Circumstances surrounding the death of a man at HMP Norwich on 11 June 2005

Prisons and Probation Ombudsman for England and Wales

November 2005

The man was aged just 28 when he died on 11 June 2005 in his cell at HMP Norwich. He had been found hanging from the bars at his window. This is a report into the circumstances surrounding his death.

The loss of any family member is distressing, but especially so when they are in custody, have mental health problems, and have apparently taken their own life. I offer my sincere condolences to the mans family and friends.

A member of my office carried out the investigation. I wish to thank the Governor of Norwich, for making the necessary facilities available to my investigator and for the help and support of the Liaison Officer. Additionally, I wish to commend the Governor, his Area Manager, and his Head of Healthcare for their whole approach towards this investigation. This has resulted in immediate action being taken to remedy the majority of my investigator's findings.

In the course of the investigation, I asked for a clinical review to be carried out into the care and treatment received by the man. I am extremely grateful to the Assistant Director of Quality and Nursing, Norwich Primary Care Trust (PCT), for her assistance. Again, an excellent relationship was developed between her office and my investigator. Her report identifies serious concerns regarding the nursing care received by the man whilst in prison and she has recommended a separate disciplinary investigation into the actions of a nurse. I support her findings and recommendations.

I am satisfied that the officers and medical staff who attempted to resuscitate the man did everything they could to try to save him. However, I am concerned that his identified mental health problems and the warning signs he gave were not communicated appropriately.

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2005**

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Summary

1. On 30 May 2005, Norwich Magistrates' Court remanded the man into custody. He had been charged with common assault and criminal damage. The same court further remanded him on 2 June, and again on 9 June. He was due to return to court on 27 June, having been refused bail.

2. The man had a history of mental health problems, and had been a voluntary in-patient at a local psychiatric hospital on at least six occasions. He had a history of personality disorder, compulsive behaviour, self-harm and substance misuse, which had been identified by a member of the Healthcare team during the reception into prison custody. However, a further assessment carried out on 9 June, by a Staff Nurse seconded to the Mental Health In-reach Team, failed to inform anyone of his assessment that the man was hearing voices which commanded him to harm himself or others.

3. The Coroner made available to my investigator a number of documents relating to the man's mental health, which he had received from a solicitor whom he had previously used. The documents raise concern at the level of care that the man received during an earlier period of custody. My investigator made a copy of the correspondence available to the PCT for their consideration.

4. On the evening of 11 June, an officer found the man hanging from the window bars in his cell. Attempts were made to resuscitate him but were unsuccessful. He was pronounced dead at 8:56pm.

5. My report makes seven recommendations in addition to those in the Clinical Review.

The man

6. The man was born on 15 April 1977 in Grays, Essex. He was aged 28 when he died.

7. He was the youngest of four children, with two sisters and one brother. He attended a local primary school and secondary school. He enjoyed music and football and was a supporter of Liverpool Football Club.

8. He first came to the attention of the courts in his mid-teens and was first convicted in 1992. Since that time he had accrued a total of 16 convictions, with the most recent being in September 2004. He had served custodial sentences in young offender institutions and prisons.

9. The man had a long history of psychiatric problems and had been admitted to a local psychiatric hospital, as a voluntary in-patient, on six occasions.

HMP Norwich

10. Norwich prison holds convicted and remand prisoners, including adults and young offenders. It is designated as a local prison and serves the courts of East Anglia. The Certified Normal Accommodation is 591, and an operational capacity of 823. The current Governor was appointed In December 2004.

11. A car park and road divide the prison. The majority of the population is accommodated in the main prison complex. The other section of the prison accommodates young offenders and the Healthcare Centre, which also includes an elderly prisoner unit. The Healthcare Centre has out-patient facilities, as well as in-patient beds for prisoners with physical health problems and severe and enduring mental health needs.

12. In March 2005, Her Majesty's Chief Inspector of Prisons (HMCIP) carried out a full announced inspection of the prison. In her introduction she said that there were unacceptable deficits in safety and key recommendations from seven recent deaths in custody had not been implemented. I identify similar findings later in my report. She also identified that the management of prisoners who were at risk of self-harm was poor. Additionally, HMCIP said that key functions within the prison were inadequate, and had been poorly managed. Support plans for prisoners at risk were poor, access to the Samaritans restricted, and prisoners' cell alarm bells regularly muted. However, the report also said that, since the appointment of the new governor, performance improvement was under way. This too is recognised within my report.

