In fact, the Night Orderly Officer said that he had felt confident in beginning CPR while he awaited the nurse, however, it would seem sensible to ensure that a reasonable number of staff have up to date first aid training.

The Governor should ensure that enough staff have up to date first aid training to cover the prison at all times.

149. The investigators and the clinical reviewer were concerned to learn that healthcare staff were not confident in the use of defibrillators. The night nurse, who attended the Code Blue call on 4 January, inferred that, whilst he knew the nature of the emergency he was attending, he did not think he would need a defibrillator. Furthermore, he was not certain where the defibrillators could be found. The clinical reviewer identified that the nurse last received training in the use of a defibrillator in 2006. The investigators raised their concerns about the apparent reluctance of healthcare staff to use defibrillators to the Deputy Governor in March 2009. They were assured that the appropriate action would be taken.

The Head of Healthcare should ensure that all staff are trained, competent and updated annually in the use of the defibrillator. The guidelines for staff relating to the response to emergency calls should be revised to outline what equipment is to be taken to the call and the locations of the defibrillators.

150. The first OSG told the investigator that, on finding the man, he attempted to use his radio to call for assistance, but it was not working. Several members of staff interviewed, both healthcare and discipline, said that in the months prior to his death, they had made a number of complaints about the quality of the radios used by night staff. They told the investigators that night staff were using old radios (while day staff had been issued with new stock) and the batteries were particularly poor. This matter was raised with the Deputy Governor following interviews with staff in March, and confirmed in writing to the Governor. The investigators were told that new radio stock had been purchased and was waiting to be distributed to night staff. The second OSG, who was interviewed on 11 May, said that night staff had received new radios about two weeks before he spoke to the investigator. I am pleased to learn that all staff now have fully functioning radios, but am concerned at the length of time it took to happen.

Concerns raised by the man's family

151. The man's family raised a number of concerns, the majority of which I hope have been answered in the main body of this report. They also asked why he was not placed in a safer cell, given that he was considered a risk to himself. The Safer Custody Manager has confirmed that all of the safer cells were occupied on 2/3 January. PSO 2700, Suicide Prevention and Self Harm Management, contains guidance on where at risk prisoners should be located. There are a number of considerations, including where the prisoner will feel most comfortable and relaxed. However, the PSO directs that staff must consider whether shared accommodation (a double cell) or a safer cell would be most appropriate. Any decisions made must be recorded on the ACCT document. Decisions to locate at risk prisoners in single cells should result in additional support measures being put in place, and recorded on the Caremap. I am of the opinion that the man was probably best located in a single cell, due to his allegations of bullying. However,

there is no record in his ACCT document that staff considered where best to locate him. His Caremap had not been completed and so contained no additional support measures given that he was to remain in a single cell. The Governor will wish to consider this in the light of my earlier recommendations concerning the ACCT process.

152. The man's family also asked why items he could use to harm himself were not removed from his cell. PSO 2700 also contains guidance about removing personal items from prisoners at risk of suicide or self harm. The PSO highlights that removing personal items, such as items of clothing, belts or shoelaces, can be counter-productive, and in fact increase feelings of distress. Removing some items might deprive the individual of activities which can help to distract them. Staff had removed razor blades from his cell (although this was not recorded in his ACCT document). He had given no indication of any method of self harm he might use, and he had no prior history of self harm. It is my view, therefore, that to have removed all items from his cell which he might potentially have used to harm himself would have been a disproportionate response.
153. The man's family were worried that he had stopped eating while at Norwich. They wanted to know whether staff had known he was not eating, and if so, what they had done to help him. The C wing officer said that he had realised that he had not collected his food in the days before his death, and said that he kept an eye on him as a result. Entries in the ACCT Ongoing Record indicate that staff continued to monitor this. The officer told the investigator that, had the man continued not to eat, he would have informed healthcare staff.

Good Practice

154. The man's wife was due to visit him on 3 January. He told staff he did not think she would come and was clearly upset by this. To save him any further potential embarrassment or upset, staff explained that they decided to hold him on the wing until his wife arrived for the visit. I consider this to have been a very sensitive decision and commend the staff involved.

