

**Investigation into the death of a man
on 19 January 2006, whilst a prisoner at HMP Norwich**

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

October 2006

This is the report of an investigation into the death of a man who was discovered hanging in his cell on 19 January 2006, and died later at a local hospital. He had been in the custody of HMP Norwich since 4 August 2005. He was 50 years of age.

The investigation was undertaken by two of the investigators from my office. A clinical review of the healthcare provided to the man was commissioned by Norwich Primary Care Trust. I am grateful to for the report.

I would also like to express my thanks to the Governor of HMP Norwich, and his staff for their help and active co-operation throughout this investigation. Not for the first time, I have been struck by the personal commitment of the Governor in the aftermath of a tragedy in his prison.

Given the inevitable constraints of a prison environment, I do not believe there was more that staff at Norwich could have done to prevent the death of this man. He had at times been closely monitored whilst in prison custody, as there was concern that he might harm himself. In addition, measures were put in place to try to support him through his mental health problems. Unfortunately, these did not in the end prove sufficient to prevent his death.

I make three recommendations and the clinical review has identified a further five that I endorse.

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Summary

1. the man who is the subject of this report was arrested in August 2005, after setting fire to the stairs in his house, apparently whilst trying to commit suicide. He had tried to end his own life on ten previous occasions. He was remanded into custody at HMP Norwich on 4 August and immediately placed on a self-harm watch (F2052SH). (The F2052SH is a form used to record the details of individuals who are considered to be at risk of self-harm, their support plans and day to day observations.)
2. The man's mood was unpredictable and could lower dramatically for no apparent reason. For example, on 12 August at 4.30pm he was sleeping in his cell. At 5.05 pm, he was found with a shoelace tied tightly around his neck. Ten minutes later, he said that he was feeling fine.
3. He was placed on a F2052SH twice whilst at Norwich - once on arrival, and again on 26 October 2005 after telling staff that he had thoughts of putting a noose around his neck to make a vein stand out and then cutting it.
4. The man was taken off his self-harm watch on 23 November and moved into a single cell on A wing the following day. On 9 December, he appeared at Norwich Crown Court and was sentenced to 18 months imprisonment for his arson offence.
5. On 15 December, he refused his early release date of 21 December, writing back that he did not wish to be released on licence and was therefore looking at 1 February 2007 as his date of release.
6. During January, he complained of, and was treated for, pain in his left shoulder and neck. The prison doctor saw the man on the day he died, but neither the doctor nor the nurse who walked him back to A wing detected any signs of him being in crisis.
7. At 7.20 pm on 19 January, an officer answered a cell call bell. The man said that his electricity had gone off. The officer told him that the switch had 'tripped' due to everyone returning from association and switching on their televisions and kettles. The power was turned back on and the man appeared fine.
8. About ten minutes later, a wing officer went to check on the man and found him hanging from the window bars of his cell. He was cut down and officers began to try and resuscitate him. Paramedics arrived and he was transferred to the local hospital where he was pronounced dead at 8.32 pm.

Investigation methodology

9. The investigation was opened at HMP Norwich on 24 January 2006. The Governor and his staff produced the man's core record and a large number of other documents for examination. Notices were distributed around the prison notifying staff and prisoners of the investigation.
10. A number of prison staff were formally interviewed.
11. Her Majesty's Coroner was contacted to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.
12. One of my Family Liaison Officers (FLO) made contact with the man's close friends and family. Whilst they had concerns that his mental health problems were not sufficiently addressed by the criminal justice system, they did not wish to have a meeting with either my FLO or my investigators at that time.

The subject of this report

13. The man was born in 1955. He lived alone and had suffered from depression for a number of years for which he was receiving medication.
14. He was arrested in August 2005 and subsequently remanded into custody at HMP Norwich. He had set fire to the stairs of his own house in an apparent suicide attempt. He had made ten previous attempts to take his own life.
15. This was not his first experience of prison, although he had not offended for over 20 years.
16. He was a man who preferred to be alone, as he found it difficult when there were other people around. His friends said that his mood could change very quickly and he would get depressed over seemingly trivial things.

