

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Oliver Safioulin, a prisoner at HMP Norwich in March 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and offender supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations such as this into deaths, due to any cause, including any apparent suicides and natural causes, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened, correct any injustice and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Oliver Safioulin was found hanged in his cell at HMP Norwich in March 2015. He was 50 years old. I offer my condolences to those who knew him.

Mr Safioulin was Belarusian and did not speak or understand English well. He was very hard of hearing, which made communication very difficult, although he could sign. Mr Safioulin also had mental health problems, which were largely well managed. At the time of his death he was waiting for a transfer to a secure hospital, but sadly, no bed space was available before he died and there was no space in the prison's inpatient unit.

Although individual staff made considerable efforts to help Mr Safioulin, I am concerned that there was no coordinated response to his significant disabilities or adequate guidance for the prison staff working with him. Much of the time, he seemed isolated and frustrated. At the time of his death, Mr Safioulin was being managed under Prison Service suicide and self-harm prevention procedures. Although the investigation identified some omissions in the management of these procedures, there was little to indicate that Mr Safioulin was at imminent risk of suicide in the days before his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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Summary

Events

1. In February 2015, Mr Oliver Safioulin was remanded to HMP Norwich charged with robbery. He was Belarusian and did not speak or understand English well. He was also very hard of hearing, which made it difficult to use a telephone interpreting service. He had a history of mental health problems and had previously been a heavy drinker. Prison reception staff identified his complex communication difficulties but no one took overall responsibility for drawing up a coordinated care plan to meet his needs. Mr Safioulin preferred to communicate using British Sign Language (BSL), but it was more than two weeks before the prison first used a BSL interpreter.
2. The mental health team gave Mr Safioulin some support. On 20 February, he told a nurse that he would kill himself after his 50th birthday, four days later. He said that he had no family, no children and nothing to live for. The nurse began Prison Service suicide and self-harm prevention procedures (known as ACCT). Staff assessed him as at raised risk of suicide and self-harm. Because of his mental health problems and communication difficulties, wing staff found it difficult to engage with him or to support him effectively.
3. Mr Safioulin's mental health began to deteriorate, and prison officers were concerned that he should not be on a standard prison wing. Prison psychiatrists and psychologists considered Mr Safioulin should be transferred to a secure hospital. On 10 March, a psychiatrist assessed him for a transfer, and considered he was suffering from a psychotic illness. The next day, the hospital confirmed that they would accept Mr Safioulin as soon as a bed became available. Mr Safioulin remained living on his wing as there was no space in the prison's inpatient unit.
4. A few days later an officer found Mr Safioulin hanging in his cell. He raised the alarm and, with other officers, began attempts to revive him until nurses arrived and took over. Paramedics arrived quickly, but, sadly, they were unable to save Mr Safioulin.

Findings

5. We found that there was no properly coordinated response to managing Mr Safioulin's communication difficulties. There was no care plan to address his disabilities and the lack of structured support added to his isolation and frustration, with wing staff unsure how to manage him. Although he communicated best with a signing interpreter, little was done to make sure one was available for important appointments and assessments.
6. There were some deficiencies in managing ACCT procedures, which meant that Mr Safioulin's risk to himself was not always properly considered. His needs were not properly identified or addressed through the ACCT process. However, we acknowledge that Mr Safioulin presented with a rare and complex set of needs and there was little in the days before his death, to indicate that his risk of suicide had substantially increased.

Recommendations

- The Governor should ensure that the needs of prisoners with disabilities are identified on reception and that there is a coordinated and multidisciplinary approach to meeting the needs of those with complex conditions through effective care plans which outline the reasonable adjustments required to allow them to participate fully in prison life.
- The Governor should ensure that accredited sign language interpreting services are used for prisoners who are deaf or hearing impaired, and reliant on sign language, whenever matters of accuracy or confidentiality are a factor.
- The Head of Healthcare should ensure that prisoners under the care of the mental health team have appropriate continuity of care and that prisoners waiting for transfers to hospital under the Mental Health Act are actively monitored and prioritised for beds in the prison's inpatient unit when judged clinically beneficial.
- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines. This should include:
 - i. continuity in case management,
 - ii. properly completed and updated caremaps,
 - iii. holding ACCT reviews whenever an event occurs that could mean the prisoner is at increased risk,
 - iv. properly convened and recorded reviews, which involve the prisoner wherever possible.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
8. The investigator visited Norwich on 17 March. He met a representative from the Independent Monitoring Board and visited Mr Safioulin's cell. He obtained copies of relevant extracts from Mr Safioulin's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Safioulin's clinical care at the prison.
10. The investigator interviewed three prisoners at Norwich on 17 March, and 18 members of staff at Norwich on 18 and 19 May and 22 and 23 June. The clinical reviewer joined Mr Lusted for interviews with healthcare staff.
11. We informed HM Coroner for Greater Norfolk of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. Mr Safioulin had not listed any next of kin. The prison, police and coroner's office, made extensive efforts to trace next of kin for Mr Safioulin but were unable to find any family.

