Investigation into the circumstances surrounding the death of a prisoner at HMP and YOI Norwich in August 2004

Report by the Prisons and Probation Ombudsman for England and Wales

March 2005

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This is a report of the investigation into the death of a prisoner who was just 19 years old when he died in HMP Norwich in August 2004.

I would like to offer my sincere condolences to the man's family and friends.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service, which came into effect on 1 April 2004. The bulk of the investigative work has been conducted on my behalf by a governor from HMP Littlehey and a member of staff from HMP Blundeston. A clinical review was conducted by Norwich Primary Care Trust. I am very grateful to all members of the team for their work. A colleague from my office, liaised with the investigating team.

The man's death was the first self-inflicted death at Norwich prison since the Ombudsman was passed responsibility for the investigation of deaths in custody. Sadly, another prisoner died in September 2004. The report into that death will consider if the issues can be drawn together to see if any lessons can be drawn to try to prevent similar tragedies in the future.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN

SUMMARY

The man who died was born in January 1985. He was 19 years old when he died.

He had previously served a period of custody in HMYOI Warren Hill, where he had attempted suicide and self harmed. After a period of relative stability living with his girlfriend and her parents, he was remanded into HMP & YOI Norwich on 26 July 2004. During the reception process the man had been identified as requiring a detoxification programme from alcohol, which was successfully completed. He had found this difficult, and following the detoxification programme was prescribed anti depressants. He was well liked by his peers, and staff did not have any serious concerns about the man who was described as generally cheerful. He suffered mood swings and reported feeling anxious and being unable to sleep at times.

During his time at Norwich prison, the man attended education classes, and underwent a Substance Awareness and Relapse Prevention course via Care Assessment Referral Advice and Throughcare (CARATS).

In August, the man moved from a shared cell to a single cell after being on a waiting list for such a move. He was seen to be cleaning the cell, making the best of a cell that was in poor repair.

That evening he had been upset following a telephone conversation with his girlfriend, a conversation that was cut short because he ran out of phone credit. It was his perception that the relationship was over. An officer was concerned when he saw the man upset and allowed him to use the office phone to try and contact his girlfriend again. He was unable to contact her but spoke to a friend who the man described as a "go between". Following the phone calls, the officer arranged for a Listener (another prisoner trained by the Samaritans) to speak with the man.

The officer was not sufficiently concerned about the man to warrant opening a F2052SH (a form used by the Prison Service to monitor and support prisoners thought to be at risk of suicide or self-harm). He did, however record in the handover book that the man had been upset and spoken with a Listener. Staff who came on duty for the night were not aware of any concerns relating to the man, and did not read the handover book.

In late August, the man was found hanging at 5:50am by an Officer Support Grade (OSG) during the morning roll count. The OSG radioed for urgent assistance and went to the office to get the ligature knife from the "self harm box". Staff arrived, entered the cell and cut the ligature, made from torn bed sheets from around the man's neck. Efforts to revive him proved fruitless and he was pronounced dead at 6:30am. It was the Doctor's opinion that he had been dead for some time.

The police were asked to inform the man's sister (his next of kin), of his death. However, the police did not confirm they had informed her, and the first news his sister received of her brother's death was in a telephone call from the governor of the YOI.

He was a vulnerable young man. However, without previous knowledge of him, there were no specific indications that he was at a high risk of harming himself during his time at Norwich. Nevertheless, a number of lessons can be learnt from the man's death to help prevent another tragedy in the future. This report contains 16 recommendations.

INVESTIGATION PROCESS

In April 2004, the Prison and Probation Ombudsman was passed the responsibility of investigating all deaths in custody. Under transitional arrangements, two governor's of HMPS were appointed to conduct the investigation on the Ombudsman's behalf along with and investigator from the Ombudsman's office.

The investigation team visited HMP & YOI Norwich, where they received a brief from the in charge Governor, ahead of visiting the cell where the man died. They also met with members of the Prison Officers' Association (POA) local branch committee and the Independent Monitoring Board (IMB).