13. All prisons undergo internal audit inspection by the Prison Service Standards Audit Unit (SAU). The SAU examine the establishment's compliance when measured against national standards and award overall scores for Standards, General Standards (Critical Baselines) and Security. Following an audit, the Governor is issued with an action plan identifying areas where improvement is required in order to bring the performance up to the required standard. The Governor is required to comment against each area identified and explain how and when the action will be completed.

14. In October 2004, HMP Norwich was audited and it was identified that six critical baselines, which included suicide and self-harm, were non-compliant. On 19 May, an internal re-assessment of the six baselines identified that they were still non-compliant.

    The overall scores awarded were:

    - Standards, 88 per cent.
    - General Standards (Critical Baselines) 80 per cent.
    - Security, 78 per cent.

15. The executive summary noted that the score for the subjects under the Safety banner was the lowest at 76 per cent. Attention was needed in the areas of Segregation, Use of Force and Suicide and Self-Harm.

16. During my investigator's first visit to Norwich after the man's death, he identified that the baselines had still not been acted on and he raised the finding with the Governor. I understand that the Governor has now given the responsibility for suicide prevention and the action plan to the Deputy Governor, and that he has implemented the baselines. The Deputy Governor has introduced a robust monitoring system, including a daily management check of all active F2052SH (suicide and self-harm) documents. Additionally, he reviews and assesses all F2052SH documents that have been recently closed. He has tasked another manager to ensure that the audit baselines are complied with.

17. Each prison has an Independent Monitoring Board (IMB). Their role is to monitor the prison and to report any concerns that they have regarding the prison or how prisoners are treated. They feedback in the first instance to the Governor, but they may write directly to more senior officials or to Ministers should they wish. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Board produces an annual report for the Home Secretary.

18. The Norwich IMB Annual Report for the period 1 March 2004 to 28 February 2005 raises a number of concerns, two of which relate directly to aspects of my investigation. These are:

    - grave concerns for prisoners with severe mental health problems, who should not be in the criminal justice system; and
    - a higher profile for suicide prevention with lessons being learnt from the past.

    The IMB also comment on delays in the holding of inquests following a death in prison custody.

19. The Governor has a Service Level Agreement that he has agreed with the Area Manager and which sets out the priorities for the prison. Priority two of the agreement relates to suicide prevention.

20. The prison has a number of prisoners who have been trained by the Samaritans in how to help and support any prisoner who feels vulnerable or is considering suicide or self-harm. They are known as Listeners and their work is carried out on a confidential basis, overseen by a member of the Samaritans team. The Governor has recently appointed a Principal Officer as the manager with responsibility for the Listener scheme. His role is to raise its profile, which sadly has been neglected. My investigator spoke to one Listener who said that, since the Principal Officer took over, he had seen noticeable improvements at the prison, especially freephone

telephone access to the Samaritans. He also said that access to Listeners at times when prisoners are locked in their cells was a problem, as not all staff will unlock prisoners or Listeners. My investigator has confirmed that the man did not ask to speak to a Listener.

21. An examination of the minutes of the Suicide and Self-Harm meetings shows evidence that access to Listeners during the night-time has been raised previously, as not all night managers have facilitated the scheme. This is not acceptable and requires urgent attention. My investigator fed this back to the Governor during his regular briefings with him, and I believe that the Governor has taken steps to address this. My investigator also met with the Principal Officer. It was clear that not all staff have embraced the Listener scheme, and its implementation presents a considerable challenge. Given that the Listeners have been successfully in place at most prisons for a number of years, it is disappointing that a prison like Norwich does not have the foundations right. I have been pleased to learn of plans to re-focus the work of the Listeners and heighten staff awareness.

    The Governor should remind staff of the value of the Listener scheme and, as a matter of priority, ensure prisoners have the opportunity to meet with a Listener at any time of the day or night.