Background Information

HMP Norwich

13. HMP & YOI Norwich is a multi-functional prison, mostly serving the courts of Norfolk and Suffolk. The prison holds up to 769 men. Virgin Care provides health services at the prison, including a healthcare centre inpatient unit. There is 24-hour nursing cover.

HM Inspectorate of Prisons

14. The last inspection of Norwich was in August 2013. Inspectors found serious weaknesses in case management and planning for prisoners at risk of suicide and self-harm. ACCT documents did not show a dynamic response to meeting prisoners' needs, with little to indicate that necessary actions were taken or followed through. Case reviews were usually poorly attended, cursory and rushed and all were chaired by the duty custodial manager, who often had little knowledge of the prisoner. Records of reviews did not indicate positive engagement with the prisoner or full consideration of their views.
15. Prisoners found it difficult to get basic issues sorted out and the personal officer scheme was not operating effectively. Inspectors reported that induction arrangements were unsatisfactory, with some prisoners receiving no or only a partial induction. Arrangements for equality and diversity work were adequate but, although assistance for disabled prisoners had improved, more was needed. Provision for foreign national prisoners was reasonable.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its annual report for the year to 28 February 2015, the IMB noted there were difficulties transferring prisoners with mental health problems to more suitable facilities. Disability care plans took time to be formulated. The IMB noted that ACCT entries did not always reflect meaningful interactions with prisoners.

Previous deaths at HMP Norwich

17. Mr Safioulin's was the sixth apparent self-inflicted death at Norwich in the last three years. There were no significant similarities with the circumstances of the other deaths or the recommendations we have made.

Assessment, Care in Custody and Teamwork

18. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
19. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There

should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

20. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

21. On 4 February 2015, Mr Oliver Safioulin was remanded to HMP Norwich, charged with robbery. Mr Safioulin was Belarusian and spoke little English. He was deaf, with only limited hearing. He had a history of drug and alcohol misuse, and had suffered from mental health problems in the past. He had a number of previous convictions and had been in prison before, including at Norwich, in 2011.
22. Mr Safioulin's escort record recorded that he said he had tried to hang himself in 2014. It noted his alcohol use, that he was deaf and could lipread, suffered from depression and insomnia, and said he was prescribed diazepam. The court did not alert Norwich in advance about his communication problems.
23. At a prison reception health screen, a nurse recorded that it was difficult to communicate with Mr Safioulin, because of his hearing loss and because English was not his first language. He noted that Mr Safioulin could lipread. There were no staff on duty in the prison at the time who knew British Sign Language (BSL). Mr Safioulin then seemed to indicate that he did not sign. The nurse used a telephone interpretation service, Language Line, and spoke to Mr Safioulin using a Russian interpreter. The interpreter said that Russian was not Mr Safioulin's first language, but they were able to communicate to some extent, despite this and his hearing loss. (Belarusian and Russian belong to the same group of languages, but there are significant differences between the two.)
24. The nurse said that it was still difficult to carry out a full mental health assessment, but Mr Safioulin was calm and behaved appropriately. He was unable to find out whether Mr Safioulin was prescribed any medication, but noted that his previous prison medical records showed that he had been prescribed medication for mental health problems and had been diagnosed with bipolar disorder and schizophrenic affective disorder, as well as a history of alcohol abuse and liver failure. Mr Safioulin said he no longer drank, and he appeared physically well. He said that he had tried to hang himself in 2014, but the nurse had no concerns that he was at risk of harming himself at the time.
25. Mr Safioulin could not recall the name of his GP, but he gave the nurse the name and telephone number of a friend. His friend gave the nurse the name of Mr Safioulin's doctor, but the nurse was unable to get a reply from the GP practice at the time. The nurse sought advice, but his colleagues and manager said there was nothing else he could do to address the communication difficulties. He referred Mr Safioulin to the doctor, the substance misuse team and the mental health team for further assessment. The nurse recommended that Mr Safioulin should have a single cell until someone from the mental health team assessed him.
26. At about 5.00pm, a doctor from the substance misuse team saw Mr Safioulin. The doctor spoke Russian and recorded that Mr Safioulin did not speak Russian well, which made it difficult to assess him. He noted that Mr Safioulin no longer took medication for depression, and said that he no longer drank heavily. The doctor noted that Mr Safioulin displayed signs of paranoia, and thought that he might have a learning disability, but did not refer him for a learning disability

assessment. He concluded that Mr Safioulin did not need any treatment for withdrawal symptoms from drugs or alcohol.

