Investigation into the circumstances surrounding the death of a man at HMP/YOI Norwich in July 2005

Report by the Prisons and Probation Ombudsman for England and Wales

May 2006

This is the report of an investigation into the circumstances of a man's death. This man was found hanging by a ligature attached to his cell window grille at HMP/YOI Norwich, the day after he arrived. It was his first time in custody. He was 20 years old. My colleagues and I would like to extend our condolences to his family and to all those touched by his sad and untimely death.

The investigation was carried out on my behalf by two of my colleagues. A clinical review of the man's health care was conducted by Norwich Primary Care Trust.

I would like to thank the Governor of Norwich and his staff for their co-operation and assistance with this investigation.

It cannot be known what was in this man's mind when he attached a ligature around his neck. He had given staff no special cause for concern about his welfare. However, a letter addressed to his mother and found in his cell after his death demonstrates the distress and anxiety he was suffering.

This report is also notable for what it reveals about the way the this man's mother was informed of the loss of her son.

Stephen Shaw CBE
Prisons and Probation Ombudsman **May 2006**

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Summary

1. This man was convicted on 4 July 2005 of assault. He was due to reappear in court on 21 July, and was remanded for a Pre-Sentence Report. It was his first time in custody.

2. On arrival at HMP/YOI Norwich the man saw a nurse on reception and said that he had not harmed himself in the past and did not have thoughts of self harm. He struck up a good rapport with Reception staff and appeared to be upbeat and jovial.

3. The man was allocated a single cell on the induction landing in F wing, as he was the only newly received prisoner into the Young Offender Institution that day. An officer gave him a brief explanation of the rules and facilities of the prison and, although he said to the officer that he was nervous about being in prison for the first time, there were no general concerns about his well-being. As evening recreation periods (association) were only available on alternate days on each wing of the YOI, the man did not have association that evening and was locked in his cell after the evening meal was served.

4. On 5 July, he saw the nurse again for a secondary health screen as he had mentioned the day before that he suffered from asthma. He told the nurse that he had not yet managed to make a telephone call. When he was taken back to his wing, the nurse mentioned this to an officer and he was given the opportunity to telephone a friend. He also tried to telephone his mother several times, but was unable to get through.

5. On interview by an Assistant Chaplain as part of the induction process, the man discussed his crime and speculated that he had probably lost someone close to him for good. When the man returned to F wing, he received a fuller induction and, in the afternoon, was moved from an induction cell to a single cell on G wing. Normally there was a waiting list for single cells but, unusually, there were no names on the list and the man seemed suitable for one.

6. The cell that he was allocated, in common with all the cells on that side of the wing, had a perforated metal grille over the inside of the window to stop the retrieval of contraband thrown over the perimeter wall.

7. The man made contact with his mother in the afternoon. They briefly discussed the events that had led to his imprisonment and whether he should contact his partner. His mother asked him if he was alright and he replied “No, it’s fucking shit”. As the man had moved wings, he did not have association for a second consecutive evening.

8. The roll (the correct number of prisoners on the YOI) was due to be submitted around 8:00pm. When the roll was reported to the communications room just before 8:00pm, the evening patrol officer had in fact checked the prisoners on the wing at about 6:30pm.

9. When the night officer came on duty, he found the man hanging from the window grille from a bed sheet at 8:53pm. Nursing staff attended and Cardio Pulmonary Resuscitation was started. However, no vital signs were detected and, despite the prompt arrival of paramedics, he was pronounced dead at 9:10pm. Police attended the prison and were satisfied that there was no third-party involvement.

10. As the man's mother lived in away, the duty governor of Norwich decided that a governor at the prison nearest to her home should tell her of her son's death rather than the police. Governors at two prisons in the North West were asked to perform this task but declined to do so. However, the duty governor at HMP Preston agreed to visit the man's mother and did so at 2:30am on 6 July.

