

**Investigation into the circumstances surrounding the  
death of a man in the custody  
of HMP Norwich in January 2009**

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

**February 2010**

This is the report of an investigation into the self inflicted death of a man in the custody of HMP Norwich on 27 January 2009. He was due to be released from prison a week after his death and was not likely to face deportation.

I offer my sincere sympathies to the man's family in Lithuania and his friends in the area where he had lived for a year before he was taken into custody. A translated version of the draft of this report was sent to the man's family at their request.

I appointed my colleague to lead the investigation on my behalf, assisted by another investigator from my team. I would like to thank the Governor of Norwich and his Deputy Governor for the support they gave the investigation. I am also grateful to the local NHS for the appointment of an independent consultant to complete a review into the medical care that the man received while he was at Norwich.

After four months without incident, the man reported that he was being bullied by other prisoners on the wing in December 2008. He told staff that he was particularly worried about being targeted by other prisoners after his release. Staff started suicide prevention monitoring days before his death. Reluctant to leave his cell, he collapsed while collecting his meal and was taken to hospital where he was diagnosed with dehydration. Upon his return to the prison that evening, staff increased the frequency of observations, only to be reduced the following morning. Later that day, he was found hanging in his cell.

I am critical of the failure to use a defibrillator during resuscitation efforts. Also, I am concerned about some aspects of suicide prevention and staff's willingness to challenge anti-social behaviour. Despite concerns being raised about his mental health, I am also concerned that the man was not referred assessment by the mental health team. I explore the provision for foreign national prisoners at Norwich, which were in development at the time of the investigation.

The man who died was the third of three self-inflicted deaths at Norwich in two months. Although there are few similarities to the other investigations, there are shared lessons in relation to emergency response and violence reduction. I make 11 recommendations in this report.

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

**Jane Webb**  
**Deputy Prisons and Probation Ombudsman**

**February 2010**

## **CONTENTS**

Summary	4
The Investigation Process	6
HMP Norwich	7
Key Events	9
Issues	23
Conclusion	34
Recommendations	35

## SUMMARY

The man arrived in the UK from Lithuania in August 2007. Just four months later, he was involved in an offence that led to his eventual sentencing in August 2008 to two years in prison. He said he had never been in trouble with the police before in Lithuania and he certainly had no criminal record from his short time in the UK.

In October 2008, the man who died successfully appealed his sentence, which was reduced to one year. His release date was recalculated to 5 February 2009. He spent his first four months in prison without much to note, sharing a cell with another Lithuanian prisoner. The man's English was at the most basic level when he arrived at Norwich, but he worked hard at his English lessons and improved over time.

After his friend was released, and his own release drew nearer, the man told staff that he was afraid of other prisoners. He believed that they were shouting abuse at him through the windows. In the week before his death, he approached a member of staff claiming that he would be killed by other prisoners. The officer started suicide prevention measures, but did not report the alleged anti-social behaviour or refer him for a mental health assessment. He was moved to a quieter landing, near to the staff office, which is used for prisoners who have demonstrated compliance with the regime. His risk of self harm was assessed as low, but staff continued to monitor him throughout the day and night.

The man told staff that he was not eating his meals, but continued to collect them. Two days after suicide prevention measures were started, he collapsed on the way to collect his evening meal. He was examined by a nurse who was concerned that he had taken something and transferred to hospital. Blood tests were taken but the results never received. After treatment for dehydration, he was transferred back to prison, where a meeting to review his suicide prevention monitoring took place. He was assessed as low risk again, but his observations were increased to three checks per hour, until a review could take place the following morning with an interpreter.

The next day, he refused to get up to attend a medical appointment, following his transfer to hospital the previous evening. The suicide prevention monitoring review took place without an interpreter, with no healthcare professional and without the man, as he claimed he did not want to attend. Two senior officers attended the review and reduced his observations to once hourly.

The man collected his lunch that day but did not eat all of it. When an officer challenged him about not collecting his evening meal, he said that he still had some lunch left. He was found hanging in his cell at about 8.25pm. Staff cut the ligature and attempted resuscitation until the nursing staff arrived, without a defibrillator. Neither nurse who attended was appropriately trained to use a defibrillator, but they continued to administer oxygen and chest compressions. The paramedics arrived

and after treatment, regained a pulse and transferred the man to hospital. He remained in a critical condition overnight, but died the following afternoon, after the Catholic priest had administered last rites.

The investigation report explores the response to the man's allegations that he was being bullied, both in terms of his mental health but also the formal violence reduction procedure. I am concerned about the resources for foreign national prisoners at Norwich. I examine the nurses' emergency response and failure to take or use a defibrillator after the man was discovered hanging. I also consider in detail suicide prevention procedures at Norwich, particularly the circumstances of the case review that took place just hours before he was found hanging in his cell.

## THE INVESTIGATION PROCESS

1. I appointed one of my investigators to lead the investigation into the man's death and she was assisted by another investigator. An investigator visited the prison on her behalf to collect the man's records and meet the liaison officer. Notices were posted around the prison, inviting staff and prisoners to contact the investigator with any matters that might be relevant to the investigation. There was no response to these notices.
2. The local NHS appointed an independent consultant to conduct a clinical review into the care that the man received at Norwich. After a review of the paperwork, the clinical reviewer accompanied my investigation team to the prison to conduct 12 interviews with staff between 16 and 19 March.
3. My Senior Family Liaison Officer contacted the man's mother in Lithuania to explain the role of the investigation. I would like to thank her for her contribution to the report.
4. A further five interviews were carried out with staff at the end of March. During this visit, the investigation team observed the prison during an evening shift to witness firsthand the behaviour of young offenders when they are locked in their cells overnight. After each visit, the investigation team fed back their findings to the Deputy Governor and wrote to the Governor to confirm those initial findings.
5. During the course of the investigation, serious concerns arose about the accessibility of defibrillators during the night, and staff's competence to use them. These concerns were immediately brought to the attention of the Principal Officer in charge of healthcare (in the absence of the Head of Healthcare) to be addressed without delay. The concerns were also highlighted to the Deputy Governor during the general feedback at the end of the second investigation visit.
6. The investigator contacted the National Offender Management Service's (NOMS') Violence Reduction policy lead to clarify the policy regarding shouting out of windows. The man's probation officer spoke to my investigator on the telephone about suggestions that he was involved in gang-related issues that might have affected him upon release.

## **HMP & YOI NORWICH**

7. HMP & YOI Norwich underwent some change during the course of this investigation. As of 1 September a new wing has opened and the prison can now accommodate 557 prisoners. The prison serves the courts in the local area, as well as having an Elderly Lifer Unit.
8. Until the opening of the new wing on 1 September, Norwich had a separate population of young offenders, adult male offenders aged between 18 and 21 years. The young offender institution (YOI) was made up of two wings and the man who died spent time on both of these wings. My investigation team found significant differences in the two sides of the prison, not least of all that out of 41 ACCT documents that were open throughout the prison at the time of interview with the Safer Custody lead, only six ACCT documents were open in the YOI. Physically, the corridors were narrower in the YOI and the association area was separate from the residential landings. Alongside the opening of the new wing, I understand that young offenders are being integrated with the general population of the prison.
9. The Chief Inspector of Prisons last carried out a full inspection unannounced in November 2006. Her team was particularly concerned about the lack of activity available for young offenders. The lack of resources for foreign national offenders had begun to be addressed by the prison by the time of this inspection, although my investigation team found that it lapsed in the meantime.
10. The Chief Inspector was pleased to note the development in the delivery of suicide prevention management, especially the response to my investigation reports.
11. The Independent Monitoring Board (IMB – a voluntary organisation who visit the prison frequently to ensure that prisoners' welfare is being appropriately looked after) found that healthcare staffing levels did not meet the needs of prisoners. They recommended that an analysis of the required skills mix of healthcare professionals be undertaken, a view shared by Ms B, the clinical reviewer in this case.
12. The IMB report developments in foreign national resources, which had lapsed at the time of the investigation. The bi-monthly meetings had resumed and foreign national liaison officers and prisoner representatives had been appointed on each wing.
13. The Prison Service publishes quarterly performance ratings for each prison on their website. The rating is based on self-audit, security information, and

external reports (including those of the Chief Inspector and the IMB). Norwich was rated as a good performing prison (achieving level three of four) in January 2009 and April 2009.