27. Mr Safioulin moved to a single cell on A Wing, the induction wing. The officer who saw him for an induction interview that evening knew that he had communication difficulties because this had been noted in the wing observation book. Mr Safioulin was with another prisoner, who could speak Russian, but despite this the officer could not communicate with him and complete the induction interview. The officer completed the disability induction questionnaire, highlighting that Mr Safioulin was deaf, and passed the form to the disability liaison officer through an administrator.
28. On the morning of 5 February, a prison GP saw Mr Safioulin's and noted his English was very broken, but they managed to communicate a little using a Russian interpreter from Language Line. (Language Line offers a Belarusian interpreting service, but it is not clear whether staff asked for a Belarusian speaker each time they used the service.)
29. Mr Safioulin said that, in the past, he had been prescribed medication for depression and that he was lonely, but that he was sleeping without problems. He told the doctor that he had hearing aids but that they gave him headaches. (He did not have the hearing aids with him at the prison.) He said that he had liver disease. The doctor noted from the records that Mr Safioulin had been in the UK since 1997, had been diagnosed with a depressive disorder and previously with psychosis and paranoia. He prescribed a low dose of sertraline (an antidepressant) and requested blood tests. (There is no record of these tests being carried out.)
30. That afternoon, a nurse from the mental health team saw Mr Safioulin on the wing who indicated that that he used British Sign Language (BSL). She noted on his record that she would discuss this with the team leader and someone would try to assess him again the next day.
31. On Friday 6 February, another prisoner helped Mr Safioulin submit an application to get some of his clothing, which he thought was stored in reception. The prisoner wrote that Mr Safioulin was Belarusian, did not speak English and did not understand how things worked. A member of reception staff replied the same day and said that Mr Safioulin did not have any clothes in reception, but the prison could supply more clothes if he needed them.
32. That day, a nurse saw Mr Safioulin for a second health screen. He told the investigator that he had noted from the records that Mr Safioulin had communication difficulties, but he had not realised the extent of them. He tried using an online translation service, using both Russian and Belarusian, and also tried using Language Line. However, he said Mr Safioulin became frustrated and verbally abusive, and left the room. The nurse suspected that Mr Safioulin might not be able to read well and possibly had a learning disability, so he referred him for an assessment.
33. Shortly afterwards, Mr Safioulin went back to see the nurse with a Russian-speaking prisoner who he wanted to use to help him communicate. The nurse noted that, although Mr Safioulin had a history of bipolar disorder, he denied any

- current mental problems and became aggressive when asked about it. He said he did not have any physical health issues, and asked only for hearing aids and glasses. (There are no further entries in his medical record to show that staff did anything about getting hearing aids or glasses.) The nurse noted that Mr Safioulin had been referred for a mental health assessment.
34. The nurse checked with the mental health team that someone was due to review Mr Safioulin. The nurse told them that using an online translation system was not sufficient. He also telephoned the safer custody department as he was concerned about Mr Safioulin's communication difficulties. It was suggested that the nurse should contact the prison's Head of Learning and Skills, who had some knowledge of BSL and that she would discuss Mr Safioulin with her manager, the Head of Safer Custody. There is no record that the Head of Safer Custody or anyone from the safer custody department took any further action.
 35. That afternoon a nurse from the mental health team and the A Wing supervising officer (SO) discussed healthcare staff's concerns about Mr Safioulin's communication problems and his mental state. She recorded her concerns in the wing observation book and noted that a formal mental health assessment could not be completed until a BSL interpreter was available. There is nothing to indicate that the wing SO took any further action or gave wing staff any guidance about how to manage their interactions with Mr Safioulin.
 36. A nurse also went to see Mr Safioulin that Friday afternoon, as she knew Mr Safioulin from his previous stay at Norwich in 2011. Initially he did not remember her, and became agitated, so she used Language Line to communicate. Mr Safioulin said people were treating him well. He said he did not like wearing hearing aids as he felt they affected his brain and made him depressed. He said he wanted to use sign language, in either English or Russian, and she told him that she would try to arrange a BSL interpreter. He seemed to be quickly angered and shouted at the telephone interpreter, but was easily calmed and the interpreter said he was not being abusive. After several questions, he said he did not want to answer any more. The nurse thought this might have been because he was frustrated about not being able to hear the telephone properly. She said that she would see him again on Monday and would ask wing staff to let the duty nurse know if there were any concerns over the weekend. Mr Safioulin said that he was tired and would like something to help him sleep. She spoke to a GP, who prescribed a short course of zopiclone.
 37. On Monday 9 February, the nurse went back to see Mr Safioulin, who was friendly, and signed hello. He indicated that he did not want to use telephone interpretation, but wanted to sign. She established through gestures that the medication had helped him sleep, and he was eating and drinking normally. She asked the librarian to provide some books in Russian.
 38. In the early hours of 10 February, Mr Safioulin pressed his cell bell a number of times, but when the night officer answered he could not understand what Mr Safioulin wanted. A nurse came to see him, and Mr Safioulin was touching his head and saying sleep, while making an eating gesture. The nurse gave him some paracetamol, and Mr Safioulin gave a thumbs-up gesture. The nurse checked Mr Safioulin's medical record and noted that he had not collected his

sertraline since it had been prescribed on 5 February. He indicated to Mr Safioulin that he should collect his medication from the medical hatch in the morning, and Mr Safioulin seemed reassured and calm. The nurse then used an online translation service to print some questions, but when he gave them to Mr Safioulin he would not respond. The nurse noted in his medical record that when he handed over to day staff he would ask them to ensure that Mr Safioulin was helped to get his medication.