11. A letter addressed to the man's mother was found in his cell after his death. A post mortem examination concluded that the death was due to suspension. He was 20 years old.

Investigative Process

12. My investigators visited Norwich on four occasions between July and September 2005. They were given access to the man's prison records including his medical record. My investigation team met the Governor of Norwich, and with representatives of the Independent Monitoring Board and the Prison Officers' Association, to offer them the opportunity to raise relevant issues. They also visited the cell where the man died and spoke to staff on F and G wings.

13. Contact was made with the Coroner and with Norfolk police.

14. Notices to staff and prisoners announcing the investigation were displayed around the prison.

15. The man's family were offered, and accepted, the opportunity to contribute towards the investigation process. Separate visits were made to each of his parents, who are estranged. I believe that all the concerns they raised are covered in this report. The man's partner did not wish to participate.

16. Norwich Primary Care Trust (PCT) were told of this death and asked to carry out a clinical review, in accordance with NHS procedures. An independent clinical reviewer, carried out the review.

HMP/YOI Norwich

17. The main part of HMP Norwich was built in 1887. The Victorian prison houses adult prisoners whereas the Young Offender Institution (YOI), built in the mid 1960s, and used solely as a YOI since 1998, is a self-contained establishment opposite the adult prison. The YOI consists of two wings and the living accommodation is characterised by narrow corridors with cells down both sides. It is able to hold up to 120 prisoners aged between 18-21 years.

18. At the time of this man's death, there was no governor with specific responsibility for the YOI. The post had been vacant for at least four months and was being covered by the Head of Residence for the adult prison.

19. Norwich underwent a full inspection by Her Majesty's Chief Inspector of Prisons in March 2005. The Chief Inspector's report noted that, while relations between staff and newly arrived prisoners were good, key recommendations from previous death in custody investigations had not been implemented.

20. A review of prisoner care at Norwich was undertaken in August 2005 following a series of deaths of prisoners. The review found that the management of prisoners vulnerable to suicide or self-harm needed to be improved.

21. This death is the second in the YOI since August 2004. The previous death of a young man at Norwich questions about how the Prison Service notifies a family of a death.

Events leading up to the man's death

2 July/ early hours 3 July

22. Documentation from Norfolk police shows that the police were called to a caravan park just after half past midnight on 3 July after security staff at the caravan park reported a fight taking place. The man was found by the police hiding under a caravan and was arrested.

3 July

23. He was charged at Great Yarmouth police station with assault occasioning actual bodily harm (ABH). He was kept in custody at the police station overnight. According to the Custody Officer Detention Review, the grounds for detaining him were that the man had previous convictions for committing the same offence against the same victim

and that he had a pending court case again involving a similar offence and the same victim. He had also failed to surrender previously.

4 July

24. The man was produced at Great Yarmouth Magistrates' Court to answer the charge of ABH. At 9:36 am, he was briefly interviewed in the court cells by a colleague of the Matthew Project, a local drugs and alcohol advisory service. This was a routine visit as all new prisoners at the court are visited in this way. The visitor is also a Community Psychiatric Nurse. The man did not raise any concerns whilst he was at court and, although he had talked about probably losing his partner because he had been charged with assault according to the Custody Manager, he did not seem overly concerned about this.

25. The man pleaded guilty to ABH and was remanded in custody. My investigators contacted the court to find out the reasons for this. The magistrates took into account that he had a previous conviction for assaulting his partner and a previous conviction for failing to surrender, had been under the influence of alcohol, had run away from the police and had breached a conditional discharge imposed earlier that year. The magistrates thought that he might need help with anger management and alcohol abuse so he was remanded in custody for three weeks for a Pre-Sentence Report. He was due to return to court on 21 July.

