

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in January 2013,
at HMP Norwich**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, a prisoner at HMP Norwich. He was discovered hanging in his cell in January 2013. He was 30 years old. I offer my condolences to his family and friends.

A clinical reviewer conducted a review of the man's clinical care at HMP Norwich. The prison cooperated fully with the investigation.

The man had been remanded into custody at Norwich on 24 October 2012, charged with serious sexual offences. This was his first time in prison and when he arrived he indicated that he was depressed about his situation, but said he had no thoughts of harming himself, which he had previously done. These were key risk factors. He was referred to the mental health team because of his previous history of self-harm and low mood, but reception staff did not consider providing formal support under suicide and self-harm prevention procedures. He received some help from the mental health team but was discharged from their care in early December before his impending court case which was one of the sources of his anxiety. At court, he pleaded guilty and was convicted of two charges of rape. He did not have a healthcare screen when he returned from court, and a planned mental health assessment for 24 December was cancelled because of staff holidays and never rebooked.

While we cannot know whether this would have affected the outcome, too much reliance appears to have been placed on the man's personal presentation when assessing his risks and needs. In particular – and in line with national suicide prevention guidance - more weight ought to have been placed on the nature of the charges he faced and his other known risk factors when assessing his risk of suicide or self-harm. There is also a need for the prison to ensure that prisoners are properly assessed in reception, particularly when their status changes and that prisoners have prompt access to mental health support when needed.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2013

CONTENTS

Summary

The investigation process

HMP Norwich

Key events

Issues

Recommendations

SUMMARY

1. The man was remanded into custody at HMP Norwich on 24 October 2012, charged with serious sexual offences. It was his first time in prison. At an initial health screen he said he had no immediate health concerns. However, he disclosed that he had taken an overdose in 2010 when a relationship had broken down but said that despite his shock at being in custody for the first time he had no current thoughts of self-harm. Because of his previous self-harm and his low mood, the reception nurse referred him to the prison's primary mental health team, but he was not assessed as at risk of suicide and self-harm.
2. The day after he arrived at Norwich, a member of the man's family telephoned the prison as they were concerned about his state of mind. A wing manager spoke to him about this but he again said that he had no thoughts of harming himself. The investigation found that the procedures for handling such calls were unclear and there was no reference to the prison's safer custody team, which the team expected.
3. A mental health nurse and a nurse practitioner reviewed the man a number of times between October 2012 and January 2013. He was prescribed medication to help alleviate some of his anxieties caused by his ongoing court case and concerns about his children but he consistently said he had no thoughts of self-harm.
4. Nurses recorded that the man appeared to be withdrawn and not mixing much with other prisoners or engaging with the regime. Prisoners who knew him said that he attended work daily and appeared light-hearted. However, one of his friends said that when they were alone he spoke more openly about how he felt and the impact his conviction and sentence might have on his children.
5. The man pleaded guilty to his charges on 21 December 2012 and returned to the prison to wait for sentencing. When he returned from court after his conviction he was not referred to the reception nurse for a health screen to assess his mood and the possibility of self-harm in response to the change in his circumstances.
6. The man was discovered hanging in his cell in January 2013. Staff acted promptly and professionally and attempted resuscitation until the paramedics arrived. The paramedics quickly assessed that resuscitation would not be possible and pronounced him dead at 5.53am.
7. While we cannot know whether this would have affected the outcome, prison staff did not fully take into account known risk factors and potential triggers for suicide and self-harm during the man's reception screening and his risk was not further assessed when he returned from court after being convicted. There also needs to be proper systems to deal with family concerns and to ensure appropriate mental health support. We make recommendations about these matters.