39. On the afternoon of 10 February, a nurse saw Mr Safioulin with a colleague from the dental team who had some knowledge of BSL and confirmed that Mr Safioulin could use it. Mr Safioulin explained that he had been depressed in the past, but said that he had no current thoughts of harming himself. The nurse said she would try to arrange for a BSL signer to come into the prison later in the week, and advised him to prepare a list of questions.
40. On 11 February, the co-ordinating disability liaison officer, based on A Wing, went to see Mr Safioulin. (It appears that it took five days for the information on the disability induction questionnaire to reach the officer.) She put in place a personal emergency evacuation plan but nothing to address his hearing disability or how to help staff communicate with Mr Safioulin. She told the investigator that Mr Safioulin had moved to B Wing later that day, before she was able to do so.
41. On 12 February, a learning disability nurse and a nurse discussed Mr Safioulin. The nurse said that there were no indications that he had a learning disability. She said that he could sign fluently and appeared able to communicate well that way. They agreed that Mr Safioulin did not need a full learning disability assessment or any other support from the learning disabilities team at that time.
42. That afternoon, a nurse and the Head of Learning and Skills saw Mr Safioulin. The Head of Learning and Skills said that she found Mr Safioulin had a good understanding of BSL and engaged well. She said that her own level of BSL was not very high and so she could not understand everything that he signed. She noted in Mr Safioulin's prison record that he said communication was a problem and that made him feel depressed. He said that people were treating him as though he were stupid. He had told her he was just about able to read, that he felt healthy and was eating and sleeping okay.
43. In the early hours of 13 February, Mr Safioulin rang his cell bell a number of times. A nurse went to see him and, using an internet translation service, concluded that he was complaining that he had a headache and could not sleep. She gave him some paracetamol. He appeared to settle, though she noted that he spent most of the rest of the night sitting in a chair. She went to see Mr Safioulin again in the early hours of 14 February, and he said he could not sleep. A prison GP prescribed a five day course of zopiclone.
44. On the afternoon of 18 February, a nurse saw Mr Safioulin. As she was not planning to discuss medical matters she said she had asked a Russian-speaking prisoner to interpret. She had booked a BSL interpreter for 20 February. Mr Safioulin said that he was angry that he had had to make his last court appearance by video link (on 13 February) with only a Russian speaker to interpret. He said that he wanted a new solicitor, and that he might as well be dead. She asked if he had any thoughts of harming himself, and he said that he

was okay. She spoke to a Supervising Officer (SO) and suggested that Mr Safioulin might benefit from moving to the Russian speaking prisoner's wing to make everyday communication easier.

45. On 19 February, a member of staff noted in the wing observation book that a BSL interpreter was coming to see Mr Safioulin the next day and that if staff had any questions they wanted the interpreter to put to Mr Safioulin, they should contact a nurse.
46. At about 2.00pm on 20 February, the nurse saw Mr Safioulin with a BSL interpreter. During the meeting, Mr Safioulin said that he would kill himself when he was 50 years old. His 50th birthday was the following Tuesday, 24 February. The nurse immediately began ACCT procedures because of what he had said, although she told the investigator that she did not believe that Mr Safioulin actually meant to kill himself.
47. A SO completed an ACCT immediate action plan and noted that Mr Safioulin needed to remain in a single cell because of his mental health issues, and he needed input from the mental health team. He noted that he had explained to Mr Safioulin the support he could access from the Listeners scheme (prisoners trained by the Samaritans to offer other prisoners confidential support) and the Samaritans phone, though it is not clear how Mr Safioulin would have been able to use these services.
48. At 3.00pm, a nurse assessed Mr Safioulin as part of ACCT procedures, with the help of the BSL interpreter. Mr Safioulin said he had no partner, no family, no children and nothing to live for. He said he would kill himself when he was 50 years old, though not necessarily on his birthday. He said he might do it in March or in April. Although he had previously mentioned a suicide attempt in 2014, he said that he had not self-harmed since he moved to the UK in 1997. He said he did not want to self-harm but had thoughts of suicide. He would not say any more about this. He said he had been praying and reading the bible, but that many people were possessed by the devil. They discussed a possible move to C1 landing, where the Russian speaking prisoner lived, to help communication. The nurse referred him for further mental health assessment.
49. At 3.30pm, a SO chaired the first ACCT review, with a nurse and the BSL interpreter. When interviewed, the SO said that some of the answers Mr Safioulin gave to questions at the review were bizarre, giving random answers with no link to the questions asked. He said he did not want to move to C1 landing. He noted that Mr Safioulin's risk of suicide and self-harm was raised and that staff should check Mr Safioulin at least hourly for the next 24 hours. He did not complete an ACCT caremap with actions identified to help reduce risk and told the investigator that, because of Mr Safioulin's mental health problems, there were no specific issues he could list. He noted that Mr Safioulin's triggers for suicide and self-harm were his mental health issues and his upcoming birthday.
50. At 9.30pm that evening, Mr Safioulin pressed his cell bell, but refused to acknowledge the officer who responded. The next day, he would not go outside for a period of time in the open air. On 22 February, a wing officer gave him a behaviour warning when he threw a bucket of urine and excrement onto the

landing. He appeared to be angry, but officers were unable to find out why. The staff were concerned that his mental health appeared to be deteriorating and contacted healthcare staff to see if Mr Safioulin could be admitted to the inpatient unit.