HMP Norwich

17. HMP Norwich prison holds convicted and remand prisoners, including adults and young offenders. It is designated as a local prison and serves the courts of East Anglia. The Certified Normal Accommodation is 591, and the prison has an operational capacity (total crowded capacity) of 823. The current Governor was appointed In December 2004.
18. A car park and road divide the prison. The majority of the population is accommodated in the main prison complex. The other part of the prison accommodates young offenders and the Healthcare Centre, which also includes an elderly prisoner unit. The Healthcare Centre has out patient facilities, as well as in-patient beds for prisoners with physical health problems and severe and enduring mental health needs.
19. In March 2005, Her Majesty's Chief Inspector of Prisons carried out a full announced inspection of the prison. In her introduction, the Chief Inspector, said that there were unacceptable deficits in safety and key recommendations from seven recent deaths in custody had not been implemented. She also identified that the management of prisoners who were at risk of self-harm was poor. Additionally, she said that major functions within the prison were inadequate and had been poorly managed. Support plans for prisoners at risk were poor, access to the Samaritans restricted, and prisoners' cell alarm bells regularly muted. However, the report also said that, since the appointment of the new Governor, performance improvement was under way.
20. Since my office took over responsibility for investigating deaths in prisons in April 2004, there have been eight deaths at Norwich prior to that of this man. Six of those deaths were apparently self-inflicted.

Clinical Review

21. A clinical review of the medical care that the man received whilst at Norwich was carried out by the Norfolk Primary Care Trust.

22. In the report the author highlights similar areas to those reported by my investigators. I have reproduced sections of her report below:

“The man was diagnosed with depression 3 years ago. He has a poor self image and demonstrates social phobic behaviours. He was referred to a Mental Health Hospital by his GP approximately 3 years ago and he was receiving support from a Community Psychiatric Nurse until approximately 2 years ago. The treatment for his depression seemed adequate and doctors had reassessed this medication on a number of occasions. Following his initial health care assessment he was referred to the Mental Health In-reach team and was also seen by a psychiatrist. It appears that he was well supervised and cared for and that every opportunity to help him was taken, e.g. ensuring he has a single cell as requested. The man was receiving medication for his depression. He had had eleven previous attempts at suicide since his teens, ranging from drinking mercury to attempts at hanging. He remained on an active F2052SH for most of his time at the prison. This is a reflection that the staff took his comments and state of mind seriously.

“The man has a history of alcohol abuse especially binge drinking and a previous dependency upon Heroin and Crack Cocaine. He complained of generalised pains in his body including shoulders, back and hand areas for which he received pain relief as and when necessary. There was no specific reason identified for these pains.

“The issue of drug administration to prisoners and the fact that it took two days before anyone questioned why the man had not collected his medication or food suggests that these practices should be examined and redesigned where appropriate.

“The resuscitation appears to have taken place as per guidance and staff behaved professionally. Paramedic support was summoned as soon as possible and during the wait every attempt was made by both Discipline and Health staff to save the man’s life.

“As a general point the quality of record keeping could be improved. This would include the dating of entries and the clarity of handwriting.”

23. The clinical review has identified five areas for learning, which are listed in full in the recommendations section of this report. Commendably, I note that steps have already been taken to address these and their implementation will be monitored by the Clinical Governance structure.

Events prior to the man's death

24. Following his arrest for arson in August 2005, the man appeared at West Norfolk Magistrates' Court and was remanded to HMP Norwich.
25. A detailed assessment report was provided by the Criminal Justice Mental Health Team at the magistrates' court. It ended by saying that, in the opinion of the author, the man was a high risk of suicide due to the impulsive nature of his previous attempts but that he was of low intent. It was felt appropriate that he continued to be dealt with through the Criminal Justice System.
26. The Prisoner Escort Risk form (PER) noted the man's risk of self harm, stating the number of previous suicide attempts and that he suffered from depression. During the reception process at HMP Norwich, the man told the nurse that he had last been in prison 30 years ago. He said that he was prescribed venlafaxine for his depression and that he was a binge drinker. He said that he felt stressed but not unduly so, but was concerned that he might harm himself. He also stated during his cell sharing risk assessment that he did not wish to share a cell as he felt like killing people when they invaded his space.
27. The man was referred for a mental health assessment and an F2052SH was opened. (The F2052SH was a Prison Service system used at the time in Norwich to list observations of prisoners suspected of having thoughts of suicide or self-harm, and to record details of any support plans put into place during their period in crisis. The F2052SH has now been replaced at Norwich and at an increasing number of other prisons by ACCT (Assessment Care in Custody and Teamwork).)
28. He was placed into the healthcare unit for observation and assessment. During the next few days, the man said that he was feeling 'ok' but finding it difficult to settle into prison life. He also expressed concern about moving into the main prison. On several occasions, he refused to come out of his cell for association, not wishing to mix with the other prisoners.
29. On 12 August, the man was checked at 4.30 pm when he was asleep in his cell. When he was next checked at 5.05 pm, he had a shoe lace twisted tightly around his neck using a plastic knife as a tourniquet. He was blue in the face and the ligature had to be cut off with a safety knife. Ten minutes later, he said that he was feeling fine now but that he had been very depressed earlier. He was put onto an irregular 15 minute watch.
30. The man's case was reviewed again on 14 August. He said that he self-harmed to cope. He spoke of going into a 'pit' and when in that 'pit' he self-harmed. He also said that he never knew when he would go into the 'pit' - being fine one minute and suicidal the next. He said that he was feeling happy at the present and had no complaints about the way he was being looked after, although he was worried about going to court.