14. The man's death was the third of three self-inflicted deaths at Norwich in a period of six weeks. I recognise the devastating effect this can have on prisoners and staff. Unfortunately, there have been three more deaths since, although only one of these is apparently self-inflicted. Although there are few similarities, my investigation teams have been sharing their findings where appropriate. Such a high number of deaths reinforces the importance of staff support and learning lessons from death in custody investigations. I am pleased that Norwich has demonstrated a commitment to both.

## KEY EVENTS

15. The man who is the subject of this report arrived at HMP and YOI Norwich on 8 August 2008. No warnings had been raised by the police or escort staff about the level of risk that he posed to himself or others. He underwent a first reception health screen on 8 August. (A first reception health screen is an interview by a member of healthcare staff which should determine any physical or mental health conditions that need treatment, including the risk of self harm that a prisoner may pose.)
16. The nurse used a computerised system during the interview, simultaneously entering the information that he told her onto his electronic medical record. She noted that he was “calm” and appeared to be “fit and well”. Despite indicating that he had no community doctor or diagnosed mental illness, she entered that he had a psychiatric worker in the community. During her interview for this investigation, the nurse said she thought that must have been an error in input because it was unlikely that he would have had a psychiatric care worker without having a doctor. She did not make the mental health referral required for any prisoner that has a psychiatric care worker in the community.
17. The nurse explained that all staff have access to a telephone translation service. She said that she did not access this service during the man’s health screen. She was confident that he could understand most of the interview and when he had problems with comprehension, she used the translation tool bar on the computer. When asked by my investigator why she did not access the telephone translation service, the nurse said that when a prisoner could read and write, she used the translation tool bar rather than the telephone translation service. A doctor subsequently examined the man and found that he had “no health issues”.
18. Later that night, the man told an officer on the first night centre that he was not expecting to be in custody, but that he was not concerned about it. He said he had no history or thoughts of hurting himself and he was unclear about whether he was facing deportation. As a foreign national, he had to be referred to the Criminal Casework Directorate at the UK Border Agency. He was considered for deportation as he had committed a criminal offence while a resident in the UK. The referral was made by the administration department of the prison on 11 August, and they received a letter with an identification number for him three days later.
19. On 12 August, an officer completed an Initial Classification and Allocation form that determined the man’s security category. She completed the algorithm, noting his lack of previous convictions and the nature of his

previous offence and determined that he could be considered for open conditions. In the next section of the form, the officer recognised that his “possible immigration issues” increased his security risk but did not suggest that open conditions were unsuitable. She went on to recommend that he was allocated to HMYOI Rochester, a prison with open conditions, nearly 150 miles from Norwich. In fact, he was never moved from Norwich.

20. On 18 August, the man who died attended his first English lesson. He was assessed as an Entry Level One student which the English for Speakers of Other Languages (ESOL) Team Leader in the prison’s Education department, explained to my investigator is the basic level for students. During her interview for this investigation, the ESOL team leader said that he made good progress with his English throughout his time in custody. He attended classes regularly in the afternoons and progressed through to the intermediate classes. She said that the man did not mix well with other students but that students in the classes used to support each other with immigration issues and difficulties in prison.
21. On 3 September, a probation officer interviewed the man in order to complete an OASys. (OASys is the Offender Assessment System is a structured questionnaire intended to identify a prisoner’s likelihood of reoffending and risk of serious harm to others.) She noted that he “was getting on well with staff in custody and he has a good wing report.” She assessed that he was not at risk of harming himself or attempting suicide and that he had no problem with coping in custody. That same day, the Criminal Casework Directorate refused his proposed transfer to open conditions because he was being considered for deportation. (If a foreign national prisoner receives a sentence of over 12 months, they are automatically considered for deportation.)
22. Her Majesty’s Court Service (HMCS) wrote to the Governor on 22 September to inform him that the man had been granted leave to appeal his sentence. Just over three weeks later, the Governor received another letter confirming the date of the appeal hearing as 21 October. On 19 October, he was examined by a doctor and found fit to appeal in court. He was transferred to Feltham the next day, and eventually appeared at court in London on 21 October. The court supported his appeal and his sentence was reduced to one year. That evening, he was taken back to Norwich. His sentence dates were recalculated and he was due to be released on 5 February. Norwich contacted the Criminal Casework Directorate with his new release date and to confirm whether there were any outstanding immigration issues that would prevent him from being released on that day.

23. The man was eligible to be considered for a Home Detention Curfew (HDC) on 7 November. The HDC scheme allows prisoners to be released on licence between two weeks and four and a half months before they are due to be released. There are strict conditions attached to the licence, including that the prisoner must have appropriate accommodation. On 14 November, a questionnaire was sent to him on the wing for him to complete as part of the risk assessment for HDC. When asked about his offence, he wrote, "I feel sorry for what happened, this will not happen again. This is my first offence." On 26 November, he said that he would stay with his friend during the term of his licence. His application for HDC was sent to Norfolk Probation Service for assessment on 28 November.
24. No response was received from Norfolk Probation Service. On 12 December, the prison contacted the Probation Service and were told that they could not find his HDC application. The application was re-faxed on 16 December.
25. The man approached an officer who worked on his wing, on 25 December. Following their conversation, the officer wrote the following entry in the wing observation book:

"Asked to see me at approximately 5.30pm. Said G wing prisoners keep shouting out of the cells that he is a grass. Scared would be juggled. Asked if he could move to F1 landing."
26. No entry was made in his wing history record and the officer did not raise a Security Incident Report or anti-social behaviour form. The following day, he was moved to F wing.

## **January 2009**

27. After chasing the progress of the HDC application, the prison were finally contacted by his probation officer, to say that she had tried to assess the proposed home address but there was no one at the property when she wanted to carry out her assessment. His probation officer explained to my investigator that she had to check that the occupiers of the address were aware of the terms of the licence. She was also obliged to check that they understood the violent aspect of the man's offence before she could approve the application. His HDC application was refused on 21 January. The prison's probation officer, wrote the following:

"There is now insufficient time remaining on your sentence to allow a risk assessment to be undertaken which would enable you to serve the required 14 days on curfew".

The man would have been released on 5 February. There was not enough time for him to be released under the HDC scheme.

28. At 11.30am on 23 January, the man went into the wing office to speak to an officer. She recorded her conversation with him in the Concern and Keep Safe form:

“The man came into the F1 office and told me that today was the day he was going to die in this prison and it would be in the newspapers tomorrow. He said people were shouting through his cell windows at night. He believes all staff are aware of this. When I tried to guarantee him this would not happen he shrugged his shoulders and said just lock me up miss, you cannot stop it. I will die in this prison today. I don't want to die but it will happen. I don't know if the voices are in his own head or is being bullied.”