51. At 1.20pm on 22 February, a nurse went to see Mr Safioulin with a BSL interpreter. He seemed distracted, and kept changing the subject in an apparent attempt to avoid answering questions. He said he was sleeping and eating well. He had been praying and reading the bible, and said he was concerned that some people on his wing were possessed by the devil. When the interpreter tried to question him about this, he said that she too was possessed. He explained that earlier he had used a bucket as the devil was in his cell toilet and he could hear voices coming from it. He would not answer questions about his previous mental health. He said he was concerned that his blood had gone black. The nurse referred Mr Safioulin to the mental health team the next day for a review, and to see a psychiatrist the day after. She booked the BSL interpreter for these appointments. She did not record whether she thought his risk of suicide and self-harm had changed.
52. In the early hours of the morning of 23 February, Mr Safioulin repeatedly pressed his cell bell but refused to engage with the prison officer who responded. When a prison officer checked on him at 7.10am, he appeared to be arguing with himself. When prisoners were locked into their cells at lunchtime, he pressed his cell bell, but again refused to speak to the officer who answered. That afternoon he declined to go outside for an exercise period in the open air.
53. As a particular nurse was on leave from 22 February for three weeks, another nurse had taken over as his case manager. She went to see Mr Safioulin but was unable to assess him because of the communication difficulties. Records do not show why the BSL interpreter was not present, although the previous nurse had booked one. The nurse rescheduled the review for the next day, to ensure she had a BSL interpreter. Through that evening and night, prison officers noted that Mr Safioulin behaved in a bizarre manner. He was shouting and talking to himself, he rubbed soap in his eyes, which he had mixed with the contents of teabags. At 9.30am on 24 February, he again pressed his cell bell but would not engage when staff answered. A note in his medical file shows that he had not been collecting his medication. Although the previous nurse had recorded that Mr Safioulin's mental health issues were a potential trigger for suicide and self-harm, no one convened an ACCT review or considered whether his behaviour and apparently deteriorating mental health, indicated an increase in his risk.
54. That afternoon a consultant psychiatrist assessed Mr Safioulin, using a BSL interpreter. The psychiatrist noted that Mr Safioulin had previously been admitted to a psychiatric hospital, and was displaying clear evidence of psychotic illness. Although Mr Safioulin was refusing medication, the psychiatrist considered he needed to be medicated and he prescribed olanzapine. He thought that Mr Safioulin should be considered for transfer to hospital under the Mental Health Act. His symptoms were not acute, and the psychiatrist did not consider him to be at risk of suicide or self-harm and recommended that a doctor from the mental health team should assess him again two days later. The psychiatrist arranged to review Mr Safioulin the next week. He noted in his

medical record that, if Mr Safioulin's mental health deteriorated in the meantime, staff should consider transferring him to the healthcare inpatient unit.

55. A SO was due to chair an ACCT review on 25 February. However, she had not booked a BSL interpreter so postponed the review until the next day. Mr Safioulin would not collect his medication that evening, and the next morning.
56. On the afternoon of 26 February, a doctor and a nurse assessed Mr Safioulin using a BSL interpreter. Mr Safioulin refused to go to the consulting room as he said he was frightened that the devil might harm him, so they saw him in his cell. He said that he was concerned that the devil was interfering with his food, so he was only eating half of it. The doctor noted that he was clearly psychotic and might have paranoid schizophrenia. She referred him for a hospital assessment, which was faxed to the hospital immediately. She did not record whether she considered Mr Safioulin to be at risk of suicide or self-harm.
57. After the assessment, a SO spoke to a nurse instead of holding the rescheduled ACCT review. The SO said that she did not ask Mr Safioulin if he wanted to attend the review, but thought that, as he had just had a mental health appointment, it would be stressful for him to be asked more questions. The nurse said that Mr Safioulin's concerns about the colour of his blood might mean that he would cut himself to check. The SO raised the observation level to twice an hour. The SO noted on the caremap that, because of language difficulties, managers arranging reviews would need to book a BSL interpreter. Mr Safioulin had not been collecting his meals or his medication, and she noted that wing officers should ensure that he did. She noted that he was suffering from mental health problems, which might result in transfer to a psychiatric unit.
58. The next afternoon, as the nurse had predicted, Mr Safioulin deliberately cut his finger. He refused to let a nurse examine it, but she was satisfied that the injury was very minor. At 9.10pm, a prison officer noticed that Mr Safioulin's finger was bleeding, but Mr Safioulin said he did not want any help.
59. On the morning of 1 March, Mr Safioulin took off his trousers and put them in the bin. Staff gave him a new pair, which he put on. A nurse from the mental health team went to see him, but Mr Safioulin refused to engage with him. That evening he did not collect his medication.
60. On the morning of Tuesday 3 March, the psychiatrist, with a BSL interpreter and a nurse, assessed Mr Safioulin. Mr Safioulin was suspicious that the psychiatrist was not a real doctor and was selective in the questions he would answer. He said that the colour black was associated with the devil, and he had cut his finger to check the colour of his blood. He said that sometimes the television in his cell would talk to him during programmes. The psychiatrist noted that Mr Safioulin was not taking his medication. He said that there was clear evidence of mental instability. The psychiatrist told the investigator that he had not considered that Mr Safioulin was at risk of suicide or self-harm at the time.
61. Later that day, the mental health team discussed Mr Safioulin in a team meeting. The psychiatrist said prison was not a suitable place for him and he should be in hospital. Officers on his wing were concerned about his inappropriate behaviour and had asked if he could be moved. Mr Safioulin was showing evidence of