31. The man was encouraged to talk to staff rather than self-harm when in the 'pit'. He remained in healthcare.
32. The man was seen by the prison doctor on 17 August. He said that he had his court appearance in two weeks and needed something to calm him down or he would not go. The doctor agreed that he would benefit from medication at that time, but told the man that he should not demand medication or make threats not to go to court if he did not get it.
33. At his next F2052SH review on 19 August, the man said that he had been withdrawn since being seen by the doctor. He felt that he had been spoken to aggressively by the doctor, which had led him to withdraw and decline his food. He said that it was his intention to be too unwell to attend court. But at the same time, he stated that he was no more at risk than previously. I note that there is no record of him declining food in his F2052SH.
34. The man was seen by a forensic psychiatrist on 23 August. The psychiatrist concluded that, despite his denial of any thoughts of suicide or self-harm, it seemed suitable for him to remain on the F2052SH while he was facing the uncertainty of court appearances.
35. When his case was reviewed on 27 August, he told staff that he still felt suicidal several times a day, even describing the methods he had thought about. The review team decided to keep the F2052SH open. The same day, it was noticed that the man had two superficial two-inch cuts to his right wrist. He claimed to have done them early that morning. No treatment was required. He did not mention having made these cuts during his review and there is no record of the incident in the F2052SH booklet.
36. By 3 September, the man said that he felt more stable in his mood and had not been having any thoughts of self-harm or suicide. He said that he would like to be more occupied and it was decided to give him a trial as a cleaner. The review team, with the man's approval, decided to close the F2052SH booklet. He began helping the cleaners over that weekend and there is a note in his main record, dated 11 October, that he had been an excellent cleaner. An entry was made in his medical record on 23 September, noting that he looked relaxed and conversed well. He said that he felt safe from himself at that time.
37. On 30 September, the man complained of pain and swelling in his right hand, and of an aching pain in his right shoulder and forearm. He was prescribed diclofenac, an anti-inflammatory drug, and told to attend work at his own discretion. On 5 October, the man was pronounced fit for work. Two days later, he was seen by the doctor who noted that the pain in the man's arm had settled, and that, while he was still not sleeping well, generally his mood had improved. He was still anxious about going to court.
38. On 26 October at 6.30 pm, the man spoke to staff in the B wing office and said that since he had left healthcare in early September he had not been coping well. He said that he did not like being surrounded by too many

people. He added that he had thoughts of putting a noose around his neck to make a vein stand out and then cutting it. He promised that he would not do anything at present, but also said that he had not been taking his medication for a couple of days. The man was moved to a single cell on C wing and another F2052SH was opened.

39. He was seen the following morning, 27 October, in the healthcare treatment room when it was noted that he was feeling very down and had not collected his medication. He was offered the opportunity to return to healthcare, but the man said that he would try to cope on the wing.
40. The man was the subject of a F2052SH review at 4 pm that day, when he said that he was very emotional but would ring his cell bell if he felt like self-harming. A support plan was set up for him. This was for him to take his medication, to collect his food (staff would try and unlock him last), and to find him employment (he had moved to C wing from B wing where he had been a cleaner). He was also offered the support of a Listener. (The Listeners are prisoners who volunteer to be trained by the Samaritans. They then offer a similar service within the prison as the Samaritans outside.) There is no record of the man ever actually having spoken to a Listener.
41. That afternoon, the man was seen in healthcare at the request of the wing staff. He said that he was feeling low and had not been taking his medication and had not eaten. The importance of eating regularly and taking his medication was explained to him.
42. His mood continued to drop over the next few days. At his F2052SH review on 8 November, he stated his intention to take his own life several times. His support plan was for him to have an urgent mental health review, to see the doctor the following morning, for him to be given a sedative for his court appearance and for hourly observations at night.
43. A few hours later, the man had cleared up his cell – apparently so that it would not have to be done after he had committed suicide. The observations were increased to every 10 minutes, until he was transferred back into healthcare. He was agreeable to that. It was not possible to accommodate him in healthcare that night as all of the beds were occupied. It was therefore decided to place the man under a constant watch until the following day, when further endeavours would be made to admit him into healthcare. He watched television and then slept with the bed covers over him for the rest of the night.
44. At 7.45 am the following day, 9 November, the man told the observing officer, “You missed it”. When the officer checked, he saw that there was dried blood on his sheets and superficial cuts on his wrists. A nurse was called and his injuries were cleaned with saline, but he declined any dressing. The man seems to have spent his day talking about how he would kill himself either in prison or on the outside if he got released.