THE INVESTIGATION PROCESS

8. Notices were issued informing staff and prisoners at HMP Norwich of the investigation and asking them to contact the investigator with any relevant information. No responses were received.
9. The investigator obtained copies of the man's medical record and relevant prison records and visited Norwich in March to conduct interviews with prison staff and prisoners. The local PCT appointed a clinical reviewer to conduct a review of the clinical care he received at Norwich. She joined the investigator for interviews with clinicians. After the interviews, the investigator gave the Governor written feedback about the preliminary findings of the investigation.
10. HM Coroner for Norwich was informed of the investigation. A copy of this report has been sent to him.
11. One of the Ombudsman's family liaison officers contacted the man's next of kin to outline the purpose of the investigation and ask if there were any issues she wished the investigation to consider. Some family members had been in contact with him in the days before his death. They thought that he had sounded positive about the future and wanted to know if anything had changed to prompt his actions.
12. The man's family were provided with a copy of the draft report. His mother said that she had been very upset at reading about the issues raised by our investigation. However, she also hoped that recommendations which had been made as a result would benefit other prisoners in the future.

HMP & YOI NORWICH

13. HMP & YOI Norwich is a multi-functional prison, predominantly serving the courts of Norfolk and Suffolk. The prison accepts adult and young adult men under 21, both convicted and on remand. It holds up to 767 prisoners. At the time of the man's death the prison's health services were commissioned by the NHS and provided by a private company and their subcontractors. There is a healthcare centre which provides 24-hour nursing cover and a dedicated unit for older prisoners.

HM Inspectorate of Prisons (HMIP)

14. HMIP last inspected Norwich in January 2012. Inspectors noted that the suicide prevention policy was well promoted and analysis of trends in self-harm was good, although management arrangements and the quality of self-harm documentation indicated that some of the care for prisoners at risk was inadequate.

Independent Monitoring Board (IMB)

15. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In their most recent annual report, for March 2012 to February 2013, the IMB noted improvements in healthcare provision and that healthcare staff now regularly attended monthly safer custody meetings. However, they remained concerned that healthcare staff seemed unwilling to share important information that might assist in keeping prisoners safe. The Board was also concerned that aspects of the safer custody procedures were unsatisfactory and some staff were still awaiting training. In view of the number of repeated recommendations, the IMB intended to monitor implementation of Prisons and Probation Ombudsman's recommendations.

Previous deaths at Norwich

16. In the twelve months before the man's death, there was one other self-inflicted death at Norwich. The investigation into the previous death identified that the prisoner had not been correctly assessed by nurses after his return from court. A similar issue is evident in this investigation.

KEY EVENTS

17. The man was remanded to HMP Norwich on 24 October 2012, charged with serious sexual offences. This was his first time in custody. He was 30 years old.
18. A Person Escort Record (PER) accompanies each prisoner during journeys between courts, police stations, prisons and is used to allow the different criminal justice agencies to pass on any identified risks. The man's PER indicated that his risks were identified as suicide/self harm (he had taken an overdose two and half years before) and the nature of the current charges of rape. It was noted he had asthma and an allergy to penicillin.
19. When the man arrived at Norwich, a nurse completed an initial health screen. He told her that he had no concerns about his physical health but disclosed that he had previously taken an overdose of mixed medications after the breakdown of a relationship, for which he had had hospital treatment. He said he was uncertain about being in prison and felt run down and low in mood as a result of his situation. The nurse referred him to be assessed by a mental health nurse.
20. The nurse told the investigator that she could not remember the man or assessing him that day, but said she would normally make a mental health referral for anyone with a self-harm or mental health history or those who seemed low in mood. She did not recall referring him because of any urgent concern about his immediate wellbeing. She said that if she had immediate concerns about a prisoner, she would either open an Assessment, Care in Custody and Teamwork (ACCT) plan (the process for supporting and monitoring prisoners at risk of self-harm), or refer them to a member of the mental health team who would do so.
21. On 25 October, the day after the man arrived at Norwich, a nurse practitioner reviewed his asthma and related medications so that they could be re-prescribed. He had been without medication for a few days while he had been held in police custody. As it was his first time in prison, she asked how he felt. He told her that he was okay, but a little shocked. She saw in his reception notes that he had taken an overdose in 2010 and they discussed the circumstances. He said he was all right now and he would never do that again. She noted that he had an appointment scheduled with the mental health team directly after their discussion who would conduct a full assessment.
22. The nurse explained that her assessment consisted of standardised questions, one of which was, 'has the patient self-harmed in the last 12 months?' She ticked 'no', but did not record their conversation about his previous self-harm. She said that they had since reviewed their procedures and nurse practitioners now record all conversations with prisoners about their mood and any previous history of self-harm, whenever it had occurred.
23. A registered mental health nurse (RMN) assessed the man after his appointment with the nurse. She recorded:

“Taken an overdose in 2010 after a split with his girlfriend, but immediately regretted it. Denies any suicidal thoughts now, says he had depression 7 years ago when he was physically unwell and unable to work and got into money difficulties. He was treated with antidepressants for 2 years but stopped taking them when he felt better. First time in prison, has never been in trouble. Angry that he has been charged and denies any wrongdoing. Says he is shocked at his predicament and worried about everything he will need to sort out.”

24. When interviewed by the investigator the RMN said that he had considered the man's problems and upset to be related to his situation, first time in custody, strange surroundings and the nature of the charges against him. He did not wish to be prescribed any medication to help him to sleep or cope with his situation. The RMN planned a follow-up appointment for a further assessment and review of the need for medication. He had no immediate concerns about him and found no evidence of mental health issues. He had spoken positively and said he had no thoughts of harming himself.
25. The man was allocated to C wing, which accommodates vulnerable prisoners, (usually those who might be threatened by other prisoners because of the nature of their charges or offences). He initially shared a cell with Prisoner A, who told the investigator that he had been in custody a week when the man arrived. He described him as nervous and 'sort of shaky' and said that they did not really talk to one another for the first couple of days. However, he had told him that before his imprisonment he had attempted to take his own life. He asked him how this had affected his family and he replied that it had been foolish and 'not the thing to do'. The prisoner had no concerns that he was contemplating harming himself during the time they shared a cell and said he began to mix well with other prisoners.
26. The prison advertises a telephone helpline for prisoners' families and friends to inform the prison about any concerns about a prisoner's welfare. On Friday 26 October at around 4.30pm, the man's cousin telephoned the prison to say his family were worried about him because of his previous self-harm and he had made some comments to his mother which had concerned her. The prison switchboard tried to put the call through to the prison safer custody team, but no one was available. The switchboard operator then spoke to staff on C wing who agreed to pass it on to the wing manager. The SO (the senior officer in charge of the prison) said that he has also spoken to the man's cousin, but it was unclear whether this was a separate call.
27. The SO explained that the safer custody staff were off duty at the time and the normal procedure was for such calls to be passed to either the duty governor or orderly officer. He said he received a telephone call at around 5.03pm, from the man's cousin, who was concerned about comments he had made to his mother. The SO contacted the C wing manager, who said that he had already spoken at length to him, who said that he was fine and that his mother had taken his comments out of context. The SO Radcliffe did not find out what he had actually said to his mother.