- psychosis and delusional ideas, and the meeting agreed that he should transfer to the prison's inpatient unit.
62. After the meeting, a nurse telephoned a forensic psychiatry registrar responsible for assessing Mr Safioulin for a hospital place. He said that he would be unable to assess him before 10 March.
 63. A SO had been due to chair an ACCT review on the afternoon of 3 March, and discussed Mr Safioulin with a nurse. The SO again decided not to involve Mr Safioulin. The nurse told the investigator that he had not realised that their discussion would be logged as an ACCT review. The nurse told the SO that Mr Safioulin had not engaged with the psychiatrist that morning and was claiming that people were the devil. He said that Mr Safioulin might transfer to the healthcare centre. The SO left the observation levels unchanged at twice an hour and did not update the caremap, as she believed that his issues remained unchanged. The SO said that she felt the mental health team were taking the lead in supporting Mr Safioulin. That evening, and the next morning, Mr Safioulin declined his medication. There is no record that healthcare staff took any action as a result.
 64. On 6 March, it was agreed that Mr Safioulin would move to the healthcare centre as an inpatient, as soon as there was space. A nurse and a member of the mental health team went to see Mr Safioulin with a BSL interpreter. Mr Safioulin was agitated and refused to engage. He did not want to go outside for an exercise period that afternoon. The next morning, he collected his medication and mixed with other prisoners. However, that afternoon and the next morning he would not come out of his cell. On 9 March, he came out of his cell but did not collect his medication.
 65. At 10.00am on 10 March, a SO chaired an ACCT review, with an officer and a BSL interpreter present. Mr Safioulin attended only reluctantly and was very cautious of the others and said he believed them to be the devil. He did not engage well, but said that he had no thoughts of harming himself. The SO assessed his risk of suicide or self-harm as low, and reduced the level of observations to twice each morning, afternoon and evening, with three observations during the night. He did not update or make any changes to the caremap.
 66. That morning, a forensic psychiatrist doctor, with the help of a BSL interpreter, assessed Mr Safioulin. He noted his history of mental illness and his current delusional ideas. He recorded that Mr Safioulin was withdrawn and paranoid, did not fully understand the situation he was in, or that he was unwell, and he did not want any medication. He said he had no thoughts of harming himself. During the assessment, he became uncooperative and left. The doctor thought that Mr Safioulin had suffered a psychosis relapse, and needed to be transferred to hospital. The forensic psychiatrist discussed Mr Safioulin with another psychiatrist and, although he had been refusing to take his medication, they agreed to change the prescription to aripiprazole (an antipsychotic). The next day, 11 March, the forensic psychiatrist telephoned the prison and said that a hospital, had agreed to accept Mr Safioulin when a bed was available.

67. On 12 March, staff noted in Mr Safioulin's prison record that he was behaving in an erratic manner, invading other prisoners' personal space. Officers were concerned for his safety and contacted the healthcare team to ask for an urgent move to the inpatient unit. Healthcare staff again said that they would take him as soon as they had a space. No one held an ACCT review or considered whether Mr Safioulin's behaviour meant that his risk had altered and whether his level of observations needed to be changed.
68. A few days later, Mr Safioulin asked Officer A for some nail clippers. The officer said that they did not have any, and another prisoner explained to Mr Safioulin how to order some, which he seemed to understand and accept. The officer recorded in the ACCT document that he had no concerns about Mr Safioulin.
69. At 12.00pm, Mr Safioulin collected his meal and, although he seemed quiet, there were no apparent problems. According to CCTV footage, at 2.03pm, Officer A opened the observation panel in Mr Safioulin's cell door and looked in, before he unlocked the door and moved to the next cell. The officer noted in the ACCT record that he had checked Mr Safioulin and he was sitting on the bed looking out of the window at the time.
70. At 3.00pm, officers began checking which prisoners wanted to go outside for an exercise period. The CCTV shows that Officer A arrived at Mr Safioulin's cell at 3.05pm. He looked through the observation panel and said that Mr Safioulin appeared to be sitting on the bed at a strange angle. He went into the cell and found that Mr Safioulin had hanged himself by a bed sheet tied to the bunk bed frame. He tried to radio a code blue (an emergency medical code indicating a prisoner is unconscious or not breathing) but got no reply. He then left the cell and pressed the alarm button on the landing wall. The alarm records (which have slightly different timings from the CCTV) shows that the general alarm was activated at 3.03pm. As the officer went back into the cell he shouted for help and again radioed a code blue emergency. Recordings of the radio traffic show that this was at 3.03pm, just after the general alarm. The officer cut the sheet from Mr Safioulin's neck, using an anti-ligature knife.
71. An officer was on duty in the control room and heard the general alarm and then the code blue call. He radioed for the healthcare emergency responder and the duty manager to go to B Wing, then telephoned for an ambulance.
72. Other staff responded quickly and as Officer A was cutting the ligature, a SO and another officer arrived followed shortly afterwards by a third officer. The SO radioed another code blue call (recorded at 3.04pm). He checked Mr Safioulin for a pulse, but could not find one and then began to try to resuscitate him.
73. Two nurses arrived at the cell approximately two minutes later and took over the resuscitation attempt. One nurse could find no signs of life. They applied a defibrillator, which found no shockable heart rhythm, and continued cardiopulmonary resuscitation. Paramedics arrived at Mr Safioulin's cell within seven minutes of the initial 999 call and took over emergency treatment. At 3.30pm, an ambulance service doctor pronounced Mr Safioulin dead.