22. In Reception, a Listener is available at all times that prisoners are being received into the prison. They introduce themselves to new prisoners, explain their role and issue the Samaritans' freephone telephone number. Prisoners can readily identify Listeners, as they wear either a black T-shirt, with Listener written on the shirt, or by a name badge. However, photographs of the Listeners are not displayed anywhere. In addition to Listeners, a number of prisoners are trained as 'Insiders'. The role of Insiders is to explain the regime and how prisoners can access information. I note that, in contrast to the Listeners, photographs of Insiders are displayed around the prison. Considering the importance of the work carried out by Listeners, it might be sensible also to display photographs of Listeners throughout the establishment.

    The Governor should consider displaying the photographs of all Listeners.

23. The Prison Service has a well-established Policy on Suicide and Self-Harm Prevention and it is for the Governor of each establishment to prioritise any training in the subject. The training includes the use of the Self-Harm at Risk Form (F2052SH) which can be opened by any member of staff who has concern about the safety of a prisoner. As a minimum, prison staff are required to report on the prisoner's mood and behaviour, at least daily. However, the level of observation is decided on a case by case basis, dependant on the level of risk of suicide or self-harm. Once the document has been opened, the prisoner is invited to meet with a multi-disciplinary team who assess the reasons behind the raised concern and jointly agree an action plan with the prisoner. The team has a wide

range of support interventions available to them and will design a plan to fit the individual needs. The plan is reviewed regularly and only closed when the team agrees that the raised risk of self-harm has been reduced.

24. The report from HM Chief Inspector of Prisons said that, given the prison's recent history, she was dismayed to discover other negative features of the suicide and self-harm arrangements. Support plans for at-risk prisoners were inadequate, entries in F2052SHs often demonstrated no engagement with prisoners, care suites were of a poor standard, some Samaritan telephones were broken or missing, cell bells were regularly muted and personal identification number calls to Samaritans were cut off after seven minutes. While there were some positive aspects to the anti-suicide arrangements, the Chief Inspector considered that this area required major and urgent senior management attention.

25. Although the man was not being monitored under the F2052SH procedure, there is evidence to show that on 12 November 2004, during a previous period in custody, he had been monitored. He told an officer then that he had a history of self-harm, and had attempted suicide by heroin overdose three weeks previously. An entry in the F2052SH "Summary of Review" section said that the man admitted that he was impulsive and therefore at risk that he might self-harm. A case review was carried out on 24 November 2004 and a decision taken to close the document. However the chair of the meeting did not record whether the man attended the review or not.

26. Although I do not think that a formal recommendation on this point is required, the Governor will wish to satisfy himself that staff are now fully completing the F2052SH documentation.

27. I am aware that the Governor has introduced a system whereby he or the Deputy Governor reviews all active F2052SH documents each morning at his management meeting. Additionally, the Deputy Governor reviews the entries at his Suicide and Self-Harm meeting. The purpose of the reviews is to examine the quality of the entries being made and the appropriateness of the action plans. It is evident that he is raising the profile of Suicide and Self-Harm amongst his managers, and I welcome this. Commitment from his managers is required to ensure that they cascade and enforce the monitoring, and appropriately challenge entries and decisions. Additionally, staff need fully to understand the Governor's message about the importance of Suicide and Self-Harm prevention, intervention and support mechanisms. Information is communicated through the local IT system, but a more formal re-training programme may be best to deliver the information and ensure that everyone understands what they are required to do.

    The Governor should ensure that Suicide and Self-Harm prevention refresher training is prioritised and delivered to all staff employed at the prison.

28. My investigator was surprised to find that the minutes of the Suicide and Self-Harm meeting held on 17 June 2005 did not show that the meeting acknowledged or referred in any way to the death of the man. Although the Governor had issued Notices to Staff and Prisoners informing them of his death, an acknowledgement in the minutes would have been appropriate.

29. Since September 2001, there have been 15 deaths at Norwich, plus two men who died shortly after being released. Of the deaths in custody, ten appear to have been self-inflicted, with five of the prisoners being monitored under the F2052SH procedure at the time.

30. Prior to April 2004, the Prison Service investigated the circumstances of all deaths in custody, and then produced a report containing any necessary recommendations. The report and recommendations were issued to the Area Manager and relevant Governor, and it was their responsibility to produce an action plan and implement any recommendations. Soon after the Governor's, he reviewed the recommendations from the previous investigations and found that 48 had not been acted upon. He has since produced his own action plan and begun the process of implementing the recommendations. However, a number remain outstanding which should be dealt with as soon as possible. HM Chief Inspector also identified this matter and reported that there have been seven self-inflicted deaths in the past three years. The inspection team was seriously concerned to find that action plans had not been fully implemented, even where a remedy was quick and easy to implement such as staff carrying ligature shears. The Chief Inspector recommended an immediate review of progress against actions arising from all seven deaths in custody investigations, and that all outstanding recommendations should be implemented quickly.