45. He took part in another review, during which he expressed very similar suicidal thoughts. He was kept on a constant watch with his agreement and, after the review, transferred back to healthcare. He was due at court the following day and was very anxious about it.
46. On 10 November, the man was convicted of arson with sentencing postponed until 9 December. He had another F2052SH review on his return to the prison. He was feeling very depressed and reluctant to talk. After some encouragement, he said that he had constant thoughts of self-harm and was finding it difficult to cope with his depression. He felt safer in the healthcare unit and being in a single cell. His support plan was to encourage him to comply with his prescription medication, to receive support from the chaplaincy, to remain on constant watch and to be encouraged to read and watch television.
47. I note from the F2052SH that, during the night of the 11 November, the officer on night duty in healthcare was asked to keep a constant watch on two at risk prisoners.
48. The man was taken off his constant watch with his agreement on 12 November. A minimum of four irregular observations an hour replaced the constant observation. That was reduced to three per hour on the following day, and to frequent irregular checks by 16 November.
49. Whilst it would seem that his mood was improving, there were still a number of entries in the F2052SH regarding his refusal of food. On one occasion, it was noted that he had not taken his food for 48 hours.
50. The man was seen in healthcare on 17 November by two doctors who conducted a forensic psychiatric review. He claimed that he was no longer feeling suicidal, but he had a longstanding wish not to be alive. He again expressed his concern about a forthcoming court appearance.
51. On 19 November, the man told staff that he was not eating meals and had not eaten for 48 hours, saying that he just did not feel like eating at that time. He was encouraged to take fluids and a note to that effect was put on his F2052SH. Later that day, he told staff that he was feeling better and planned to have his tea meal. He took his meal, but did not eat it. By 5.10 pm he felt much better and was given some bread to make a sandwich which he ate.
52. The following morning, the man told staff that he was feeling much better. He told staff that he was a community carer outside of prison and that he also had some knowledge of epilepsy. The man was very motivated when a member of staff asked him to consider writing a self-help guide for prisoners who have epilepsy.
53. Over the next few days, his mood went up and down. On 22 November, he did not speak to staff, apologising the following day. That day (23 November), he told staff at 8.05 am that he was so frustrated at the

possibility of going into dormitory accommodation that he had broken his glasses and thrown them out of the window.

54. At 3 pm that day, the man took part in another F2052SH review. He told the review team that 'he would not do anything silly'. He wished to be on his own and specifically asked to return to the main prison. He was adamant that he no longer needed to be on a F2052SH. The general feeling of the review team was that it could be closed, but that he needed to be in a single cell.
55. The same day, the man was seen by the prison doctor who also recommended that he be allocated a single cell. He was moved to A wing the following day.
56. On 28 November, the man told a wing officer that he had not been taking his meals, just saying that he did not want to. He was seen by healthcare staff on A wing the next day. He said that he felt okay in his mood, but that his appetite was intermittent. He was not mixing with the other prisoners and felt anxious at times. The man said the anti-depressants were helping and that he did not have any thoughts of suicide.
57. On 3 December, The same wing officer wrote in the A wing Staff Observation book that the man was 'now a fully paid up member of the 4's landing'. The officer meant that, in his opinion, the man had settled into life on the wing and was interacting with staff and other prisoners. The same day, he put in a healthcare application stating that his right hand was painful and becoming immobile due to swelling. The application was received on 4 December and the man was seen by the nurse on 6 December. At that time his wrist was not inflamed, but he was given some aspirin to take when needed.
58. The man was seen by a nurse on 8 December and declared fit to attend court the following day.
59. On 9 December 2005, he attended Norwich Crown Court and was sentenced to 18 months imprisonment for his arson offence. Later that day, he submitted a further healthcare application, requesting reading glasses after his were broken in healthcare. His application was received on 13 December and the man was put onto the optician's list.
60. On 15 December, the man was informed that his release dates had been calculated. His earliest date of release on home detention curfew was 21 December. He wrote back saying that he did not wish to be released on licence and was therefore looking at 1 February 2007, his sentence expiry date, as his date of release.
61. An entry in the A wing Staff Observation book on 24 December stated that the man was quiet and generally polite to staff. He was now employed in the print shop which he seemed to be enjoying.