Notices were issued to both prisoners and staff, inviting anyone whom might have information relating to the man's death to make themselves known to the inquiry.

Along with my investigator, one of the Ombudsman's family liaison officers visited the man's girlfriend and her parents. The family liaison officer also had telephone contact with the man's sisters and adoptive parents and offered to visit them. The family liaison officer remained in touch with them.

We interviewed prison staff who were involved in attempts to save the man's life, and prisoners who knew him including the Listener who spoke with the man the evening prior to his death . We also interviewed and examined documentation from other staff who were either associated with the wing or known to the man who died. There were also prisoners from neighbouring cells and a Listener who were interviewed.

We examined the man's prison record and a series of prison documents.

A clinical review of his health care whilst in prison custody was undertaken by Norwich Primary Care Trust.

BACKGROUND

The man who died had previously spent time at Warren Hill Young Offenders Institution (YOI). In the records of his time at Warren Hill, the man had spoken about the problem he had with using drugs and alcohol. Pre sentence reports state that these issues left him vulnerable to the influences of others when in a group.

During his time at Warren Hill he attempted suicide. He was twice placed on a F2052SH form. This is a mechanism that is used by the Prison Service to monitor and support prisoners who are at risk of suicide and/or self harm. The man had felt particularly vulnerable after the break up of a relationship with his girlfriend at that time. Norwich prison were not in receipt of the information contained in this record.

He was remanded to HMP & YOI Norwich on 26 July 2004 from Colchester Magistrates Court. He was also attending court for a separate matter and had attended a hearing in August at Harwich Magistrates Court.

When he arrived at Norwich prison he went through the reception and induction procedures. He was open with staff about previously being subject to a F2052SH, and about having a history of alcohol abuse.

The initial Cell Sharing Risk Assessment for the man was completed on 26 July. Section 2.7 of the form asks if the prisoner is on an open F2052SH form, it is ticked as 'yes'. There is also a part on the form that allows you to mark where this evidence was gained from, and it is marked 'P' for prisoner, indicating that the man provided this information himself. There is one additional explanatory note, which reads, 'states may have been on an F2052SH previous'. Section 3 of the form is completed by healthcare staff and asks for a conclusion on risk the man may pose to himself or to others. The box "Insufficient evidence to give opinion" is marked. The 'Low' risk box was also marked (detailing no current indication / evidence of risk, suitable for multi cell location.) Following this, the Assessment asks: 'Following the self harm assessment have any concerns been raised?' This was ticked as 'no'

In his healthcare reception screening, he disclosed he had not expected to be sent to prison, and a friend had taken his own life some two years earlier. He also said he drank eight units of alcohol a day. He later told the Doctor he drank up to 30 units of alcohol per day and the Doctor prescribed him a twelve day chlordiasziporxide detoxification programme.

The man was also referred to the CARAT'S team for an assessment. This took place on 30 July. It was noted that, '*The man was very upset when we met. He had just been put on remand, which he was not expecting. He seems very distressed and worried.'* On interview, the CARAT worker said the man had been 'sobbing' and that he was very worried about his girlfriend having an accident on her moped. It seems he may have believed that his girlfriend was expecting his baby. The CARAT worker said she tried to contact his girlfriend on his behalf. She stated, that although clearly upset, he did not appear to be at risk of harming himself at this time. This was the last time she had had direct contact with him. He later attended a four day Substance Awareness and Relapse Prevention course via CARATS, during which

he had spoken of his belief that he would soon be released. He did not display the signs of distress the CARAT worker had previously witnessed.

In August, the man submitted an application to see healthcare staff. He stated "Doctor prescribed me chlordiaziproxide for shakes, depression, lack of sleep. Don't seem to be working, waking up feeling worse than ever." He was seen by a detox nurse, the next day. The nurse noted in the man's Inmate Medical Record (IMR), that once the detoxification programme had been completed the Doctor might prescribe zispin (an antidepressant). Indeed, the man was prescribed this once he had completed his detoxification programme.