Conduct of the Investigation

31. The investigation opened at the prison on 17 June 2004. My investigator met with the Governor, Liaison Officer, PCT and Healthcare Manager, and received a briefing about the circumstances surrounding the man's death. He then visited the cell where the man had been found.

32. A number of prison documents were made available by the Governor, which the investigator read. The prison records and reports helped identify which members of staff the investigator would seek to interview.

33. A number of prison staff and managers were interviewed and, in the majority of cases, the interviews were carried out using recording equipment. One prisoner had written to me requesting a personal meeting. I passed his letter to my investigator, but when the investigator met with him the prisoner terminated the interview. He said that he was in direct correspondence with the Coroner and he had advised him not discuss the man's case with anyone. One other prisoner was interviewed.

34. A clinical review was commissioned to review the care and treatment received by the man during his time in custody.

35. Sadly, whilst my investigator was investigating the man's death, another prisoner was found hanged in his cell at Norwich. As a result, the Area Manager commissioned a team of his own staff to review prisoner care arrangements at the establishment. I welcome this review.

36. One of my Family Liaison Officers (FLO) attempted to contact the man's aunt, whom the man had identified as his next of kin. However, it is the sister who took over responsibility for speaking on behalf of his family. She raised questions regarding the care the man received, and I hope that my report will provide her with the answers. Additionally, she believed that the man had a property in the Norwich area, but did not know the address. My FLO identified the property and passed the information on to the man's sister. She said that his family was happy with the after care they received from the prison, and in particular the support of the Governor. She added that the Governor offered assistance with the cost of the funeral. In sad circumstances, this was all good practice that reflects well upon the Governor and the Prison Service as a whole.

37. My investigator met regularly with the Governor to brief him of his findings, which the Governor gave an assurance he would action. Following the Area Manager's own Review of Prisoner Care, which was carried out independently to my own report, my investigator met with the Governor and Area Manager to feedback his overall findings and assessment of the mans care and treatment. The meeting was constructive and assured the investigator of the extent to which suicide prevention was now a priority for the establishment.

Key Findings

38. On 30 May 2005, the man arrived at Norwich's Reception Department, having been charged with common assault and criminal damage. Had he been returning to custody following a period of licence, his original prison file would have been available under his old prison number. However, as he had been remanded into custody on a new charge, he was issued with a new prison number. This meant that his previous prison record, and especially information relating to his mental health problems, was held under his previous prison number. The information was not accessed, although it was still available, as it was stored in the prison records room. The old file included the F2052SH form opened on 11 November 2004. It is the usual procedure in reception that all prisoners are asked if they have been in custody before, but staff are not required to ask for previous prison numbers.

    The Governor should ensure that previous custodial periods are linked to earlier prison numbers and the records of any prisoner identified during the reception procedure as being at risk, or as having serious health problems, obtained and examined.

39. The same day, a member of the prison nursing team interviewed the man to complete the initial screening interview. He identified that he had seen a doctor due to a personality disorder and impulsive behaviour. He recorded in the First Reception Health Screen in answer to question ten, "have you ever tried to harm yourself" that the man said:

    > *yes, outside prison, the other day, 1.5g heroin*.

    As the man said yes to the question, the form asks the writer to consider opening a F2052SH. My investigator found no evidence that the nurse had considered opening a F2052SH, other than this entry in the "Continuous Clinical Record" (CCR):

    > *states he feels fine at present and does not feel like self-harming.*

    Additionally, the nurse noted that the man asked for assistance regarding drug misuse.

40. On 31 May, a locum GP met the man to discuss his request for drug misuse assistance. The doctor prescribed medication. As the man had previously been a voluntary in-patient at Hellesdon Hospital, which is a psychiatric hospital, the doctor requested his past medical records from his external psychiatrist and doctor. The notes had not been received by the time the man died.