62. He submitted another healthcare application on Christmas Day complaining of not being able to sleep. He added that, as a result, he had stopped going for his medication and food. On 27 December, he was given a sleep leaflet.
63. Another application was submitted on 2 January 2006, as the man had been unable to sleep for more than two or three hours a night for almost 14 days. He also had an ear infection due to a head cold. He was seen by the doctor on 6 January and given 50mg of phenergan at night for seven days to help with his sleep, and a course of erythromycin, an antibiotic, for a chronic infection of his left ear.
64. Later that day, the man spoke with a member of the wing staff about the sale of his house. He was given advice for which he said he was grateful. He was also corresponding with his friends who were helping with the sale.
65. The man was seen in the healthcare treatment room on 14 January, when he complained of pain below his shoulder blade. Lanosil ointment was rubbed in to good effect and he was given some aspirin. He was advised to keep mobile.
66. He submitted a further application on 16 January, which he marked as urgent, saying that he had pain in his left shoulder blade and poor movement in his arm, neck and back. His name was put on the list to see the doctor on 20 January.
67. The man reported sick from work on 17 January, complaining of pain in his shoulder. The wing staff contacted healthcare on 18 January, stating that he had not been attending work, had not collected his medication for two days and may not have been going to the servery for his meals. The wing officer spoke at length with the man on the wing. The man said that, although he had not had lunch, he would have tea and continue to collect and eat his meals. He also said that he would attend his doctor's appointment on 20 January. The officer later told the investigating police officers that he did not get any indication that anything was wrong, or that the man was upset about anything apart from the pain in his shoulder.
68. The man was seen on 19 January, by a prison doctor and prescribed some 'Deep Heat' cream and 400mg ibuprofen tablets to ease the pain in his shoulder. Neither the doctor nor the nurse - who walked the man back to A wing - detected any signs of him being in crisis and likely to self-harm.

Events surrounding the man's death

69. About 6 pm on 19 January, the man spoke with the wing officer on A wing. He confirmed that he had seen the doctor and been given some painkillers. They had a brief conversation and then the man got himself a cup of tea and went to his cell to watch television. At about 7.20 pm, he rang his cell bell and the officer asked one of his colleagues to respond. The officer went to the cell and the man asked him if someone had turned his electricity off. The officer checked the trip switch which is outside of the cell. He assured him that it had just tripped, probably because association was coming to an end and the other prisoners were switching on their kettles and televisions, thus overloading the system.
70. The officer left to continue with his duties. During his interview the officer said that the man appeared to be alright when he left him.
71. At 7.30 pm, the staff called for association to end and for the prisoners to return to their cells. The wing officer went up to the 4's landing to begin locking the cell doors. When he got to the man's door he saw that it was shut, which he said in interview was not unusual. If the cell bolt is not shot the prisoners can shut their doors themselves. The wing officer entered the cell to check on the man and found him hanging from the metal window bars at the rear of the cell, facing the window. He had used a bed sheet as a ligature and there was an overturned chair just below him.
72. The officer turned around immediately and, when he could not see his colleague on the 4's landing, called over the rail to another officer who was on the 3's landing below. The first officer supported the man and cut the sheet ligature with his safety knife. He lowered him to the floor and began cardio pulmonary resuscitation (CPR). He was joined by the other officer who called for further assistance on his radio stating that there was a 'code blue'. (That code is used to quickly communicate that there is an emergency medical situation involving a person being unconscious, having breathing difficulties, a ligature involved or something similar.) Two nurses arrived at the cell a few minutes later. An ambulance had already been called. The Senior Officer (SO) also arrived and assisted with the CPR.
73. The nurses found no signs of life when they examined the man. They put an oxygen mask on him, and CPR was continued until the Rapid Response paramedic arrived at 7.41 pm and the ambulance crew at 7.45 pm. The crew took over attempts to resuscitate the man, including shocking him with a defibrillator. After a few minutes, the paramedics believed that his condition had slightly improved and arrangements were made for him to be transferred to an outside hospital.
74. The man left the prison at 8.14 pm and was taken to the local hospital. Unfortunately, he was pronounced dead at 8.32 pm, shortly after he arrived at the hospital.