(A Concern and Keep Safe form can be raised by any member of staff and is the first step in the ACCT process. ACCT stands for Assessment, Care in Custody and Teamwork and is the suicide prevention system used by the Prison to identify and support prisoner who are thought to be at risk of self harm.)

29. During interview for this investigation, the officer remembered her concern for the man during this conversation. She said that she followed him back to his cell and spoke with him for about half an hour, trying to reassure him. She described “putting my hands on his shoulders, looking him right in the eye” and telling him he would be okay. He replied that she “could not stop it”. The officer said that she was convinced he was not going to hurt himself but that he was scared of other people. She said it was “only with hindsight” that she thought he might have been hearing voices, although she acknowledged that she wrote as much on the Concern and Keep Safe form. The officer has not had mental health awareness training.
30. After opening an ACCT document, a member of staff would normally go the senior officer on the wing so that the prisoner can be assessed and the ACCT formally opened. The officer told my investigation team that she was sufficiently worried about the man following their conversation that she went straight to the principal officer in charge of the wing. The principal officer told the officer to monitor the man over the association period, and when the prisoners were all locked back in their cells, give him the opportunity to move cells.

31. In the meantime, the principal officer and a senior officer completed the Immediate Action Plan, the second step in the ACCT process. The senior officer recorded that the man who died did not need to be located in the healthcare centre but that he could be moved to the G1 landing. In interview the principal officer described the G1 landing as the quietest area of the prison. There are four cells which are removed from the rest of the landing and can only be accessed through three locked gates. The cells are often used for prisoners who have gained enhanced status, or for prisoners who staff want to monitor more closely. (Enhanced status is given to prisoners who are compliant with the prison's regime and have earned additional privileges through their behaviour.) During their visit to the prison, my investigation team visited these cells and noticed that the noise from other prisoners shouting out of the windows is much reduced in that area. The senior officer also noted that the man should be subject to hourly observations until his ACCT assessment had been completed.
32. At 4.30pm, the officer who raised the initial Concern and Keep Safe form asked the man if he would like to move cells. He packed his belongings straight away, ready to move. He told the officer that he did not want any contact with any of the prisoners on the wing, describing them as "killers". During her interview for this investigation, the officer said she thought this comment was strange at the time, but that it was not until after his death that she reflected it might have indicated some paranoia or mental health problem.
33. The following morning, the man who died decided not to go to chapel, but to stay in bed. The principal officer spoke to the ESOL team leader "to find out more about him and what he was like, was he difficult, did he engage?" She told him that the man engaged well with the classes and there had been a clear improvement in his English since he had been at the prison. After this conversation, the principal officer took him to a private room to complete the ACCT assessment. The principal officer described him as anxious during the assessment. He told my investigation team that he was happy to move wings and had not heard any abuse overnight on G wing. He wanted to stay on the same landing until he was released. He said that he was nervous about his release because he thought there might be someone waiting to intimidate him. The principal officer discussed the possibility of him being released earlier or later in the day than other prisoners being released. The principal officer explained that he always oversees the release of young offenders at the gate personally and could ensure that such an arrangement took place.
34. When asked by investigator whether he thought the man had mental health problems, the principal officer said he was mainly concerned about the threat

from other prisoners. He said he made good eye contact. Using the brief mental health training he received as part of the ACCT Assessor course, the principal officer said he did not think that the man had a mental health problem. When asked what action was taken about the suspicion that he was being bullied, the principal officer explained that he thought the problem had been addressed by him moving landings. He said that he “was not 100% sure” that he was being bullied and thought he might have misunderstood general shouting out of windows as being directed at him, due to the language barrier.

35. The principal officer briefed another senior officer on what the man had said during his assessment. That senior officer then chaired the case review to discuss what ongoing support he needed. The man and the principal officer attended the case review in the senior officer’s office. The senior officer remembered him as worried during the case review, especially about prisoners shouting at him at night and the circumstances of his release. The senior officer recalled that he was pleased to be on the G1 landing. The senior officer, principal officer and the man agreed that he was at low risk of self harm, but that the ACCT document should remain open in order to monitor him. The senior officer recorded that staff should check him at least once every shift and hourly overnight.
36. Following the case review, the principal officer completed a CAREMAP which was countersigned by the senior officer. (A CAREMAP is another step in the ACCT process, where detailed actions are identified to reduce the prisoner’s risk of harming themselves.) The principal officer recorded two issues on the CAREMAP, bullying and the concerns that he had about his release. When asked during interview whether he considered starting violence reduction procedures (for prisoners being bullied or bullying), the senior officer explained that there was little that could be done in that respect without any idea of who the bully was. The senior officer was confident that by moving him and making special arrangements for his release, the two officers had met his immediate needs and reduced his risk.
37. On his second day on G1 landing, 25 January, the man had a shower in the morning then went back to his cell and closed the door, rather than associate with other prisoners. An officer on duty that morning recorded in his ACCT ongoing record, “does not mix well with others on landing. Asked if he was okay and he moaned about being imprisoned”. There were two officers on duty that morning. During interview for this investigation, the other officer described the man as “a bit moody” at that time. He said that he suggested to his colleague that they should keep an eye out for him because he seemed troubled.

38. The man collected his lunch at midday and immediately returned to his cell, where he remained alone throughout the afternoon. One of the officers unlocked his cell at 4.15pm so that he could collect his meal. As he made his way to the servery. The same officer remembered that he was unsteady. He collapsed to the floor and twitched. Officers responded, holding his head and putting him in the recovery position.
39. A nurse was distributing medication in the treatment room nearby at the time that he collapsed. When she got to him, she felt that his pulse was unusually high and his pupils were dilated. Staff helped him into the treatment room. The nurse asked him if he had taken anything and he said that he had not but then said "he wouldn't tell me even if he had". The nurse contacted ToxBase (a telephone service whereby symptoms can be used to determine what substances an individual might have taken). She also contacted the on-call doctor service, Medicon. (As in the community, out of hours doctors provide telephone advice.) Both services agreed that he might have taken something and he should be taken to hospital.
40. While the nurse was assessing him, officers noted that he had not left his cell much and had told staff that he had not eaten or drunk anything. The senior officer who chaired the man's case review the previous day recalled that officers went into his cell and found partially eaten food and a warm kettle. They concluded that he had been eating and drinking and was misleading staff.
41. At hospital, the man gave blood samples to be tested. He was diagnosed with dehydration and an intravenous drip was attached to re-hydrate him. After his condition was stabilised, he was told that he could return to the prison. Upon hearing this, he became very anxious and told officers that he did not want to return. According to a statement made by an officer escorting the man after his death: "The man stated prisoners on the wing were shouting at him out the windows at night and he said they would get him when released. His mood was very low".
42. Nevertheless, the man was escorted back to the prison at about 9.00pm. The senior officer in charge of the prison that evening met the man and the escorting officer and took him to the treatment room between F and G wing, where the nurse had treated him earlier. A different nurse was the night nurse on duty that evening. He had been briefed when he arrived at the prison that the man was at Accident and Emergency and cleared with the duty manager that, should he return to the prison that night, he should go straight back to the wing. The nurse happened to be nearby at the time of the man's arrival back on G wing and examined him. During interview, the nurse expressed his frustration that he had been escorted back to the prison

without the results of his blood test. After examination, the nurse was satisfied that his dehydration had been stabilised and he would be fine to be located on the wing, rather than the inpatients' unit.