28. The SO updated the man's record, detailing the telephone call and follow up actions. He thought that the safer custody team would look at these entries, but acknowledged when pointed out by the investigator, that the safer custody team would not be aware of the entries unless they were drawn to their attention. Both senior officers said that it was not usual to contact the family member or friend who had raised the concern to let them know what action they had taken, but they would feedback to the member of staff who had taken the call, such as a duty governor or orderly officer, to confirm that they had spoken to the prisoner concerned.
29. A member of the safer custody team told the investigator that they answer the majority of calls from relatives or friends but were not always told of those received outside the normal office hours. He added that although there were no written procedures, all staff should be aware that they should notify him of calls received about the welfare of a prisoner.
30. The investigator spoke to a number of prisoners who had either been friends with or worked with the man. Prisoner B had shared a cell with him around three weeks after his arrived at Norwich. He described him as quite anxious when they were in their cell, but when out on the landing or with other prisoners he gave the impression of a loud and jolly person who engaged well. He said it was the prospect of a long sentence that he was most anxious about. The prisoner said that he had heard that when he first arrived at the prison, he had been a different person, a lot quieter and more anxious about his case. He did not talk much about this when he was out of his cell, but spoke about it when he was on his own with a cell mate.
31. Prisoner C said that he was close friends with the man at the prison and that when he first arrived he was very emotional and upset so he had taken him 'under his wing' and looked out for him. He and other prisoners gave him coffee and biscuits until he was able to buy his own items. He said he sat with a particular group of prisoners with whom he would have a laugh and a joke. He had never mentioned harming himself or thoughts about self-harm, but he recalled that when he had first arrived, a member of his family had telephoned the prison as they thought he might do 'something bad'. He said that staff had kept a close eye on him but his mood improved from upset and emotional, to being happy and having a laugh. However, he said that it was also evident that he was concerned about maintaining contact with his young children.
32. On 13 November, the man attended an appointment with nurse practitioner. The nurse completed a PHQ9 questionnaire, which lists a series of questions about current thoughts or behaviour. Each question is scored between 0 to 3 and an overall score indicates the severity of a person's depression:

Total Score Depression Severity

0-4 None

5-9 Mild depression

10-14 Moderate depression

15-19 Moderately severe depression

20-27 Severe depression

33. The man had scored 21 on the PHQ9 scale, which indicated severe depression. The nurse recorded that it was his first time in custody. His children had been added to his telephone account so he was now able to call them. He said he was finding it increasingly hard to cope, felt low and stayed in his cell as much as possible. She recorded that the plan was for him to be seen by the mental health team and she added him to their waiting list.
34. The nurse said that on the 13 November, when she had seen the man, he had 'poured his heart out' and had come across as a very family orientated man. He had spoken about a recent visit from his daughter during which he had become very tearful. This had led to him making the appointment with her. They had discussed self-harm and he had described his family as a protective factor. He told her about his previous overdose, describing this as a 'flash in the pan', and said that he had not intended to do this. She did not record their discussion.
35. The nurse arranged a follow-up appointment for a week later but thought someone ought to see the man in the meantime. She therefore spoke to the primary mental health lead nurse. She explained that it was his first time in prison, he had an ongoing court case and other issues and that she would like someone to visit him on the wing. The mental health lead nurse asked whether he was suicidal and the nurse reported that he had said he had no thoughts of self-harm and his protective factors were his family. An appointment was made for him to be seen the next day, but he was actually seen on 15 November, as a follow up to his original assessment on 25 October had already been planned.
36. On 15 November, the man told the nurse that he had felt worse since his imprisonment as he was missing his children, but he was receiving regular visits from his partner. He was finding it increasingly difficult to talk to his children over the telephone without becoming upset. Although he had initially declined medication, he agreed to try a course of citalopram (an antidepressant) to try and lift his mood. (At an appointment with a nurse on 3 December, he scored 15 (moderately severe) on the PHQ9 scale, indicating some improvement.)
37. On 6 December, a nurse had a routine follow-up appointment with the man, who said he was feeling much better, but was unsure whether this was due to medication or if he had adjusted to his situation. The nurse recorded that he appeared calm and relaxed. He felt he no longer needed input from the mental health team, but was appreciative of the support he had been given. The nurse reminded him that if he required further support in the future he should contact them, which he agreed to do. The clinical reviewer comments that there is no record in his medical notes to indicate that the nurse had considered his impending court case when he discharged him from the care of the mental health team.
38. The man had started working in the printshop soon after he arrived at Norwich. A textile instructor said that he had engaged well with other prisoners and,

when she spoke to him, they always had sensible conversations. She was not aware of any issues and was not concerned about him. However, she said it was clear that he was concerned about his children and the way his case was being reported in the local newspapers.