A few days later, the man did not collect his detoxification medication. That afternoon, a nurse from the Mental Health In-reach team went to see the man but did not speak with him as he was at education.

He seemed to settle into prison life and was popular with his peers. The man's personal officer, described him as a well-liked prisoner who mixed well and was generally cheerful.

We spoke to a number of prisoners throughout the investigation. A cell mate had shared a cell with the man until sometime in August. He said the man had been anxious when he had not received a letter from his girlfriend for a few days, but when one arrived he was fine. He was not expecting to be sentenced to a long period in custody and was looking forward to getting out and making it up to his girlfriend. The man rarely expressed concerns to other prisoners and seemed generally happy.

He had a substantial amount of personal mail in his cell. Most of it was letters and cards from his girlfriend. The mail was not dated so we cannot follow the sequence. All the letters contained messages of love for the man, and were looking forward to his release. However, there was one letter where his girlfriend had been told some things that had upset her and made her feel that the man kept letting her down. Although a number of negative subjects were raised, the letter closed with her saying she wanted to be with him and that she would love him forever.

EVENTS LEADING UP TO THE MAN'S DEATH

The man was located on F Wing in the Young Offender part of the prison. There are three landings on the Wing, holding 169 young people. There were 30 prisoners on F2 landing. The man was relocated from a double cell on F2 landing to a single cell (F2-18) a few days before he died. The man's personal officer explained that prisoners who requested a single cell were put on a waiting list and allocated a space when it arose. Staff said there had been no concerns evident about the man moving into a single cell. An officer stated that he had recalled speaking to the man in the afternoon about the good job he was making of cleaning his cell. He had no concerns about his behaviour at the time. A wing mate, who lived in the cell opposite, also reported seeing the man during the afternoon. He had been cleaning his cell, and the wing mate did not see anything of concern in the man's mood. It is worth mentioning that, when investigators saw the man's cell, it was in a poor condition.

During evening association on the night before he died, the man telephoned his girlfriend. The man's cell mate said he saw the man after the phone call and he seemed upset, but not in tears. His cell mate gave him a cigarette, turned round briefly and he was gone. The man left association early and returned to the wing. An officer said he saw the man crying at approximately 6.30pm.

We were able to listen to a tape of the telephone conversation between the man and his girlfriend. He sounded anxious and asked several times if the relationship was over. At no point during the conversation did she say the relationship was over. They also discussed his sentence. She was worried he would get a significantly longer sentence than he anticipated. She was clearly upset but agreed at the end of the conversation that he could phone her again on Thursday and they would talk more.

In his written statement, the officer said the man had told him he thought his girlfriend was trying to finish with him and that his money had run out during his phone call to her. The officer allowed the man to use the office phone to call her back again. The first number he tried was to her mobile. This was switched off, so the officer allowed him to try a second number, this time to a friend who the man described as a 'go-between'. He asked his friend to speak to his girlfriend and assure her he was going to change when he got out of prison and that he would ring her again Thursday evening when he got some more phone credit. The officer said he appeared in a better frame of mind following the call.

The officer offered the man the services of a Listener (another prisoner trained by the Samaritans) which he accepted. The Listener went into the man's cell and stayed with him for half an hour. After this, the officer asked the listener how the man was and he replied that the man was okay. The officer said he then asked the man if he was okay and he nodded. The officer could not recall anything positive or negative about his body language at the time.

The listener said that he had heard the man talking out of his cell window later that night, and passing tobacco.

THE CRISIS MANAGEMENT

At 5.50am the day the man died, an Officer Support Grade (OSG) performed the landing roll check as usual. When he looked inside the man's cell he saw him with a ligature around his neck tied to the window bars. The OSG contacted the control room and asked for urgent assistance to the man's cell.