43. After the nurse's examination, a senior officer convened a case review at 9.30pm in the treatment room. The case review was attended by an officer, the man and the nurse who happened to be there and agreed to participate in the review. The senior officer recorded that the man seemed to be scared of prisoners on F wing but that his new location on G wing "is usually quiet and well behaved". The senior officer asked him for the names of the prisoners who were bothering him and he did not say. The senior officer assessed as a low risk of suicide but increased the frequency of his observations overnight to three per hour until he could be reviewed in the morning. The senior officer noted that the relevant interpreter should be invited to the next case review. When asked why during interview, the senior officer explained: "although he gave me what I thought was fairly good answers in English, I thought possibly in inviting an interpreter may help him with deeper conversation as to how he was really feeling."

#### **26 January 2009**

44. The following morning, the man who died was scheduled to attend a medical appointment to follow up the circumstances of his collapse. He was woken by an officer for the appointment, but he refused to get up. The officer noted in his ongoing ACCT record that he said that he was "alright".
45. The senior officer who chaired the man's second case review was also the senior officer in charge of the wing that morning, 26 January. He noticed that a case review was due from a note in the senior officer's office and asked another senior officer to accompany him for the review. When asked by my investigation team whether he knew the man who died, the second senior officer said that he did not remember him. He explained: "I wasn't there just because I was familiar with [him], it would have been a case of who is available, well let's do it together". Despite the senior officer on night duty's note on the previous case review, no interpreter was invited. When asked about this during interview, the senior officer chairing the review explained that he had spoken to the man at length over the weekend. He was satisfied that he could communicate effectively and understood English well. During his interview, the second senior officer described the telephone interpretation service, 'The Big Word', used by the Prison Service, as "an absolute nightmare". He said it was "long-winded" and sometimes people ask for less information because setting up the service takes so long. SO R thought that imperfect English was more informative than using The Big Word because it allowed the two senior officers to read his body language.

46. Despite the man having been taken to hospital the previous evening and his missed nurse's appointment that morning, the senior officer chairing the review did not invite a healthcare professional to attend. When asked why he did not specifically request a nurse be invited in the case review the previous evening, the senior officer on duty the previous night said that he thought a nurse was always invited to ACCT case reviews as a matter of routine and he expected one to attend anyway. During his interview, the senior officer chairing acknowledged that, in hindsight, a member of the healthcare team could have had valuable input into the case review.
47. The senior officer chairing the review knocked on the man's door and asked him to attend. He was still in bed and said he did not want to attend. The senior officer told my investigation team that he understood that he was still tired from the events of the previous evening. Although ACCT case reviews are not often held without the prisoner, the senior officer explained that it does happen "on occasion". The two senior officers held the case review between them in an office on the wing.
48. The other senior officer attending the review explained to the investigation team in interview that the man who died was supposed to be refusing food and drink. However, he recalled the officers' visit to his cell after he was taken to hospital and the discovery of food and a hot kettle. Neither of the senior officers were aware that he was treated for dehydration at the hospital. When asked about this during interview, the chair explained that such matters are considered to be confidential medical information and cannot be shared with staff without a prisoner's consent. The senior officers were also unaware of the anxiety that he had shown when he was told he was going back to prison from hospital.
49. When considering the level of risk that the man posed to himself, the chair considered that his claims of food refusal were not substantiated and that his concerns about other prisoners had been effectively dealt with by his relocation to the G1 landing. The senior officer said that there had been no issues of self harm to that point. Based on consideration of these factors with the other senior officer and his brief conversation with the man through the door, the chair concluded that he was a low risk and dropped the frequency of observations from three an hour to one an hour. During interview with my investigation team, he said:

"... because there were issues I didn't drop them straight back down to the one am and the one pm, I still kept them, so they were still higher than they were the day before even though they had been up at three

so I didn't drop them down completely so I must have had some sort of concern but not concern enough to leave them at three an hour... “

50. The same officer from the day before was on duty again that morning. He did not notice any abusive shouting targeted at the man who died. He did not recall him leaving his cell that morning or afternoon. When he went to collect his lunch at midday, the officer asked him if he was eating and he said that he was not. The officer noticed ten minutes after collecting his lunch that he had not eaten it. When the officer asked him why he had not collected his tea that afternoon, he said that he still had some of his lunch left. The officer recalled the confusion about whether he was eating or drinking during the course of those few days. He recalled that officers had found food in his cell and a hot kettle and thought that his food refusal might not have been long-standing. He was not working the following day and remembered that he told a member of staff, “He hasn't had any tea, make sure that he get some lunch tomorrow”. The officer did not make a note of the observation.
51. According to the prison's foreign national department, the man received notice that afternoon that he was not going to be deported. As his sentence was reduced at appeal to 12 months, he was no longer to be considered for deportation.
52. Another officer started her shift at 8.00am that morning. She had been qualified as an officer for a matter of weeks at that time, having recently undergone the Prison Service training course. That day, she was first allocated to F wing but moved to G wing at lunchtime. She said that at some point that afternoon she carried out one of the man's hourly ACCT observations. When asked what that entailed, she explained:

“... often you'll have some contact, eye contact you know through the flap in the door that you look through. Quite often, more often than not they'll actually give you a thumbs up or sort of you'll speak to them through the glass you know, sort of ask how they are and they'll say I'm alright or okay everything's find, it's generally a sort of a short conversation ...“
53. It was her first time on the wing and she could not remember how the man was that afternoon. She was monitoring prisoners in the association room on G wing on the floor above him. The officer stayed for the evening duty. She told my investigator that she did not hear shouting at all that day. When the officer arrived to take over the night duty at about 8.20pm, the officer agreed to do his ACCT check while the night officer did the roll check, required between the evening and the night duties.

54. The officer went to the man's cell. She opened the observation panel and used the night light (dimmer than the main cell light) to illuminate the cell. She thought that he was sitting on the floor, but then noticed a strip of material near his neck that appeared to be attached to the middle of the bunk bed. The officer was not carrying a radio so ran to the staff office, about ten metres away from his cell to alert staff. A second officer was in the office and followed the first officer to the cell. While he was making his way there, the second officer made a Code Blue radio call. ("Code Blue" means a prisoner who is unresponsive and having trouble breathing so requires urgent medical attention.) The officer also requested an ambulance, which was called by the communications officer.
55. The first officer opened the cell door. The second officer cut the man's ligature and the first officer removed it from around his neck. As a new officer, the first officer had a plastic resusci-aid in her belt. She detached it and inserted into his mouth to start mouth to mouth resuscitation. The second officer started chest compressions.
56. The nurse who completed the man's reception healthscreen was the nurse on duty that evening. She heard the Code Blue emergency call just as she was being briefed by a nurse who was just finishing her shift. The healthscreen nurse explained: "you get a code blue, you respond really quickly because obviously it could be anything." As a nurse on duty during the night, the healthscreen nurse would not ordinarily have keys to move around the prison and would have to rely on the Orderly Officer who managed the prison to escort her. The nurse coming off duty still had keys from her day shift so agreed to assist the healthscreen nurse in getting to the emergency.
57. The nurses made their way to G1 landing. The healthscreen nurse told my investigation team that there was emergency equipment in the treatment room on G wing so she did not have to carry anything with her. My investigation team asked the healthscreen nurse whether she took a defibrillator with her to the Code Blue emergency, she responded: "I haven't been trained in the usage of a defibrillator". My investigation team also asked the other nurse whether she considered taking a defibrillator, she responded:

"it's not something that even crossed my mind at the time, it just, it just didn't occur to me and I'm not even sure, I've thought about this since, I'm not even sure that I knew that they didn't have one on the YOI. I just don't know whether I was consciously aware of that or not."