75. The staff who were involved took part in a hot debrief which gave them the opportunity to talk through the events. They were also offered the support of the prison care team and welfare services. The prison's contingency plans for a death in custody were implemented, which included informing the police.

76. The man had not listed any next of kin when he arrived at Norwich. In an effort to trace any family he could have had, staff looked through documents in his cell. The Governor was able to trace some of the man's friends through letters. He drove out to see them that night. They confirmed that the man had been estranged from his family for some considerable time and had not wanted contact with them.

77. I commend the actions of the Governor.

Findings and conclusions

78. From the outset, it was obvious that the man would be a challenging prisoner for Norwich to assist and care for. Not because he was disruptive or violent, but because of his history of suicide attempts and his apparent determination to end his life. I believe that the staff at Norwich did their best within the inevitable limitations of a prison regime. It may be that his mental health problems were not so severe as to justify compulsory treatment in a secure psychiatric hospital, but it may also be doubted that prison was the right location for someone with the man's problems.

79. There were several periods during his time in custody at Norwich when the man stopped eating and/or collecting his medication. On at least one occasion, the fact that he had not been taking his medication or eating his food was only brought to notice by the man himself, suggesting that the issuing and record keeping procedures in these areas were less than vigorous. Those procedures should be examined and any deficiencies addressed.

The Governor should review existing arrangements for monitoring the nourishment of vulnerable prisoners and consider if improvements are necessary.

80. One particular area of concern is that, on the night of 11 November 2005, the officer tasked with keeping a constant watch in healthcare wrote in his F2052SH that he was responsible for two prisoners who required a constant watch. I do not believe that situation to be in the best interests of either the two prisoners in crisis or the officer. Sufficient staff should always be deployed to carry out these duties, as it is not possible for a single officer to give sufficient constant attention to more than one prisoner.

The Governor should ensure that staffing levels for prisoners requiring a constant watch for reasons of self-harm are at least one to one.

81. The man was moved onto A wing on 24 November 2005, where he stayed until his death. During interviews with staff conducted as part of this investigation, my investigator, found that the wing officers were not aware of the man's self-harm history or the fact that he had twice been on F2052SH booklets during his time at Norwich. I believe it is crucial for staff having day to day interaction with prisoners to have sufficient information about those prisoners, particularly if they have a history of self-harm. My investigators and I were pleased to learn that, after the man's death, steps had already been taken to inform staff of past self-harm issues. An orange coloured card has been introduced as part of the ACCT documentation. This is placed in the general wing file to flag to staff that a prisoner has recently been taken off an ACCT. I commend this practice and believe that the Prison Service should consider implementing it throughout all establishments.

Consideration should be given to implementing as national policy the use of a coloured card to notify staff that a prisoner has recently been taken off of an ACCT.

82. The man broke his glasses in frustration on 23 November 2005 and threw them out of his cell window. He told staff of his actions that morning. He was still on an F2052SH at the time and the conversation was duly noted in the document. Despite that, it was not until 9 December, when the man asked for a replacement set, that any action was taken. It was unfortunate that, even though a F2052SH review took place a short while after the man had told staff about his glasses, nothing was done to obtain a replacement.

Recommendations

Policy

- Consideration should be given to implementing as national policy the use of a coloured card to notify staff that a prisoner has recently been taken off of an ACCT.

Local

- The Governor should review existing arrangements for monitoring the nourishment of vulnerable prisoners and consider if improvements are necessary.
- The Governor should ensure that staffing levels for prisoners requiring a constant watch for reasons of self-harm are at least one to one.

Health

The clinical review has identified a further five recommendations to be addressed jointly by the prison and Primary Care Trust and their implementation monitored by the Healthcare Governance structure:

- Systems of communication should be put in place to ensure that wing staff and other relevant people e.g. doctors are made aware of previous self harm attempts so that they can observe, assess and record prisoners' behaviours and state of mind more effectively.
- Healthcare staff receive training on record keeping and or be reminded of their professional responsibilities.
- A record keeping audit should be completed and the learning implemented.
- Mechanisms are in place to alert staff to prisoners failing to pick up medication, especially if this medication is related to keeping the individual mentally stable
- A critical incident review by the staff involved in the decision to stop the F2052SH might aid decision making in the future.