Two officers responded from F1 office. As they were approaching F2 landing, one of the officer's saw the OSG run to the office and collect the "Self Harm box" which included scissors in order to cut the ligature.

This officer opened the cell door and saw that the ligature was tied at the top of the window and the man had one foot on a chair nearby. The ligature was made from a torn bedsheet. The officer contacted the control room to request medical assistance recording a 'code 1'. There are three codes used at Norwich prison to call for urgent assistance, code 1 is used when a prisoner is not breathing and is believed to be dead. A Prison Service Nurse (PSN) stated she received this call at 5.55am.

The OSG cut the ligature from the man's neck. They laid him onto the floor by his bed and started CPR. A prisoner, who lived in the opposite cell, confirmed that he had seen staff attempting to resuscitate the man on the floor and that they had continued to try for "20 minutes".

The PSN arrived at 5.59am. She had come via the F Wing treatment room to pick up the emergency response kit. The PSN asked the OSG to call an ambulance and took over CPR from the officer.

There are different accounts of the exact time of arrival of the ambulance. These vary from 6.06am to 6.13am. Once the paramedics arrived they continued CPR until the doctor arrived at 6.28am, and pronounced the man's death at 6.30am.

Following the man's death the staff carried out all contingency plans. This included switching off the pin phone system until his Next of Kin could be informed.

He left a suicide note. The content of the note shows that he felt his relationship with his girlfriend had finished, but he made it very clear in the note that she was not to blame for his decision. He was very upset during and after the phone call. However, the content of his telephone conversation on the night of his death shows that although the man's perception was that the relationship had ended, in fact, she had left it open to him to engage in further dialogue later that week.

NOTIFYING THE MAN'S FAMILY

The prison asked the police to make the initial contact with the man's sister and break the news of her brother's death. The prison did not receive confirmation that the police had contacted her, and she reported that she heard of her brother's death in a telephone call from the Governor.

The Chaplain, made further contact with the man's sister by telephone. The Chaplaincy department maintained all further contact with the family. The Chaplaincy visited the family, as well as his girlfriend and her family. They also conducted the man's funeral service. The man's girlfriend and her family commented on the level of support they had received from the Chaplaincy and were grateful for this.

The man's sister and her adoptive parents visited the prison. They were met by the Deputy Governor and the Governor.

STAFF SUPPORT FOLLOWING THE MAN'S DEATH

All staff involved in finding and attempting to revive the man were asked to attend the office of the Deputy Governor for a "hot debrief". Staff were offered the services of the Care Team and Staff Care and Welfare. The Governor then spoke to the staff separately. The staff directly involved in the incident have since been offered and, where requested, given support from the Care Team, Chaplaincy and other staff and managers at the prison. Staff reported follow-up contact having been made by the care team. Those interviewed felt they had been well supported.

The Samaritans had been in regular contact with the Listener and he had received additional support from other agencies, including CARATS, and the Chaplaincy.

The manager of the YOI ensured staff spoke to all prisoners likely to be affected by the man's death as soon as possible. When the prisoners were on exercise at 9.00am, the chaplain led a prayer and a minute's silence. Following this, the Samaritans attended the unit at 11.00am to offer support. The Listeners were briefed and also offered support.

SUICIDE PREVENTION AT NORWICH PRISON

A monthly meeting is chaired by a Senior Manager and the Suicide Prevention Co-ordinator and is attended by all functional areas within the prison.

The current policy document states that a F2052SH should be opened if staff have any concerns.

The two previous audits for Suicide and Self Harm Prevention were carried out in 2003 and 2004. The result in June 2003 was an 'Unacceptable' 52% rating. The follow up audit in July 2004 showed significant improvement to an 'Acceptable' 72% rating.

The training department provided training records relating to Suicide and Self Harm Prevention for staff involved in the incident. They held records on only three of the staff involved. The three staff had undergone suicide prevention training, varying from 15 months and over tens years prior to the man's death.