The second nurse also told my investigator that she had not been trained in the use of a defibrillator.

58. The second nurse estimated that it took the two nurses about three minutes to reach the man's cell. When the healthscreen nurse arrived at the cell, she also requested an ambulance over the radio. The two nurses found the two officers performing Cardio Pulmonary Resuscitation (CPR) and took over from them. They checked his breathing, and the healthscreen nurse started using the ambubag to improve ventilation. The other nurse did chest compressions. The two officers continued to support the nurses' resuscitation efforts, taking over chest compressions when necessary and holding the ambubag in position.
59. The healthscreen nurse said that it took between 20 and 25 minutes for the paramedics to arrive at the cell. She described the officers' assistance as "superb" throughout the resuscitation efforts, which were maintained until the paramedics took over. During this time, the Orderly Officer in charge of the prison arrived at the cell. He did not help with resuscitation attempts because he saw that there were sufficient staff to do that. Instead, he notified the Duty Governor and made arrangements so that the man could be transported to hospital if needs be.
60. After the paramedics arrived, they applied a defibrillator and used it twice to restart the man's heart. The paramedics also administered drugs. His heart restarted and his condition improved sufficiently for him to be transferred to hospital.
61. He was transferred to the Intensive Treatment Unit at the local hospital. He remained in a critical condition overnight. Two officers were assigned bed watch duty for him on 27 January, as he still remained in the custody of HMP and YOI Norwich. One of the officers contacted the Orderly Officer at 12.35pm that afternoon to alert the prison that all medication was going to be withdrawn that afternoon and that it was expected he would not survive.
62. At 1.00pm, two new officers took over the bed watch and were briefed by one of the officers handing over "to expect the worst". The officers were told that all medication had now been withdrawn and he was just receiving pain relief to make him comfortable. About five minutes after they had come on duty, a chaplain arrived from the prison to perform last rites. The man's blood pressure dropped quickly. At 2.00pm, he stopped breathing and was pronounced dead. One of the bed watch officers informed the duty governor that the man had passed away. The man had a Lithuanian expression written on his stomach in blue biro. It was later translated as "I love mummy".

## Family Support

63. While the man was in hospital, a governor was alerted that he was in a critical condition and that his family must be informed. The governor is a trained family liaison officer. The man's mother lives in Lithuania. The governor contacted the Lithuanian Embassy and requested that they arrange for the news to be broken to his mother in person. She also asked that his mother should contact her after the news had been broken. The governor telephoned the embassy and then followed the call up with a fax, confirming his mother's contact details. The Lithuanian Embassy contacted local police, who broke the news to his mother that her son was in a critical condition. The Governor of Norwich spoke with her on the evening of 27 January and told her that her son had died. The governing Governor explained the circumstances of his death. She was not aware that her son was in prison and said that he had not been in touch with her or his younger brother for "a while". She asked that he be cremated and his ashes sent to her in Lithuania. The Governor of Norwich said that someone from the prison would be in touch with her soon to discuss these arrangements. He explained that his funeral expenses would be met by the prison.
64. The Safer Custody Manager, took over family liaison at this point. She contacted the man's mother the following day and explained my investigation process, the Coroner's process and discussed arrangements for his ashes to be sent back to her. The Safer Custody Manager told his mother that he would have to be released by the Coroner in order to arrange for cremation. She also asked his mother for the details of a funeral director in Lithuania with whom she could coordinate the return of his ashes.
65. The man's cremation was arranged for 11 February. The prison arranged for flowers to be sent to the cremation on his mother's behalf. She requested that the flowers be white roses and this was arranged. His cremation went ahead and was a catholic ceremony. The Safer Custody Manager arranged for the Order of Service to be sent to his mother with the man's ashes. The Lithuanian Embassy had to complete paperwork before his ashes could be repatriated. Despite the man's mother's understandable anxiety to receive her son's ashes, the delay in this paperwork meant that they did not arrive until 24 February, almost a month after his death. The Safer Custody Manager kept in regular contact with his mother throughout this time to explain the progress of arrangements and, as far as possible, why there were delays. She contacted her again to confirm that she had received his ashes. His mother confirmed that she had and the Safer Custody Manager again explained my role and that a family liaison officer

from my office would be in touch to discuss any concerns that she would like investigated.

66. The Ombudsman's senior family liaison officer contacted the man's mother, who did not have any particular concerns about the care that he received in prison. She agreed that she would like to receive a copy of the investigation report.

### **Support for prisoners**

67. Staff told my investigator that the man's death was a shock to everyone on the wing. All open ACCT documents were reviewed. A prisoner who told staff that he was a friend of the man's was upset when the news was broken to him following his death. That prisoner asked that he be watched overnight and an ACCT document was opened to support that plan. My investigation team wrote to the prisoner to invite him to contribute to the investigation. Unfortunately, no response was received to this letter.
68. The Chaplaincy visited the YOI and made themselves available to prisoners on the wing who needed them. Staff reminded prisoners that Listeners were available for additional support. (Listeners are prisoners trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.)

### **Staff support**

69. The Orderly Officer at the time of the emergency described how he supported staff throughout the resuscitation attempts and checked how they were once the paramedics had taken the man to hospital. The Duty Governor arrived that evening to speak with the staff involved. One of the officers involved explained to my investigation team: "he asked us just to you know do a quick report on what happened. I think he sort of he wanted to satisfy himself we'd done everything that we could do. He said you know, we'd done a good job". All staff that the investigation team spoke to found the hot debrief useful.
70. The man left the prison in a critical condition, but staff were hopeful that they had improved his chances of survival. When my investigation team asked the officer who found the man how she had learned of his death the next day, she said that she "a little bit peeved about that, to be honest". She learned of his death incidentally by an officer who happened to mention it to her in passing during an afternoon shift on 27 January, without realising her role in the response. The healthscreen nurse similarly learned of his death from an officer she was working with the following night. The Orderly Officer

asked when he arrived on duty the next evening and again was told by an officer that the man had died. I consider the appropriateness of staff support later in the report.

71. A further critical incident debrief took place a few weeks after the man's death. It was coordinated by an external staff support service. The officer who found the man attended and was very positive about how helpful the session was. She said she was keen to take up whatever support was offered and found it useful to "talk it through". Unfortunately, a number of staff were unable to attend the critical incident debrief. The healthscreen nurse explained that she did not receive the letter inviting her to the debrief until after it had taken place. The other nurse who attended the emergency said that she also received notice of the debrief. I am pleased that the Governor went beyond requirements to arrange an external support service for his staff. It is a shame that those who played a key role in the events of 26 January were not notified in time to attend. I trust that in future, staff will have good notice of such arrangements. That said, all staff that we spoke to said that they felt well supported by the prison and would know how to access additional support services should they need to.

## **ISSUES**

### **Clinical Review**

72. The local NHS commissioned an independent consultant to conduct a clinical review into the care that the man who died received while he was at Norwich. As I mentioned earlier in the report, his death was the third self-inflicted death at Norwich in less than six weeks. The clinical reviewer was asked to conduct all three clinical reviews for the local NHS. She attended the prison with each investigation team and conducted joint clinical interviews. She has produced three separate reports, with findings individual to each of the deaths in custody. The lead investigator for the case, attended the panel review meeting at the local NHS to discuss the draft clinical review.
73. Inevitably, the clinical reviewer discovered some issues that are common in all three self-inflicted deaths. While these may not have had an immediate bearing on the individual care that the man received, I commend them to the local NHS and the Governor for their further consideration. In particular, the 'Clinical Governance' section of the report, which has some far-reaching recommendations, including the suggestion that a review of the skills mix of the healthcare team should be undertaken. The clinical reviewer considers structured staff support and clinical supervision are in need of development and she recommends the appointment of a responsible manager for staff training.
74. I hope to have effectively incorporated the clinical reviewer's findings in my own consideration of the issues.