39. On 21 December, the man appeared at Crown Court, where he pleaded guilty to two charges of rape and was remanded for sentencing until 28 January. When he returned to the prison, he was recorded as convicted but unsentenced. This change of status should have led to a review by a nurse in reception but he returned to C wing without an assessment by a nurse.
40. A nurse explained that not all prisoners returning from court have a reception interview. Reception nurses see any who are referred to them by reception officers. She added that since the man's death officers paid more attention to those who needed to be seen but sometimes prisoners were missed and nurses could not be expected to see everyone.
41. A nurse said that she had planned to see the man on 24 December, after his court appearance on 21 December. However, healthcare and prison managers cancelled all clinics over the Christmas period from 24 December to 2 January, due to reduced staffing, so the planned appointment did not take place. She explained that once the clinics resumed, she had to catch up with appointments. His appointment was overlooked and not rescheduled and he made no request to see her.
42. After his court appearance on 21 December, the man continued to attend work in the printshop before and after the Christmas period. The textile instructor said she did not notice any changes in him after his court appearance and her impression was that he had resigned himself to the probability of a significant sentence.
43. The man was said to have been his usual jovial self with other prisoners and gave no cause for any concern. However, when he was alone with his friends, he said he was concerned about the likely sentence and how this might affect his children. Prisoner C said that after the court appearance, he did not show others that he was feeling low, but as he knew him, he recognised that the court appearance had 'knocked the wind out of him'.
44. On 15 January, the man's children visited him. The Service Manager for The Ormiston Trust, which organised the visit, said that feedback from the facilitator was positive. He did not seem to have been upset during the visit. However, Prisoner C described him as very emotional and crying after the visit.
45. A week before the man was due to return to court to be sentenced, he spoke to Prisoner C. The prisoner said he was very emotional and repeatedly asked him how he could face his children as a convicted sex offender. He said he advised him not to worry and that he would always be their dad. He said that he appeared happier after they had spoken and by the next week seemed to be back to his usual self.

46. On Saturday 26 January, the man spent the day associating with his friends on C3 landing. Prisoners interviewed during the investigation said that they had noticed nothing unusual about him during the day and he had been laughing and joking. All prisoners were locked in their cells at 5.00pm. He was seen watching television during a routine roll check (a count of prisoners) at 8.00pm by an Operational Support Grade (OSG).
47. The next morning the OSG began the morning roll check. This required him to look into each cell and account for all prisoners on the wing. When he arrived at cell C3-12, occupied by the man, he looked through the observation panel and saw him apparently standing at the back of the cell and looking out of his window. He could not see the top half of his body as the curtain was pulled around him.
48. The OSG called out to the man and knocked on the door and knew something was wrong when there was no response. He immediately called to his colleague, Officer A, who was carrying out the roll check on the other side of the wing. He, in turn, called to Officer B and both officers went to C3 landing. The OSG explained his concerns and the officers looked through the observation panel. For security reasons staff carry cell keys in a sealed pouch during the night. The seal can be broken if staff need to enter a cell in an emergency. Officer A broke the seal on his key pouch and opened the cell door.
49. The three staff went in and pulled back the curtain. They saw that the man had a piece of torn bedding tied around his neck, attached to the curtain bracket. Officer B called a 'code blue' over his radio to request medical assistance and the officers cut the noose from the man's neck and lowered him to the floor. (Medical codes are used in most prisons to alert medical and other staff to an emergency. The type of code indicates the nature of the problem, 'Red' for bleeding and 'Blue' for breathing difficulties and also enable nurses to take the correct emergency equipment.) As soon as the 'code blue' was called, the control room requested an emergency ambulance at around 5.30am.
50. Nurse A was the first nurse to attend within a few minutes of the emergency call. She checked the man and found no signs of breathing and no pulse. She discovered that he had what appeared to be a sock in his mouth, which she removed. The staff began cardiopulmonary resuscitation (CPR), although she noted that his arms and legs were stiff and he was cold to the touch. They continued CPR while she attached an automated external defibrillator to his chest, which indicated that no shockable rhythm could be detected. Nurse B arrived and assisted with CPR. CPR continued until paramedics arrived at 5.43am. The paramedic recorded that on examination he was cold to the touch and clear signs of rigor mortis were present. CPR continued for a further few minutes, but at 5.53am the paramedics pronounced him dead.