The Independent Monitoring Board (IMB) draft Annual Report for the period January 2003 to February 2004 notes that 'staff relationships remain good, particularly in the YOI'. It further notes that, with regard to F2052SH procedures, while these had been problematic, 'there have been definite signs of improvement in the last 2 to 3 months'.

FINDINGS

- Previous records.

The man who died had previously spent time in HMYOI Warren Hill. The records of his time in Warren Hill YOI were not requested by Norwich.

- Cell sharing risk assessment.

The cell sharing risk assessment was not completed correctly. There is no evidence that the issues raised by the form concerning the man previously being subject to a F2052SH were pursued any further.

- Healthcare issues

There is no evidence that his previous medical records from his local GP or previous sentence were requested.

There were several examples in the medical paperwork where professionals did not meet the recognised standards for record keeping. These include:

- The first reception screening form was not signed and baseline observations had not been completed.
- On xx August, a nurse from the Mental Health In reach team went to visit the man but he was at education. There is no record of the rationale behind the visit or who referred him.
- A Prescription was written for amoxycillin on x August but there is not recording clinical indication to support this and no corresponding entry in the continuous medical record.
- A prescription was written for Zispin on xx August but again there is no corresponding entry or explanation in the continuous medical record. The only reference to depression was found on x August when he saw the detox nurse. There is no evidence of a follow up assessment.
- Many entries in the IMR are not dated, and do not have the name printed against the signature.

The man was identified as requiring an alcohol detox on reception, and a twelve day chlordiaziproxide regime was prescribed and commenced the following day. His application to see healthcare on at the beginning of August clearly indicates that he was not coping with the detox. He was seen and assessed by a nurse on the following day and was advised that an anti depressant, Zispin might be prescribed when the detox was completed. No other support, advice or follow up are documented.

The nurse that went to see him did not follow up seeing the man after the abortive attempt. The reason for this is recorded in The Ledger of Contacts as being that the man was being seen by a psychiatrist on 5 August. There is no evidence that he was ever referred to or seen by a Psychiatrist whilst in prison. It would appear that there was a misunderstanding due to another prisoner's psychiatric assessment completed by the psychiatrist being misfiled in the man's IMR.

- The use of the office phone for prisoner phone calls

There is no policy in place at Norwich prison for staff to follow to allow prisoners to make phone calls from an office if they have a domestic issue.

- F2052SH and Handover procedures

The officer said in his written statement that the man had not indicated to him that he would self harm and consequently, the officer did not believe it was necessary to open an F2052SH. However, an entry was made by the officer about the man in the Observation book that night. It read, 'put in with a listener at 19.15 (been dumped by girlfriend)'. The officer did not recall speaking to anyone else with regard to the man on that evening.

Staff coming on duty stated they did not receive a handover detailing any concerns regarding the man, nor did they recall reading the entry in the observation book about him having spoken to a Listener.

The night staff coming on duty did not receive a handover from the day staff going off duty, and did not read the wing occurrence book so were not aware of the Listener talking to him during the evening.

- The man's cell

The man's cell was in a poor state of repair. The walls had not been painted for some time, and there was a space where a notice board was missing covered with toothpaste marks. The door to the toilet and washing facilities was missing. The toilet was stained inside and was missing half the seat. There was plaster missing from around the doorframe. A similar situation was found in other cells inspected on the landing.

Furthermore, the window bars in the man's cell presented a number of ligature points.

- Notifying the man's family

The man's sister, was notified of her brother's death by telephone, by the Governor. She believed the police had visited the man's sister in order to break the news.

- Crisis Management

Staff finding the man acted appropriately and with speed in removing the ligature and laying him on the floor for CPR. The evidence clearly indicates that attempts to resuscitate him continued until the Paramedics arrived.