### **Mental health**

75. During his first reception health screen, the man was recorded as having a psychiatric worker in the community. Any prisoner identified as having such a worker must be referred for a mental health assessment. Upon reading the whole screen during her interview with my investigation team, the healthscreen nurse noticed that the man had told her that he had no doctor in the community. Therefore, she thought that it was an error in her completion of the form. She explained that the electronic medical system is awkward to use and often leads to such mistakes. I accept that it is unlikely that he had a psychiatric worker in the community, if he did not have a doctor to refer him to such a service. I agree with the clinical reviewer that, if the information system frequently leads to such mistakes, steps should be taken nationally to improve the system.

76. The officer who raised the Concern and Keep Safe form has not had mental health awareness training. She was not sure whether the man had actually heard voices from other prisoners, or whether he had voices in his head. She recorded this observation on his Concern and Keep Safe form. In interview, the officer told my investigation team that it did not occur to her until after his death that this might have been an indication of mental illness. Later that day, the officer escorted the man to his new wing. She recorded in his ACCT document that he described other prisoners as “killers”. Again, she said:

“Maybe I should have picked up on something there but I didn’t ... Not at the time, I didn’t. As soon as I had come back to work and found out what happened, then it all, to me, fell into place.”

The officer did not refer him for a mental health assessment.

77. The principal officer who received the Concern and Keep Safe form received a small amount of mental health training as part of his ACCT Assessor training. He contributed to the Immediate Action Plan and completed the man’s ACCT assessment. My investigator asked him what he understood by the officer’s comment on the Concern and Keep Safe form regarding the man hearing voices in his head. The principal officer told my investigator that he did not share the officer’s concern about the voices being in his head because, in his experience, prisoners on the wings shouted at other prisoners. He said that just the man could not identify the prisoners who were shouting at him, but that did not mean it was in his imagination.
78. The ACCT assessment took place the day after the man moved wings and had described prisoners as “killers”. Before the principal officer did his ACCT assessment, he would ordinarily read the ACCT ongoing record, where the officer had recorded his comment. During interview, the principal officer initially said that he would have been concerned if he had seen that comment. He realised that “I must have read that but I don’t recall reading it”. When asked by my investigator whether this comment would have affected his assessment of the man, the principal officer said that “it might be very true and there are prisoners on there who are killers”. The principal officer did not refer him for a mental health assessment.
79. The senior officer who chaired the man’s first and third case review has not had mental health awareness training. The principal officer and the man who died were present at the first review. He could not recall specifically his impressions of his mental health. The senior officer told my investigation team that any concerns about a prisoner’s mental health are usually addressed at the CAREMAP stage, which follows on from the first case

review. He said that he had not referred the man for a mental health assessment; therefore he must not have had any concerns about his mental health. He told my investigation team that he was confident the move to the G1 landing resolved his problems.

80. The nurse who examined the man after he had collapsed, described him as “very unhappy” rather than having a mental health problem.
81. The man who died was extremely concerned for his own safety. After months of not communicating with staff, he expressed fear for his life. Questions were raised about whether he was hearing voices in his head and worrying comments he had made to staff were recorded but were not acted on.

**The Governor should introduce a training programme for mental health awareness.**

82. My investigation team asked the officer who raised the Concern and Keep Safe form how she would make a referral. She explained that there is a form to complete, which she had completed in the past, which was then handed to the mental health team. The principal officer who carried out the assessment explained that the healthcare centre had to be contacted in the first instance and the prisoner seen by a nurse, before he could be formally assessed.

**The Governor and the Head of Healthcare should raise awareness of the mental health referral system among officers.**

83. A new referral system was being introduced to Norwich at the time of my investigation. I hope that this development will improve staff awareness of mental health and encourage officers to contact the mental health team with any concerns about a prisoner’s mental state.

**Violence Reduction**

84. In the weeks before his death, the man complained to staff that other prisoners were targeting abusive shouting at him out of their windows. Most of the staff that my investigation team spoke to about prisoners shouting out of windows recognised that it can be a problem, especially at night. Most agreed that it constituted a form of bullying and was challenged by staff when it got out of hand. There is no record of a security incident report concerning the man or any violence reduction measures having taken place following his allegations.

85. My investigation team visited the YOI side of the prison during the course of an evening shift. They could hear prisoners shouting at one another in conversation. While they were on the visit, they noticed no abusive shouting.
86. The NOMS lead for Violence Reduction told my investigator that there were no national guidelines for dealing with prisoners shouting abuse out of their windows, although she would expect the matter to be incorporated into each prison's violence reduction strategy. Shouting out of windows is explicitly mentioned in Norwich's Violence Reduction policy and can be considered a form of bullying.
87. The Violence Reduction Co-ordinator had been in post since October 2008. She had been asked to update the violence reduction policy, which was reissued in January 2009. The new system means that an anti-social behaviour document should be raised for any prisoner who is identified as a potential or actual bully. Support plans are also available for victims of bullying. However, the violence reduction co-ordinator recognised the limitations when a prisoner was not aware of or prepared to identify who was bullying him. In those instances, an effective care plan could not be put into place. Nevertheless, if there was a concern about a prisoner being targeted by other prisoners shouting out of their windows, she said she would expect a security incident report to be raised.
88. Despite staff assuring my investigation team that they challenge prisoners shouting out of their windows, the violence reduction co-ordinator confirmed that no anti-social behaviour documents have been raised as a result of shouting out of windows. The security governor confirmed that there were no security incident reports concerning shouting either. While I appreciate that it is difficult to tackle a large number of prisoners shouting out of windows, I am surprised that no formal action has been taken to address the actions of any individuals involved in it.

**The Governor should audit the reporting of bullying through windows and satisfy himself that it is being dealt with appropriately.**

89. The man who died told an officer that he was going to die. That officer said that it was only with hindsight that she thought the voices might have been in his head, (despite making a note to this effect on his Concern and Keep Safe form). She brought his situation to the attention of the principal officer, who advised careful monitoring until he could be moved away from the situation. The officer did not start an anti-social behaviour report or make an entry in the wing observation book. She recorded her observations carefully in the ACCT.

90. My investigator asked the principal officer and the senior officer who carried out the first case review whether they took any steps to formally raise the man's allegations of bullying during his ACCT assessment and case review. They explained that the location of the G1 landing – removed from the rest of the wing – would have afforded him more peace from other prisoners. The senior officer went on to explain that it is difficult to effectively tackle anti-social behaviour if the perpetrators cannot be named. The principal and senior officer put protective measures in place by removing him from his location on the wing and by making arrangements to protect him on release. While it is regrettable that they did not also register the man's allegations with the violence reduction team, I think the two officers took reasonable steps to safeguard him.
91. That said, security information reports (SIRs) are anonymous reports which briefly summarise intelligence that any member of staff may have come across during their duties. While I understand that formal violence reduction procedures could not have been used without an indication of who the bullies were, I would have expected SIRs to have been submitted describing the man's allegations. If staff were satisfied that he was not hearing voices in his head, there was no other formal way to record the problem of shouting out of windows.