Actions after the man's death

51. The duty governor was notified at home of the man's death and went into the prison. When he arrived, staff were making arrangements to notify his partner

of what had happened. Due to the distance from the prison to her home, the duty governor contacted the duty governor at HMP Chelmsford, who agreed to send one of their trained family liaison officers to notify the man's family.

52. Unfortunately, there was no one at the address provided or at a second address. The duty governor therefore telephoned the man's partner and asked her to go home where there were people there waiting to speak to her. The family liaison officer from Chelmsford then informed her of her partner's death. The duty governor spoke to the man's aunt later that day and gave brief details of what had happened.
53. The duty governor held a debrief with the staff that had been involved in the emergency and offered support. Prisoner C said that he at first had been notified of the man's death by a letter placed under his door, although he had heard the events on the wing through his door and had deduced what had happened. He said the support he had received afterwards was excellent. Staff checked on him frequently, offered him a television to keep his mind occupied (he had previously chosen not to have one as he preferred to read) and a member of the chaplaincy team visited to support him.
54. Norwich appointed a family liaison officer. She contacted the man's partner on 28 January and gave her additional information about the processes that would follow. She then met his family on 30 January, offered assistance with the funeral costs and helped to facilitate some of the other arrangements.

ISSUES

Clinical care

55. The clinical reviewer found some general deficiencies in the provision of mandatory training for healthcare staff, prescribing of medication, provision of clinics and mental health services. She made a total of 17 recommendations about these matters in her clinical review and we include in this report those which are particularly relevant to the circumstances of the man's death. The NHS, which now commissions services in prisons, will need to take the remainder forward with the healthcare provider at Norwich.

Mental health provision

56. When he first went to prison, the man was referred to the primary mental health team and a nurse practitioner. No evidence of a mental health condition was found but a review was planned for 15 November. In the meantime, on 13 November, the nurse practitioner referred him to the mental health team because she was concerned about his low mood and inability to cope. The clinical reviewer comments that there appears not to have been any joint care planning apart from the referral on 13 November and no evidence in the clinical record of ongoing liaison between the nurse practitioners, the primary mental health team and wing staff about his care. There was a gap of up to two days between his appointments with the nurse practitioner and mental health staff and the clinical reviewer's questions whether this provides sufficient support for vulnerable men.
57. When the man was seen by the primary mental health nurse the PHQ9 scores recorded by the nurse practitioner were referred to, but not reassessed. He discharged himself from the care of the primary mental health team on 6 December. His presentation at that time was recorded as 'calm and relaxed' and 'coping well', but there was no reference to the PHQ9 score of 15, completed three days earlier, which indicated his level of depression was 'moderate to severe'. In addition, there was no evidence that his impending court case had been taken into account when discharging him from the service, although it was apparent this was causing him some anxiety. We make the following recommendations:

The Healthcare Manager and Primary Mental Health Lead should agree written criteria for admission and discharge of prisoners to the Primary Mental Health Team and ensure liaison and joint care planning when a prisoner receives shared care from both services, including wing staff as necessary. This should include consideration of support and intervention for prisoners in relation to their alleged offences and court appearances.

58. A nurse had planned to review the man on 24 December, after his court appearance on 21 December. However, all clinics, with the exception of some nurse practitioner clinics on part of the prison site, were cancelled between 24 December and 2 January 2013. The clinical reviewer says that clinics in the wider community would only be closed on the bank holidays and it is unclear

why the prison clinics had been cancelled. Although the nurse practitioner service maintained some clinics, many prisoners were unable to attend them as prison officers were not available to escort them. We make the following recommendation:

The Governor and all healthcare providers should ensure that clinics are closed only as necessary for bank and seasonal holidays, with sufficient provision to meet urgent needs. When prisoners' appointments are unavoidably delayed they should be rebooked quickly.