41. On 3 June, a nurse at the prison carried out a secondary health screen interview with the man. She identified mental health issues and referred him to the Mental Health Inreach Team, as a non-urgent referral. She

noted in the Secondary Health Screen document, under the heading Mental Health, History of Self-harm:

> *last year 2004 – OD. Attempted OD 4-5 days ago of IV heroin. Doesn't feel like self-harming at present.*

OD means overdose and IV means intravenous. My investigator found no evidence to show that the nurse opened or considered opening an F2052SH form, although she wrote in his CCR that he:

states he feels fine at present and does not feel like self-harming.

42. My investigator discussed these records with the Head of Healthcare at HMP Norwich. She was satisfied that the entries in the CCR show that the nurses had discussed any thoughts of self-harm with the man. However, she agreed that nurses should be reminded to record whether they considered opening an F2052SH form. I understand that she has issued new instructions to staff about the need to record information accurately.

43. Each prison offers a drugs advice service to prisoners known as the Counselling Assessment Referral Advice and Throughcare team (CARAT)). This is able to offer help and support whilst in custody and to refer prisoners onto external agencies who offer similar support following release from custody.

44. On 6 June, the man made a self-referral application to the CARAT team at Norwich. The reason for referral was given as:

> *general support inside. Support outside – engaged with Norcas.*

(Norcas is an alcohol support agency, based in Norfolk.) Although the application was submitted to the CARAT team, an initial assessment had not been completed by the time the man died. The application form does not indicate that he had any thoughts of harming himself.

45. On 9 June, a seconded nurse from the prison healthcare team, who works as part of the Inreach Team, interviewed the man. He made the following entry in his medical record:

> *had a genuine psychiatric problem and should be reviewed by a psychiatrist if possible*.

He further noted:

> *appears genuinely troubled and in need of help.*

The nurse also wrote in the medical record that the man was:

> *hearing command type voices instructing him to hurt himself or others.*

46. Following the man's death, the Head of Healthcare reviewed his medical notes. She discovered the entries made by the seconded nurse that the man should be seen by a psychiatrist, but found that he had not passed on the information about the voices which he heard. She discussed her concerns about the nurse's notes with the Duty Director for Norwich PCT. They agreed that further investigation was required and suspended him, pending further investigation. The clinical review reports and comments on the actions of the nurse, including a recommendation for a disciplinary investigation to be carried out. On 20 September, following a disciplinary investigation by Norwich City Primary Care Trust, into the actions of the nurse, a charge of misconduct was laid and a disciplinary hearing was held. The nurse was found guilty of the charges laid and appropriate disciplinary action was taken.

    The Governor in partnership with the PCT should implement the recommendations of the Clinical Review.

47. During the afternoon of 11 June, an officer spoke to the man to ask him to return his diet sheet for the following week, as he had not done so. He completed the form, and returned it to the officer. He did not give the officer any cause for concern. Diet sheets are issued to prisoners each week and allow them to pre-select their choice of meal for the following week.

48. As it was the weekend, prisoners were not working, and were unlocked to engage in wing association. Another officer recalled seeing the man playing pool with other prisoners and said that there was nothing unusual or out of the ordinary about his behaviour.

49. At 4:30pm, association terminated and was followed by the evening meal being served. Prisoners collect their meal, return to their cells and are locked up for the night. It is believed that the man collected his evening meal as normal.

50. At 5:15pm, an officer locked the man into his cell for the night. She recalled entering the cell to confirm that he was there and seeing him sitting on his bed with his legs crossed. She said goodnight to him and he replied goodnight to her. A few minutes later, she carried out a roll check of the prisoners whom she was responsible for. She said that, in order to carry out the roll check, she opens the cell door observation flap, looks inside to confirm that the prisoner is in the cell and, when all of her prisoners are accounted for, she informs the wing manager. She said that the man was still sitting on his bed, in the same position as when she locked him up a few moments earlier. She said that he had not given her any cause for concern, and his behaviour was normal. The officer was the last person to see him alive.

51. At 5:30pm, the wing is placed in patrol state, as the majority of officers who have been on duty during the day leave the prison. Patrol state means that the number of staff on duty is at a minimum and prisoners are

locked into their cells. The officers remaining on duty are there to respond to cell call alarms, to patrol the wing, and to ensure that security is maintained. Prisoners who require assistance can use their cell call alarm bell which is located within the cell.