Norwich prison's protocol for entering cells as a singleton night patrol if a prisoner is believed to have attempted to take his own life says that "you can enter the cell alone". In this instance, the OSG decided to wait for assistance from other staff, which took only a couple of minutes to arrive.

The OSG had to leave the cell to go and collect the "Self Harm box", containing the ligature knife while he was waiting for other staff to arrive.

It is clear that local procedures were followed in respect of a death in custody. A debrief took place and appropriate support was offered to staff and prisoners affected.

- Staff training

Training records were found, and showed that suicide prevention training had been undertaken by three members of staff involved in finding and attempting to resuscitate him. The time lapse from the training and the man's death varied from 15 months to over ten years.

CONCLUSIONS

It is not normal practice on entering a prison for records from a previous period of custody to be requested. There were few indications that the man intended to take his own life and it is unlikely that access to his previous custody records would have altered what happened. However, once he divulged that he had been on a F2052SH on a previous sentence, records of this might have provided useful insight. Whilst it is unrealistic to expect that previous records are requested on every prisoner entering prison, where elements of risk are uncovered it would be sensible to request back records.

I recommend that, where evidence concerning risk of harm to a prisoner or other prisoners is identified, any records from a previous period in custody are requested.

The man had moved to a single cell the day prior to his death. It is clear from evidence given by landing staff that there were no concerns as to his state of mind at the time of the move. Indeed, he was portrayed in a positive light by staff and prisoners witnessing him cleaning his cell. However, the Cell Sharing Risk Assessment that had been completed when he was remanded to Norwich was not completed properly or comprehensively. He said he had been on a F2052SH previously. I would expect the member of healthcare staff to ask further questions about this; perhaps why he was subject to the F2052SH or, if he had a single cell at that time, for example. There is no evidence of any further investigation. It may have been that the man came across as being content and assured healthcare staff he was fine, leaving them to believe there were no concerns. The point is that, given the fact that he said he had previously been on a F2052SH, staff completing the assessment should demonstrate that this has been considered.

I recommend that staff involved in completing Cell Sharing Risk Assessments are reminded of the importance of considering self harm issues when completing the assessment.

There is no evidence that the man's previous medical records from his local GP or previous sentence were requested. These would have alerted healthcare staff to previous self harm attempts. This, in turn, would have meant further support and assessment could have been made available to the man. It is recognised that if this was policy for all new receptions it would be a very significant undertaking. He did not disclose any mental health issues on the reception healthcare screening. Indeed, healthcare staff may never have been aware that he had a history of self harm as there seemed to be poor communication on this subject. However, obtaining medical records would be best practice.

There were several examples in the medical paperwork where professionals did not meet the recognised standards for record keeping. Entries in the IMR were not timed, and names not printed following a signature. What is of more concern is that there was a lack of explanation surrounding decisions that were made. This was particularly evident when a prescription was made; there was little or no corresponding entry in the IMR as to the reason for the prescription. I therefore endorse the recommendations made by the clinical reviewer.

I recommend that a record keeping audit should be carried out if one has not been completed in the last six months.

I recommend that training should be provided for healthcare staff at all levels regarding record keeping and their professional responsibilities.

I recommend that all prescriptions have a corresponding entry in the continuous record made by the Prescriber that also gives the assessment process and reasons for the prescription.

The man who died underwent a twelve day alcohol detoxification programme. However, his application to see healthcare on at the beginning of August clearly indicates that he was not coping with the detox. He was seen and assessed by a nurse the next day and was advised that an anti depressant, Zispin, might be prescribed when the detox was completed. No other support, advice or follow up are documented, and it is not clear what, if any follow up occurred to see how he was coping.

There was evidence that the CARATS team were also supporting him although no information had been shared with healthcare at this time.

I recommend that a review of the alcohol detoxification programme is carried out to explore and develop the inclusion of other support packages, advice and follow up.