**The Governor must remind his staff of the importance of security incident reports when managing challenging behaviour.**

### **Healthcare and ACCT**

92. The man was subject to an open ACCT document at the time of his death. It was raised on 23 January. The ACCT process was followed appropriately over the following days, with actions being taken within the required timescales. I am particularly pleased to note the principal officer's consultation with the ESOL team leader to find out more about him before conducting the ACCT assessment.
93. However, I am concerned that a nurse only attended the man's case review on one occasion, and the nurse told my investigation team that he "just happened" to be there. My investigation team examined a sample of ACCT documents and found it was the exception, not the rule, that healthcare staff would attend ACCT case reviews. A nurse told my investigation team that it would be too resource intensive for healthcare staff to attend all ACCT case reviews because there were so many documents opened.

94. The senior officer on duty for the night of 25 January told my investigation team that he expected a nurse to be present at the ACCT case review on the morning 26 January, what was to be the man's last ACCT case review. The senior officer who chaired that review agreed, with hindsight, that someone from healthcare could have made a useful contribution to the review. I am concerned that no one from the healthcare department was invited; despite the man's collapse the previous evening and his missed medical appointment that morning.
95. I agree with the clinical reviewer that "a multi disciplinary approach to the ACCT procedures is essential to support vulnerable prisoners". The clinical reviewer goes on to recognise the important contribution that healthcare could make to the scheduled redrafting of the prison's Safer Custody policy.

**The Head of Healthcare and the Safer Custody Manager must work together to ensure the appropriate involvement of healthcare staff in the ACCT process.**

#### **ACCT case review on 26 January**

96. The senior officer did not invite an interpreter to the ACCT case review on the morning of 26 January. At the case review the previous night, the chair recommended that an interpreter be invited so that the man could have a "deeper conversation about how he was feeling". The senior officer chairing the review the next morning explained to my investigation team that he had spoken to the man on several occasions and was confident that his level of English was sufficient for the purpose of the case review. The other senior officer who attended the review that morning told my investigation team about the limitations of the telephone interpretation service used by the Prison Service. While I agree with the senior officer from the previous night that an interpretation service could have given him an opportunity to properly express his concerns and anxieties to staff, I think the senior officer chairing the review that morning made a balanced judgement based on his experience of the man.
97. The case review went ahead with only two senior officers. During interview for this investigation, the second senior officer acknowledged that he was only invited to the review because of his availability, rather than how well he knew the man. Neither senior officer was aware that he had been diagnosed with dehydration and both doubted his claims about not eating or drinking. The man refused to attend the review and only briefly responded to the chair of the review through the door. Nevertheless, the two senior officers reduced his observations to once hourly.

98. In his interview, the chair said that he did not reduce them to as low as they were before the senior officer from the previous night's review, but he did not feel that the man was at high risk of self harm. He explained that in reaching this judgement, he considered the fact that he had not actually self-harmed, and he raised no concerns in their brief conversation through the door. In his interview with my investigation team, the second senior officer discussed at length the man's claims that he was not eating. He said that this was the only recorded form of self harm and staff had reason to doubt his claims. The senior officer also described this self harm as a "very slow method", that required monitoring only at meal times.
99. Whether the man who died was refusing food completely or not, there was undoubted evidence that he was eating less. A loss of appetite is mentioned in the ACCT document as one indication of a prisoner's "current mental state". Rather than a form of self harm, I am surprised that staff did not recognise his lack of interest in food as a further sign of his withdrawal.
100. I am concerned about the decision to reduce the man's ACCT observations. I appreciate that once hourly is still a fairly high level of observation, and if he had remained on three observations an hour, he may still have had the opportunity to take his own life. However, I think both senior officers placed too much emphasis was put on whether he was eating or drinking, without all the available information.
101. I understand that prisoners will refuse to attend ACCT case reviews. However, I am surprised that either senior officer was confident that they had sufficient information to make a decision about the man's level of risk that morning.

**The Governor should remind staff of the importance of having all available information when deciding to reduce ACCT observations.**

### **Foreign Nationals**

102. A foreign national prisoner, the man who died did not speak good English when he arrived at the prison. He became friendly with a compatriot on his wing, with whom he shared a cell and spent a great deal of time. After his cellmate was released, there was no other Lithuanian speaker on the wing. Staff repeatedly described him as "isolated" to my investigation team.
103. The ESOL team leader taught him English towards the end of his time at Norwich. During interview for this investigation, she acknowledged that his English would have been limited on arrival as he was put into the most basic English language class. She explained that students often supported each

other with concerns about deportation and immigration, but said that there is little formal resource allocated to supporting foreign nationals at Norwich. I am pleased that his English classes may have offered him some support, but disappointed at the lack of formal resources available to him.

104. My investigation team interviewed the governor responsible for foreign national prisoners, as part of the investigation. He explained that he was only at Norwich on a short term basis and he started at the prison on 10 November 2008. Upon his arrival he was charged with updating some policies, including the policy concerning foreign national prisoners. He said: "Upon taking that piece of work I found the work on foreign national team had lapsed for reasons that I don't know."
105. The governor responsible for foreign national prisoners told the investigation team that there was little support in place for foreign national prisoners while the man was at the prison. Until July 2008, there had been a meeting with foreign national representatives from each wing every two months, and he had reconvened that meeting for the first time in March 2009. At the time of the investigation, there were no foreign national prisoner representatives on the wing and staff were unclear about whether there were any officers assigned to look after foreign national prisoners. During his interview, he acknowledged the shortfall in the prison's regime and the impact this might have had on the man who died.
106. Prison Service Order (PSO) 4630 – Immigration and Foreign Nationals is the order that governs how foreign national prisoners should be dealt with in custody, "All prisons must have a local policy for managing foreign national prisoners". The PSO is surprisingly silent on what such a policy should contain, but does suggest, "Where the numbers of foreign national prisoners are significant, it may be appropriate to have a Foreign National Committee to supervise the policy."
107. It is unacceptable for Norwich's foreign national policy to have "lapsed". The governor responsible for foreign national prisoners estimated that foreign national prisoners made up about 14% of the prison's population, in line with the general prison population and therefore a committee would arguably be "appropriate" to oversee the policy.

**The Governor at Norwich should ensure there is an effective foreign national policy in his prison, supported by a Foreign National committee.**

108. At the time of issuing the draft, I was surprised to find that the Prison Service does not offer more guidance in its PSO about how to meet the needs of

foreign national prisoners. The PSO and its related Prison Service Instruction 22/2007 focus on how to refer the prisoners to the UK Border Agency and the circumstances of release of foreign national prisoners. Following the issuing of the draft, my investigator was passed a document entitled "Local Policies for Managing Foreign National Offenders", an excellent document, which includes detailed suggestions about what a local policies should contain. This document is only available in hard copy at the present time. I commend it to the attention of all Governors. Nevertheless, the Prison Service accepted the following recommendation:

**The Prison Service should consider more formal guidance about what each prison's local foreign national policy should contain.**

109. The Big Word is the telephone translation service available for staff to use when they need to communicate with a prisoner who cannot understand English. In January 2009, it was used 46 times across the prison in a number of different languages, including Lithuanian. The member of staff dials the translation service and requests the required language. Staff explained to my investigator that it can take time for the service to connect to a translator in the required language. The member of staff then tells the translator what they want to say to the prisoner and then passes to the telephone to the prisoner, who listens to the translated message and can reply. The telephone is passed backwards and forwards throughout this exchange.
110. There is no record that this service was used for the man who died while he was at Norwich. As described above, staff expressed reservations to my investigation team about the effectiveness of the telephone translation service, given the unavoidable delay in accessing the appropriate language. One senior officer also said that it can be difficult to read a prisoner's body language when the translation service is being used and therefore communication is stilted.
111. My investigation team contacted the Prison Service lead for foreign national prisoners to ask for their view on the adequacy of existing translation service available for prisoners, and received a response after the draft report was issued. The NOMS document "Local Policies for Managing Foreign National Offenders" specifically discusses the best approach to translation and language services. I recognise that the telephone translation service has serious limitations for communicating with prisoners who do not speak English as their first language. However, I consider the continued use of The Big Word to be the only solution, given the diverse nature of the prison population and the demands on Prison Service resources.