CONCLUSION

155. The man spent two periods of time at Norwich, first arriving on 16 September 2008. He was bailed from court on 7 October, but breached the conditions of his bail. He was returned to Norwich on 25 October. During his stay at Norwich, he complained of various medical problems. The clinical reviewer has identified failings in the way these concerns were dealt with. He also claimed he was being bullied. Staff on C wing, where he spent most of his time, seemed to develop a good relationship with him. However, they were not aware that he had said he was being bullied. This investigation has highlighted omissions in the prison's systems for dealing with and recording such allegations.
156. During his time in prison, the man was twice placed on an ACCT after talking about harming himself. On 2 January, he told family, friends and staff at the prison that his marriage had ended. He told a number of people that he intended to take his life. An ACCT was opened for him that day, and was still open when he died on 4 January. The management, completion and decision making in respect of the ACCT document has been a focus for this investigation. I hope that the Prison Service will take the necessary learning from both mine and the clinical reviewers recommendations.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all reception healthcare staff are competent to undertake reception screening. Competencies must include an understanding of the ACCT procedures, mental health and substance misuse, use of the PER and the importance of obtaining previous medical information.

The Prison Service has accepted the recommendation, noting that: "Re-training of all healthcare staff has taken place covering all aspects. All new staff will receive Reception Training as part of Induction. Screening tools in place for mental health as recommended by Mental Health In-Reach Team. More robust systems in place for opiate withdrawals and alcohol on reception. Letters sent to doctors within 24 hours of reception."

2. The Head of Healthcare should ensure that medication is available out of hours as well as during the day.

The Prison Service has accepted the recommendation: "A Head of Pharmacy is now responsible for re-stocking medication in Reception. Nurses have been trained to issue medication under Patient Group Directions. There is an on-call doctor for out of hours controlled drugs."

3. The Head of Healthcare should ensure there is a clear agreement with the local hospital for the response to urgent requests for x-rays. An administrative process to ensure that x-ray requests and reports are followed up should be established.

This recommendation has been accepted: "A more robust system in place to receive x-ray results and ensure follow up by doctor."

4. The Governor and Head of Healthcare should ensure that a primary mental health service is established as a matter of urgency. Nurses with a mental health qualification should undertake primary mental healthcare sessions.

This recommendation has been accepted: "Working with Mental Health Trust to develop referral pathway. NCHC to establish Primary Mental Health Care session." This work is due to be completed by December 2009.

5. The Head of Healthcare should develop a programme of mental health training for all healthcare staff. The training should cover the mental health issues of adults, young people and older adults and should include elements of mental health promotion.

The Prison Service has accepted this recommendation and a training programme is being developed and implemented. Work is due to be completed by March 2010.

6. The Governor and Head of Healthcare should ensure that prisoners with literacy problems are referred to the Disability Liaison Officer and receive the appropriate support.

The Prison Service partially accepted this recommendation: "Prisoners with literacy difficulties will be identified on Induction and identified to attend Education Literacy Courses. Disability Officers will be informed if there is a medical problem."

7. The Governor should put in place procedures to ensure that when allegations of bullying are made:

- relevant wing staff and the Violence Reduction Co-ordinator are informed, and
- relevant Wing Observation Books and prisoners' files are updated when allegations of bullying are made.

This recommendation has been accepted. The current system will be upgraded to ensure all relevant areas will be passed key information.

8. The Governor should:

- ensure that all relevant staff have now completed the ACCT refresher training, and
- undertake an audit of recent ACCT documents to ensure all training needs have been met.

The Prison Service accepted this recommendation: "Refresher training was carried out in January 2009. Monthly Foundation Training in place. Daily checks by SMT [Senior Management Team] and Orderly Officers of all ACCT documents identifies needs in different areas."

9. The Governor and Head of Healthcare should ensure that healthcare are involved in updating the prison's Safer Custody Policy to ensure that the role of healthcare is embedded in the ACCT process. All healthcare staff, including agency staff who regularly work at the prison, should undergo ACCT training as a matter of urgency.

The Prison Service has accepted this recommendation: "Safer Custody Policy to be updated in consultation with Healthcare. All healthcare staff will take part in ACCT training as a matter of urgency. New staff as part of Induction Training."

10. The Governor should ensure that enough staff have up to date first aid training to cover the prison at all times.

This recommendation has been accepted: "A review of first aid trained staff taking place across the prison. All staff identified will be trained up to provide cover in all sections at all times. Resuscitation and defibrillator training ongoing."

11. The Head of Healthcare should ensure that all staff are trained, competent and updated annually in the use of the defibrillator. The guidelines for staff relating to the response to emergency calls should be revised to outline what equipment is to be taken to the call and the locations of the defibrillators.

This recommendation has been accepted. Ongoing training is provided to healthcare staff and defibrillators are available on all wings. The policy relating to responding to emergency calls is to be reviewed by the Head of Healthcare and implemented by October 2009.