52. Two officers were the evening patrol officers for B and C wings. They were required to remain on duty until relieved by an officer, who was due to commence duty at 8:30pm and who was the night patrol officer for B wing.

53. At 8:30pm, the night patrol officer commenced her roll check of the wing. Roll checks are completed at specific times of the day. It is only when the prison roll is reconciled that those staff who have been on duty are allowed to leave the prison.

54. At 8:40pm, the officer opened the observation flap of the man's cell and saw him hanging from the cell window bars. She called for assistance via her radio and by calling out to the other two officers, who responded immediately.

55. Although the night patrol officer had been issued with a cell key, secured in a sealed pouch, she did not use it to gain entry into the cell as she felt that officers were not encouraged to break the seals. She could see that the man was hanging and believed that he was dead, but did not consider using the key to open the cell door. The Chief Inspector also found that staff were unclear about accessing cells during an emergency and reported that staff were confused about emergency unlocking procedures at night. Many staff believed that they were not to enter a cell alone even if someone was hanging, although to their credit some nevertheless had done so but believing it to be against orders.

    The Governor should remind all staff of the procedure for entering a cell in an emergency.

56. One of the officers unlocked the cell, and all three went into the cell. They saw that the man was in a seated position, with his back against the cell wall, suspended at the neck by a ligature which had been secured at the window bars. The ligature had been made using the edge of a bed sheet. The man was facing the cell door, with his legs straight out in front, and his bottom slightly raised off the ground.

57. In order to reduce the pressure on his neck, the officers lifted the man from the ground. The ligature was removed from around his neck and the man was placed on his back on the floor. His body was cold to the touch.

58. An officer said at interview that one officer carried out chest compressions, whilst another officer checked for a pulse. She could not recall anyone perform mouth to mouth resuscitation.

59. An Officer Support Grade (OSG), who had been on a different landing, responded to the call. When he arrived at the cell an officer asked him to collect the wing response box. When he returned with the box a few seconds later, he saw that the officers had removed the ligature and placed the man on his back on the cell floor. He saw an officer performing chest compressions, but did not recall anyone performing mouth to mouth resuscitation.

60. An officer confirmed at interview that the man had been placed on the floor, and that chest compressions commenced immediately. He could not recall anyone carrying out checks for signs of life prior to chest compressions being undertaken, but did add that he checked for a wrist pulse during the compressions period.

61. My investigator asked the officers and OSG what training they had received relating to Cardio-Pulmonary Resuscitation (CPR). It was evident that refresher training had not been given for some considerable time and in one case, for at least 13 years. However, it is evident that the officers were doing their best, in difficult circumstances, to resuscitate the man.

62. My investigator discussed the CPR procedure with the Head of Healthcare. She confirmed that the correct method to perform CPR is to check for signs of life and, if none are detected, to carry out chest compressions and mouth to mouth resuscitation at a rate of 15 compressions to two breaths. The investigator discussed his findings with her, and she agreed to remind staff of the correct procedure for carrying out CPR and to review training needs.

63. The response box contains an anti-ligature knife (known as a fish knife) that is designed to allow the user to get underneath the ligature. It has a blade concealed within the mouth of the knife and the action of pushing the knife forward cuts the ligature. My investigator found that not all staff knew where the anti-ligature kit was kept, and raised the matter with the Governor. The Governor made immediate arrangements to issue a notice to staff reminding them where the emergency response boxes were located.

64. Additionally, my investigator enquired if officers were issued their own fish knife. He was told that they were not, as the knives were available from the response boxes. However, the Governor reviewed the policy and subsequently made the knife available for night staff to collect and carry as part of their uniform equipment. The Chief Inspector has recommended that ligature shears are carried by staff, particularly during patrol state. I support the recommendation and extend it to ask that consideration is given to issuing all front-line staff with their own anti-ligature knife.

    I recommend that The Prison Service should consider issuing all front-line staff with their own anti-ligature knife.

65. At approximately 8:45pm, prison medical staff arrived and took over responsibility for the care of the man. However, they were unaware of the type of incident that they had been asked to attend, which resulted in them not taking the emergency bag containing a defibrillator. My investigator raised this finding with the Governor and Head of Healthcare and they issued new instructions on how requests for medical assistance should be transmitted. The Governor introduced a code blue and red system, which is a procedure that I have identified in a number of fatal incident reports as being good practice. However, I am aware that the use of such codes is not Prison Service National Policy. Code blue describes a patient who is experiencing breathing difficulties and code red describes someone who is bleeding. I welcome the Governor's prompt action in dealing with this matter.