Mr Safioulin's next of kin

74. Mr Safioulin had not listed any next of kin. He had not made any telephone calls in prison, and had told staff that he had no family. He had been brought up in an orphanage. The prison asked the police and the coroner's office for help in tracing anyone to act as next of kin but despite many attempts, both in the UK and in Belarus, they were unable to do so. No one remembered that a nurse had phoned a friend of Mr Safioulin on 5 February or contacted him again after Mr Safioulin died. The prison arranged Mr Safioulin's funeral.

Support for prisoners and staff

75. Managers debriefed staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. Staff told the investigator that managers and the prison's care team had given them good support. Staff reviewed prisoners assessed as at risk of suicide and self-harm, in case they had been affected by the news of Mr Safioulin's death. They spoke to the prisoners in the cells either side of Mr Safioulin to ensure that they had not been adversely affected.

Information received after Mr Safioulin's death

76. After Mr Safioulin died, a prisoner in the next cell told a member of the IMB that he had heard Mr Safioulin tearing bed sheets. He told the investigator that three or four days before Mr Safioulin died, he had heard the sound of bed sheets tearing coming from his cell. He said he reported it to a prison officer, who told him that Mr Safioulin was being monitored under ACCT procedures, and not to worry about it. He did not know the officer, who did not normally work on B Wing. When he later heard the sound of sheets ripping again, he did not report it as he had already been reassured. There is no record of this conversation in Mr Safioulin's ACCT document, or the wing observation book. We were unable to identify the officer who spoke to the prisoner, and so have not been able to investigate it further.

Post-mortem report

77. The post-mortem examination concluded that Mr Safioulin died from hanging. There were no traces of alcohol or illegal drugs in his system, and no natural disease that could have caused his death.

Findings

Communicating with Mr Safioulin

78. When Mr Safioulin arrived at Norwich, it quickly became clear that communication with him would be difficult. He was very hard of hearing, was Belarusian and did not speak English or Russian well. However, entries in his prison records all refer to him as Russian. Some staff suspected that he had low literacy levels and possibly a learning disability. As time went on his mental health deteriorated. Mr Safioulin's preferred method of communication was British Sign Language (BSL), although he could sometimes manage, with difficulty, to lipread, talk through a Russian interpreter or use an online translation service.
79. Staff tried to respond to Mr Safioulin's complex communication needs but there was no coordinated strategic approach. The mental health team and a particular nurse actively arranged a BSL interpreter for appointments but no one drew up a care plan to help meet his needs and advise on his management. Prison Service Instruction (PSI) 32/2011, covering equality issues, requires prisons to make reasonable adjustments to enable prisoners with disabilities to take full part in the normal life of the establishment but there was no comprehensive assessment of Mr Safioulin's needs when he arrived.
80. The first use of a BSL interpreter was not until 20 February, 15 days after he arrived at Norwich. Wing staff clearly had difficulties communicating with Mr Safioulin but no one had advised them about how to engage with him. This became more important once Mr Safioulin was identified as at risk of suicide and self-harm and when his mental health began to deteriorate. We are concerned that there was no system to make sure that a BSL interpreter was booked to attend ACCT reviews or to ensure he received an appropriate induction.
81. The principal difficulty communicating with Mr Safioulin was his hearing disability, which made use of language interpreters, either in person or by telephone problematic. According to Norwich's local disability policy, the disability liaison officer is responsible for managing and overseeing the needs of prisoners with disabilities. The co-ordinating disability liaison officer, who was based on A Wing, completed Mr Safioulin's evacuation plan but played no further part after he moved to B Wing later that day. There is no record of the B Wing disability liaison officer meeting Mr Safioulin. (Nor is there any record of involvement by the foreign national prisoners' co-ordinator.) The clinical reviewer considered that Mr Safioulin could have had a learning disability, but he did not have a formal assessment.
82. The communication problems led to some obvious omissions. Mr Safioulin did not receive a full induction, contrary to Prison Service Instruction (PSI) 07/2015 (which covers early days in custody), his mental and physical health needs could not be properly and swiftly identified and he said he felt isolated and frustrated. We acknowledge that Mr Safioulin presented with a rare and complex set of needs and some good efforts were made, particularly by healthcare staff, to meet them. However, we are not satisfied that the systems for identifying and responding to disability needs were sufficiently robust and did not meet the

requirements of Norwich's own local Disability Policy, or requirements in national instructions:

The Governor should ensure that the needs of prisoners with disabilities are identified on reception and that there is a coordinated and multidisciplinary approach to meeting the needs of those with complex conditions through effective care plans which outline the reasonable adjustments required to allow them to participate fully in prison life.

The Governor should ensure that accredited sign language interpreting services are used for prisoners who are deaf or hearing impaired, and reliant on sign language, whenever matters of accuracy or confidentiality are a factor.

Managing Mr Safioulin's mental health care

83. The clinical reviewer concluded that Mr Safioulin's mental health problems were appropriately identified and, initially, well managed. She noted, however, that when a nurse went on leave, Mr Safioulin's management was inconsistent. He continually refused to take his medication but there is no evidence of any strategy to encourage him to comply. There is little evidence of the mental health team monitoring him between the psychiatrist's reviews, despite the notes showing him to be in a psychotic state. There are no entries in his medical record for the last four days of his life. He had been accepted for a transfer to the inpatient unit on 6 March, and there was a note on his prison record that wing staff thought it was becoming critical for him to move there, yet a space was not found for him before he died.
84. The clinical reviewer noted that Mr Safioulin's referral to a low secure psychiatric unit was appropriate and within the expected standard of two weeks. She concluded that Mr Safioulin received care equivalent to that which he could have expected in the community. We make the following recommendation:

The Head of Healthcare should ensure that prisoners under the care of the mental health team have appropriate continuity of care and that prisoners waiting for transfers to hospital under the Mental Health Act are actively monitored and prioritised for beds in the prison's inpatient unit when judged clinically beneficial.

Managing Mr Safioulin's risk of suicide and self-harm

85. Mr Safioulin's Person Escort Record noted that he had tried to kill himself in 2014. However, staff who assessed him when he arrived at Norwich did not consider that he was at risk of suicide or self-harm. On 20 February, when a BSL interpreter was first used, Mr Safioulin told a nurse that he would kill himself after his 50th birthday, four days later. The nurse immediately began ACCT procedures, which continued until he died.
86. We have some concerns about the management of the ACCT process. The SO who chaired the first case review did not make any entries in the care map because he considered Mr Safioulin's problems related wholly to his mental health. PSI 64/2010 gives guidance on ACCT management, and says that by

the end of the first review the caremap should contain detailed and time bounded actions that reflect the prisoner's needs, level of risk, and triggers of distress. Mr Safioulin wanted to work, had communication problems and was in clear danger of being isolated on the wing, all of which could usefully have been addressed in caremap actions and were not medical matters.

87. Another SO added some care map actions on 26 February, but there is no evidence that these were reconsidered or updated at later reviews. Caremaps are important tools to help identify and implement actions to help reduce a prisoner's risk of suicide and self-harm and it is important that these are completed effectively and reviewed at each ACCT case review. In April 2014, we published a Learning Lessons bulletin, in which we found that one in four prisoners in the sample who killed themselves while being managed under ACCT procedures, did not have an adequate caremap.
88. Of Mr Safioulin's four ACCT reviews, only two were chaired by the same case manager. A SO was expecting to chair two case reviews, but because Mr Safioulin had had mental health appointments earlier in the day, decided not to invite Mr Safioulin to the reviews. Instead she had conversations with mental health nurses, one of whom did not realise the conversation would form the basis of the review. Mr Safioulin was not involved in ACCT reviews from 20 February until 10 March. PSI 64/2011 says that ACCT reviews must be attended by the prisoner unless there are specific reasons why this would not be possible. The ACCT document shows that he was not involved in the reviews on 26 February and 3 March because of communications difficulties, but these difficulties were known in advance and an interpreter should have been used.
89. As Mr Safioulin's mental health was a key concern, we are pleased that mental healthcare staff were always present at case reviews. Staff had noted that Mr Safioulin's mental health might be a trigger for suicide and self-harm. However, when his mental health deteriorated, wing staff did not convene additional ACCT reviews, reconsider his level of risk or review the level of observations.

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines. This should include:

- **continuity in case management,**
 - **properly completed and updated caremaps,**
 - **holding ACCT reviews whenever an event occurs that could mean the prisoner is at increased risk,**
 - **properly convened and recorded reviews, which involve the prisoner wherever possible.**
90. Although we were concerned about some aspects of the management of Mr Safioulin's risk, we acknowledge the inherent difficulties in assessing the risk he posed to himself. Staff were clearly concerned about Mr Safioulin's mental health, and he was due to move to a secure hospital. However, there were no clear indications that his risk of suicide had increased substantially in the days before his death.