Assessment of risk

59. Prison Service Instruction (PSI) 64/2011, on safer custody gives guidance on the management of prisoners at risk of harm and lists a number of risk factors and potential triggers for self-harm and suicide. These include early days in custody, previous self-harm, being charged with violent offences and court appearances, especially the start of trial and sentencing.
60. During health screens and mental health assessments when the man first arrived at Norwich, general and mental health nurses were aware of his past history of self-harm and that his mood was low. (A mental health assessment three weeks after his arrival indicated that he was suffering from severe depression.) He said he had no current thoughts of self-harm. The staff had no concerns about his immediate well-being and considered it unnecessary to open the suicide and self-harm monitoring procedures. In subsequent meetings with healthcare staff, he continued to deny any thoughts or intentions of harming himself, but accepted medication to help him cope with his depression.
61. The man's friends said he had usually appeared upbeat in public, but expressed his concerns about how his sentence might affect his relationship with his children when he spoke with friends alone. Officers and workshop instructors saw nothing to suggest that he was at risk of harming himself.
62. The man was in prison for the first time, facing charges for serious violent offences, he had previously attempted suicide and said he felt low. These factors are significant indicators of risk of self-harm and suicide, yet neither the reception nurse, nor the mental health team seem to have given appropriate consideration to starting monitoring under the self-harm and suicide prevention measures. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a snapshot of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. We are concerned that prison staff relied too heavily on his assurances that he had no thoughts of self-harm rather than making an assessment taking account of all the risk factors.
63. We consider that staff should have given more weight to the man's known risk factors, including the circumstances of his alleged offence and the fact that he was assessed as depressed, in comparison to his presentation. They should

have then considered conducting the initial assessments of the suicide and self-harm prevention procedures to determine whether he required additional monitoring or support. We therefore make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines. This should include ensuring that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of self-harm or suicide, not just their presentation. Where there are significant risk factors and self-harm prevention procedures are not started, decisions and reasons should be clearly documented.

Health screen after a change of circumstances

64. On 21 December, the man attended court where he pleaded guilty to two charges of rape. He then returned to the prison to await sentencing. His demeanour when he returned was not recorded, but we know that he had been in prison for a relatively short time, had just been convicted of serious offences and was expecting a significant sentence. We believe staff should have been alert to the possibility that this would have caused him significant anxiety
65. Guidance in Prison Service Order (PSO) 3050 Continuity of Healthcare for Prisoners states:

“Events that require a prisoner to leave the prison and pass back through prison reception [as the man did], can have significant impact on the health of a prisoner.”
66. The PSO lists events such as a court appearance or sentencing as factors which can impact significantly on the health of a prisoner and instructs prisons to have protocols in place for screening such prisoners for any potential healthcare, or suicide/self-harm issues. The man did not receive any further screening when he returned to the prison after attending court on 21 December.
67. After the man’s death, a prison manager e-mailed reception staff reminding them of the importance of ensuring that prisoners returning with a change in status are seen by healthcare staff. At interview the reception nurse indicated that, owing to the number of prisoners to be processed, nurses could not be expected to see everyone. We share the clinical reviewer’s concern that he did not have a health assessment on his return from court and make the following recommendation:

The Governor and Head of Healthcare should ensure that all prisoners receive a health screen after court appearances to assess any potential health or suicide and self-harm issues.