A nurse, from the Mental Health In-reach team went to see the man on early in August but did not see him because he was in education. There is no documentation as to how the referral was triggered, why or by whom. The nurse did not follow up the man again, but I believe this was a misunderstanding due to another prisoner's assessment being misplaced in his IMR.

There was no clear process to receive and direct Mental Health In-Reach referrals. They could be informally received via Officers, Treatment Room Nurses or other staff and there was no structured approach to recording this. The clinical review of the man's healthcare, found that systems were beginning to be developed to give clear auditable pathways, improve patient care and reduce the risks.

I recommend that the new Mental Health Referral system and policy is supported by management in its implementation and reviewed in six months.

The man was upset by the phone call he had with his girlfriend on the evening before he died. This conversation had ended earlier than he would have liked because his phone credit ran out. Realising he was clearly upset, an officer acted compassionately by allowing him to use the office phone to try and contact his girlfriend again. The officer was present in the room whilst the phone calls took place but obviously could only hear one end of the conversation. Good practice in other prisons has been for a senior officer to credit the pin phone system when prisoners need urgent use of the phone. This ensures that the calls can be recorded so situations of concern can be monitored. It also means that a senior officer has to

be consulted. This is useful for two reasons. First, one person on the wing is keeping track of the reasons the calls are being allowed to avoid abuse of the system. Secondly, a senior officer is consulted when a situation like the man's arises and a decision can be made by more than one person as to any action that needs to be taken, such as opening a F2052SH.

I recommend that a system is established for senior staff to credit the PIN phone system.

The current Suicide Prevention Policy at Norwich states that a F2052SH should be opened if staff have any concerns. The officer did not open an F2052SH as a result of his interaction with the man, although his use of the services of a Listener would indicate that he was concerned about him. The officer told us that, although the man had been distressed, he did not feel that the man was at risk of self-harm. The officer had asked the man if he was alright once the Listener had left his cell, and he had said he was ok. With the gift of hindsight this did not appear to be the case. There is no evidence of any further interaction to gauge his state of mind.

I recommend that Norwich's local instructions on Suicide Prevention be revisited to ensure staff are clear on when an F2052SH should be opened.

The officer had written in the log book that the man had been upset and had spoken with a Listener. The only person who receives a handover on issues arising from the day is the assist Night Orderly Officer. Staff on duty on the night of his death had not read the observation book entry regarding the man so were not aware of any concerns about him. Day staff had not verbally handed over any concerns regarding him. As the man had not been assessed as being at sufficient risk of self harm to require an F2052SH, it is difficult to conclude that this knowledge would have altered events. However, it is clear that even if the officer did not feel his level of concern warranted opening a F2052SH, he was sufficiently concerned to allow him to make calls on the office phone, request a Listener, and check the man was ok. Had staff been aware of this, it might have increased their vigilance.

I recommend that instructions regarding handover of issues arising from the day or night be reviewed.

The OSG had to leave the cell to collect the ligature knife from the "Self Harm box" which was in the wing office while he was waiting for other staff to arrive. The policy of entering a cell alone should be reinforced to make it clearer for officers when making the judgement call, because seconds could save lives. On this occasion, it seems that speedy intervention would not have saved the man who died.

I recommend that the paragraph in Norwich's Suicide Prevention Strategy concerning entering cells alone is re-written to give more information to patrols, in particular, that speed is of the essence when confronted by a hanging prisoner.

It is good practice for singleton patrols to carry ligature cutters on their person as a personal issue; having cutters located in the wing office wastes precious seconds.

I recommend that ligature cutters be carried as personal issue to singleton patrols.

The condition of the man's cell was unacceptable with fixtures and fittings broken and/or in poor repair. The walls had not been painted for some time. A similar situation was found in other cells inspected on the landing. Furthermore, the window bars presented a number of ligature points.

I recommend the redecoration of F Wing cells at the earliest opportunity and that inventories of cell fixtures, fittings and contents be checked on a regular basis to ensure cells are maintained in a decent condition.