66. At 8:43pm, paramedics who were very close to the establishment received a call from the ambulance service control room to attend the prison. At 8:46pm, the paramedics arrived at the man's cell. Their examinations did not find any evidence of life, and so they stopped any further attempt to resuscitate the man and pronounced him dead at 8:56pm. They left the prison once they had completed their own documentation.

67. At 9:00pm, a Senior Officer sealed the cell pending the arrival of the police and Coroner's Officer. At midnight, the man was taken from the prison and transferred to the mortuary.

68. A letter was found in the wing post box which had been written by the man and addressed to his aunt. Although it is not dated, it is assumed that he posted the letter that day, as the box had been emptied in the morning. The letter does not give any indication as to his later actions, or suggest anything that would alert anyone to believe that he was feeling suicidal. In the letter, he enquires about his parents, talks about a postal order and finishes by asking his aunt to write back soon as he enjoyed receiving letters.

69. One prisoner wrote directly to me about my investigation and I forwarded the letter to my investigator for him to consider. My investigator arranged to meet with the prisoner on 28 July. After only a few minutes, the prisoner terminated the interview and said that he had been instructed by the Norwich Coroner not to discuss the case with anyone other than him. The prisoner did not indicate the nature of the information he had relating to the man's death.

70. Following the man's death, the Governor compiled an incident file for my investigator which contained additional correspondence from the prisoner who had written to me. The correspondence was addressed to a number of people and raised issues regarding operational matters and decisions, which were outside my terms of reference. However, an examination of the documents identified a wing application dated 12 July 2005 which the prisoner had submitted to the Chairman of the local Prison Officers' Association (POA) branch. He requested a meeting with the POA

Chairman to discuss concerns that he had in relation to the man’s death and he also alleged negligence by an officer, but did not identify anything specific.

71. My investigator discussed the application with the Governor and POA Chairman. The Governor was unaware of any connection between the officer and the death of the man. The record of staff attendance for 11 June clearly shows that the officer was not on duty that day. The POA Chairman said that he had not received any correspondence from the prisoner. The investigator has not identified a link to the officer and the man’s death.

72. On 10 August, the Coroner sent correspondence to the investigator from a solicitor previously engaged by the man. The solicitor expressed concerns at the level of care he received from the prison during an earlier period in custody. The correspondence was forwarded to the PCT for consideration and inclusion in the Clinical Review. The PCT informed my investigator that the medical records relating to the man’s previous custodial period could not be found. The Governor and Head of Healthcare were made aware of the missing medical records. Following a search, the records were traced and forwarded to the PCT for consideration. It is unclear why, when the records were known to be missing, a search of the files was not undertaken until my investigator raised the matter with the Governor on 17 August. The Governors’ intervention quickly resolved the problem.

73. The Clinical Review makes 12 recommendations for the prison, which have been discussed with the Head of Healthcare and which will be monitored via the Norwich Prison and the PCT Healthcare Governance structure. The review also identifies as good practice the Prison Officers and Healthcare Staff who worked alongside the paramedics in their attempts to resuscitate the man.

Recommendations:

1. The Governor should remind staff of the value of the Listener scheme and, as a matter of priority, ensure prisoners have the opportunity to meet with a Listener at any time of the day or night.

2. The Governor should consider displaying the photographs of all Listeners.

3. The Governor should ensure that Suicide and Self-Harm prevention refresher training is prioritised and delivered to all staff employed at the prison.

4. The Governor should ensure that previous custodial periods are linked to earlier prison numbers and the records of any prisoner identified during the reception procedure as being at risk, or as having serious health problems, obtained and examined.

5. The Governor in partnership with the PCT should implement the recommendations of the Clinical Review.

6. The Governor should remind all staff of the procedure for entering a cell in an emergency.

7. I recommend that The Prison Service should consider issuing all front-line staff with their own anti-ligature knife.

Annexes

1. Post Mortem Report
2. Incident Report
3. Incident Log Sheet
4. CARAT Referral Form
5. Transcript
6. Transcript
7. Transcript
8. Transcript
9. Undated letter
10. Clinical Review (Including medical record)