## **Defibrillators**

112. One of the nurses who attended the emergency estimated that it was about three minutes between the Code Blue radio call and the nurse's arrival at the scene. The healthscreen nurse estimated that it took 20 to 25 minutes for the paramedics to arrive at the prison. The other nurse recalled that the paramedics applied a defibrillator as soon as they arrived. I am seriously concerned about the significant delay in using a defibrillator and the impact that this might have had on the outcome of resuscitation efforts.
113. Neither nurse had been trained in the use of a defibrillator since they started working for the local NHS. The issue of training was raised by the Chief Inspector in her report in 2006. While the second nurse had only been working at the prison for six months at the time of the man's death, the healthscreen nurse had been employed at Norwich for 18 months. The healthscreen nurse was starting the night shift, when she would have been the only healthcare professional expected to attend all medical emergencies. I am shocked that nursing staff are not trained in the use of a defibrillator.

**The local NHS and the Head of Healthcare must ensure that all healthcare staff are trained in the use of a defibrillator as a matter of urgency.**

114. During interview with my investigation team, the healthscreen nurse was unsure about whether the defibrillators were located in the prison. The other nurse explained that there was no defibrillator on the YOI side of the prison. She remembered that the two nurses were in the healthcare centre when they received the Code Blue radio call. When asked whose role it was to bring a defibrillator to a medical emergency, the second nurse acknowledged that it was the nurses' role, but told my investigation team, "I have to say it's not something that even crossed my mind at the time". She said that she was "not consciously aware" of the requirement to take the defibrillator.

**The Head of Healthcare must ensure that defibrillators are accessible and healthcare staff confident about their location.**

115. So serious were the concerns that the investigation team fed this information back to the prison immediately as they became aware of them. I am pleased to learn that Norwich has now introduced more defibrillators around the prison. I understand that there is now a defibrillator on F and G wing. All of the defibrillators are located in the senior officer's office so that they can be accessed by any member of staff in the event of a medical emergency at night.

116. In addition, I welcome the swift defibrillation training programme that has been introduced by the Primary Care Clinical Manager. The healthscreen nurse received defibrillator training in March and I am assured that the other nurse is scheduled to receive the training imminently.

117. The clinical reviewer shares my concerns related to the defibrillator access and training. The clinical reviewer comments, "It is difficult to say if the outcome for the man would have been different if a defibrillator had been taken to the scene by the attending healthcare staff". I agree that it is not possible to speculate on whether the outcome would have been different with the earlier use of a defibrillator. However, the stark advice from the Resuscitation Council (UK) underlines how vital it is to use a defibrillator as soon as possible:

"The chances of successful defibrillation decline at a rate of 7-10% with each minute of delay; basic life support will help to maintain a shockable rhythm but is not a definitive treatment."

Resuscitation Council (UK)

In this context, the delay of up to 25 minutes was undoubtedly critical.

#### **Care for staff and prisoners**

118. Appropriate efforts were made to support prisoners after the man had died. All staff told my investigation team that they felt well supported after his death and knew where to access additional support if they needed to. However, it was a shame that the Governor arranged for an external agency to hold the critical incident debrief that so few staff attended.

119. I am also surprised that the staff involved in the response efforts were not formally notified of the man's death as a part of the death in custody plans.

**The Governor should consider amending the death in custody procedure to ensure that staff involved in the response efforts are formally notified of a prisoner's death.**

## **CONCLUSION**

120. In the week before he died, the man was “isolated” in custody by his language and his fear of other prisoners. Staff tried to address the problem by moving him to what they considered a safer place and monitored him closely. However, no formal steps were taken to investigate the allegations of bullying or explore the possibility that his mental health was suffering.
121. An ACCT document was appropriately opened that weekend and all decisions taken within the required timescales. However, I expect healthcare staff to attend case reviews more frequently and any decisions taken to be fully informed.
122. Although there is evidence that staff worked well as a team when responding to the emergency situation on 26 January, I share the clinical reviewer’s concern at the failure to use a defibrillator. It will never be possible to determine whether the outcome in this case would have been different with the earlier use of a defibrillator, I trust that every measure will be taken to ensure that such a delay will not occur again in the future.

## RECOMMENDATIONS

1. The Governor should introduce a training programme for mental health awareness.

*The Governor accepted this recommendation and said that he was in discussions with the local Mental Health Trust to provide mental health training for all staff.*

2. The Governor and the Head of Healthcare should raise awareness of the mental health referral system among officers.

*The Governor and the Head of Healthcare accepted this recommendation referring to the development of a draft mental health pathway between the PCT, Mental Health Trust and prison.*

3. The Governor should audit the reporting of bullying through windows and satisfy himself that it is being dealt with appropriately.

*The Governor accepted this recommendation and reported that he has already taken action to address it. The YOI and adult parts of the prison have been integrated and staff have noticed a marked decline in shouting through windows. In addition, the Violence Reduction Co-ordinator has reviewed recent Anti social Behaviour Documents for references to bullying through windows.*

4. The Governor must remind his staff of the importance of security incident reports when managing challenging behaviour.

*The Governor accepted this recommendation and reported that a notice to staff about the importance of SIRs was issued in October 2009.*

5. The Head of Healthcare and the Safer Custody Manager must work together to ensure the appropriate involvement of healthcare staff in the ACCT process.

*The Head of Healthcare and the Safer Custody Manager accepted this recommendation and conducted a joint review. Healthcare staff are not to attend or report into all ACCT case reviews. All healthcare staff will attend ACCT foundation training and healthcare will be represented at all Safer Custody meetings.*

6. The Governor should remind staff of the importance of having all available information when deciding to reduce ACCT observations.

*The Governor accepted this recommendation and reported that it has been incorporated into all ACCT training.*

7. The Governor at Norwich should ensure there is an effective foreign national policy in his prison, supported by a Foreign National committee.

*The Governor accepted this recommendation and reported that such a policy is now in place.*

8. The Prison Service should consider more formal guidance about what each prison's local foreign national policy should contain.

*The Prison Service accepted this recommendation and referred to the NOMS document entitled "Local Policies for Managing Foreign National Prisoners" was issued to all prison establishments in January 2010. It provided guidance to help prisons formulate their own individual local policies to meet the needs of foreign national prisoners.*

9. The local NHS and the Head of Healthcare must ensure that all healthcare staff are trained in the use of a defibrillator as a matter of urgency.

*The local NHS and the Head of Healthcare accepted this recommendation and said that ongoing annual training for all healthcare staff is in place. In their response to this recommendation, they also say that the local Community Health and Care staff can also attend prison defibrillator training.*

10. The Head of Healthcare must ensure that defibrillators are accessible and healthcare staff and confident about their location.

*The Head of Healthcare accepted this recommendation. I was informed that defibrillators are now located on each wing, in reception and in the treatment rooms. A notice to staff has also been issued.*

11. The Governor should consider amending the death in custody procedure to ensure that staff involved in the response efforts are formally notified of a prisoner's death.

*The Governor accepted this recommendation and said that every effort would be made to notify all staff involved in any future death in custody.*