Staff at Norwich prison notified the police of the man's death and requested that they visit his sister to break the news. However, no confirmation was sought or received from the police to confirm that they had visited her. Consequently the first she knew about her brother's death was when she was called by the Governor. It is unacceptable that the man's sister, however unwittingly, was notified of her brother's death by telephone. She was on her own, and it left her deeply distressed.

Breaking the news of a self-inflicted death in custody is both sensitive and demanding. The way in which it is carried out may well colour a bereaved family's whole relationship with the Prison Service. The two main objectives should be to break the news speedily and to do so in a way that emphasises the Prison Service's accountability, sense of shared loss, and commitment to the family as members of the public that the Service serves. I appreciate that speed and personal involvement of the Prison Service may sometimes be in conflict.

If at all possible, the governor or other member of senior management in the prison where the prisoner has died should personally break the news. Where this is not possible, I do not think that the Prison Service should routinely rely on the police:

I recommend that, where it is not possible for the governor or a senior manager from the prison where there has been a an apparently self-inflicted death to break the news personally, a governor at the prison closest to where the deceased's next of kin lives should normally be asked to break the news of the death on behalf of the Prison Service as a whole.

If, as a last resort, the police are needed to inform the family, the prison should seek confirmation that the police have made the visit before they make further contact.

I recommend that if, as a last resort, the police are needed to inform the family, the prison should seek confirmation that they have made the visit before they making contact.

It should be noted that the support from the Chaplaincy was exemplary, and greatly appreciated by the man's girlfriend's family.

It is clear from examination of training records that training in Suicide Prevention was not regularly undertaken. However, staff responding to the incident had acted appropriately.

I recommend Norwich prison should promote Suicide Awareness training amongst all staff working with prisoners.

He was a vulnerable young man. He had been detoxing from alcohol, which can in itself induce sleep deprivation and mood swings. Although, the man was described as generally cheerful by staff and prisoners, it is possible that these mood swings left him particularly depressed at times with an inability to think through issues clearly.

RECOMMENDATIONS

NATIONAL

I recommend that where evidence concerning risk of harm to a prisoner or other prisoners is identified that any records from a previous period in custody are requested.

I recommend that a system is established for senior staff to credit the PIN phone system.

I recommend that a policy is adopted by the Prison Service whereby a Governor at the prison closest to where the deceased's next of kin lives breaks the news of the death to the next of kin.

I recommend that if, as a last resort the police needed to inform the family, the prison should seek confirmation that the police have made the visit before they make further contact.

I recommend that ligature cutters be carried as personal issue to singleton patrols.

LOCAL

I recommend that staff involved in completing Cell Sharing Risk Assessments are reminded of the importance of considering self harm issues when completing the assessment.

I recommend that the paragraph in Norwich's Suicide Prevention Strategy concerning entering cells alone is re-written to give more information to patrols, in particular, that speed is of the essence when confronted by a hanging prisoner.

I recommend that a record keeping audit should be carried out if one has not been completed in the last six months.

I recommend that training should be provided for healthcare staff at all levels around record keeping and their professional responsibilities.

I recommend that all prescriptions must have a corresponding entry in the continuous record made by the Prescriber that also gives the assessment process and reasons for the prescription.

I recommend that a review of the alcohol detoxification programme is carried out to explore and develop the inclusion of other support packages, advice and follow up.

I recommend that the new Mental Health Referral system and policy is supported by management in its implementation and reviewed in six months.

I recommend that Norwich's local instructions on Suicide Prevention be revisited to ensure staff are clear on when an F2052SH should be opened.

I recommend that instructions regarding handover of issues arising from the day or night be reviewed to ensure that this is effective.

I recommend the redecoration of F Wing cells at the earliest opportunity and that inventories of cell fixtures, fittings and contents be checked on a regular basis to ensure cells are maintained in a decent condition.

I recommend Norwich prison should promote Suicide Awareness training and all staff working with prisoners.