Handling of concerns raised by the man's family

68. The day after the man went into prison, staff received a telephone call from a member of his family who was concerned about his well-being. The wing manager spoke to him, who told him that he was fine. Friends of his on the wing described him as being low at the time and said that staff had kept a closer eye on him for the first few days he was at Norwich, but he quickly came out of himself.
69. Although the prison advertises a helpline number for relatives to report concerns about a prisoner, there is no written procedure about how staff should follow up and record such concerns. The SO recorded that he had spoken to the other SO about the call, but the other SO did not record the outcome of his conversation with the man. They both said that they would not necessarily inform the person who had raised the concerns of the outcome of any actions they had taken. A member of the safer custody team said that while the safer custody team would receive most such calls, some would be out of office hours and therefore be dealt with by managers. He thought that most staff would know what to do but was unaware of any agreed procedures.
70. It was explained that the Ormiston Trust also receives concerns from worried family members or friends and a procedure for dealing with such information was agreed with the prison. The procedures detail the actions that Ormiston staff should take when they receive information about a prisoner. It is surprising that the prison has provided detailed guidance for Ormiston Trust staff, but none for their own. In view of this, we make the following recommendation:

The Governor should provide written guidance for all staff on the procedures to be followed when they receive concerns about a prisoner's well-being. This should include recording how the concern was raised, the action taken and the response to the person who reported the concern.

RECOMMENDATIONS

1. The Healthcare Manager and Primary Mental Health Lead should agree written criteria for admission and discharge of prisoners to the Primary Mental Health Team and ensure liaison and joint care planning when a prisoner receives shared care from both services, including wing staff as necessary. This should include consideration of support and intervention for prisoners in relation to their alleged offences and court appearances.

The recommendation has been accepted and the action plan says:

The Clinical Lead is currently formulating the admission and discharge criteria for the Primary Mental health services. A meeting is scheduled to take place with PMHT, GPs and the Nurse Practitioners with regards to their referrals to PMHT. During this meeting it will be discussed and ratified as to the joint care-planning between the different health providers.

2. The Governor and all healthcare providers should ensure that clinics are closed only as necessary for bank and seasonal holidays, with sufficient provision to meet urgent needs. When prisoners' appointments are unavoidably delayed they should be rebooked quickly.

The recommendation has been accepted and the action plan says:

There is a new process in place for appointments that have been cancelled. The SERCO compliance team check all appointments and re-book at the next available time.

SERCO are to ensure that staffing levels are appropriate and that annual leave arrangements do not mean clinics are cancelled. Clinics should only be closed for Christmas Day, Boxing Day and New Year's Day. GP surgeries/Nurse Practitioner and Primary Mental Health clinics should be sufficiently staffed outside of these closure days.

The People Hub should ensure that they adequately profile staff for Day Care clinics at all times, with the exception of Christmas Day, Boxing Day and New Year's Day.

3. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines. This should include ensuring that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of self-harm or suicide, not just their presentation. Where there are significant risk factors and self-harm prevention procedures are not started, decisions and reasons should be clearly documented.

The recommendation has been accepted and the action plan says:

A newly created SASH risk assessment form has been created in order for the risk on newly arrived prisoners to be assessed. This is completed in conjunction with the Primary Mental Health Team. It focuses on key triggers to self harm/suicide alongside factors such as mental health issues, current offence, length or potential length of sentence and general presentation. Following this assessment a decision is made by the Custodial Manager on duty and the Primary Mental Health on an ACCT and reasons for not opening an ACCT are documented.

In addition, a full list of triggers to self harm/suicide is available in Reception and the medical screening room in order for staff to refer to when assessing new receptions.

4. The Governor and Head of Healthcare should ensure that all prisoners receive a health screen after court appearances to assess any potential health or suicide and self-harm issues.

The recommendation has been accepted and the action plan says:

Reception staff are fully aware and been reminded of the importance of this task. All prisoners who return from court with a change of status are held in reception until they have seen the nurse. Head of Healthcare is to ensure that this consultation is recorded on System One for reference.

5. The Governor should provide written guidance for all staff on the procedures to be followed when they receive concerns about a prisoner's well-being. This should include recording how the concern was raised, the action taken and the response to the person who reported the concern.

The recommendation has been accepted and the action plan says:

The Safer Custody Manager has been tasked with developing guidance for staff in dealing with concerns raised regarding a prisoners well being. This will address how feedback is provided to the individual raising the concern.