26. At 1:47pm, the man left the Magistrates' Court under escort. He arrived at Norwich at 3:31pm. He was the only newly received prisoner into the Young Offender Institution that day. He was taken through the reception process by an officer. A Cell Sharing Risk Assessment was completed and, from the information available, he was assessed as presenting a low risk of harm to others. The officer described the man as a bright, funny and fun-loving young man who appeared to be enjoying life. He said that he had laughed and joked with him as he explained the facilities of the prison such as having a television in his cell and gave him items to which he was entitled, such as a first-class letter and £2 telephone credit. The officer explained to the man that he was convicted but unsentenced and that he would have to wear clothing provided by the prison, but he could have the clothes he had arrived in washed because they were muddy. The officer told my investigators that he sought to put the man at ease, because he was new to custody. His overall impression was that he seemed happy and there were no concerns about his wellbeing.

27. The man then saw a male mental health nurse, in Reception at about 4pm, who completed the First Reception Health Screen form to identify any health concerns. The man said that he used a Salbutamol asthma inhaler, but had no other health problems. He described himself as a social drinker, smoked four cigarettes a day and had last smoked cannabis on 2 July. He was asked about his mental health history. He

said that he had not previously tried to harm himself and had not received medication for mental health problems. He was not referred to see a doctor and was pronounced fit and well.

28. The nurse described the man's demeanour as straightforward, open and honest. The nurse described the man "seemed like the type of bloke who could take prison in his stride".

29. The man was then offered an evening meal and taken by an officer to the induction landing, F1, for prisoners new to Norwich. He was located in cell F1-02 by himself, as he was the only new reception that day.

30. The landing officer was on duty on F1. She said at interview that she was told by the officer that had escorted the man to the induction landing that the mna was not from the Norfolk area and that it was his first time in prison. She gave the man a pre-packed breakfast for the next morning, spoke to him for a couple of minutes and asked him if he was alright. The officer spoke to Paul for about 20 minutes, going through the formalities of fire evacuation, the purpose of a cell bell, the existence of Listeners (prisoners trained by the Samaritans) if he needed to talk to someone, and explained that he would be back on duty the next day to carry out the full induction process. The man was given an Induction booklet which is designed to offer basic information to get a prisoner through the first 48 hours of their period in custody. The officer said that the man had laughed and joked with him, but had admitted he was nervous because it was his first time in prison.

31. The YOI consists of two interconnecting wings, F and G. Evening recreation periods (known as association) are offered to each wing on alternate evenings with F wing having association on Tuesdays and Thursdays and G wing association on Wednesdays and Fridays. There is no association on Mondays or weekend evening association but periods are available during the weekend mornings and afternoons.

32. On the evening of 4 July, there was no association for F wing, so the man was locked in his cell from about 5:00pm until the next morning.

5 July

33. The officer unlocked the man's cell at about 8:00am. He said that the man was still in good humour. Between about 8:15 and 8:30am, another officer saw Paul out of his cell chatting with other prisoners on the landing. She said his accent made him stand out, as it was unusual to have prisoners from the north. Otherwise he was chatty, mixing well with everybody and did not appear to be down.

34. The man saw nurse again for a Secondary Health Screen to follow up areas for further exploration identified in the First Reception Health

Screen. He had stated that he had asthma, so his Peak Flow breathing was measured and the box indicating that he would be referred to the asthma nurse was ticked. He was given two health information leaflets and an inhaler was prescribed. The nurse said that the man mentioned to him that he had not yet managed to make a telephone call. The nurse took the man back to his landing and let the officer know that he wanted to use the telephone. It is unclear why he did not use the telephone the day before as there is a telephone in Reception and he had been given sufficient credit to make calls.

35. The Induction officer went through a list of formalities with the man to check that he understood Norwich's policies on various aspects of prison life, including anti-bullying, disability, use of television, race relations, the Incentives and Earned Privileges Scheme, drug testing, use of the telephone, how to arrange a visit, how to select meals, the Personal Officer Scheme and Listeners. The man signed the relevant compacts to indicate that he had understood what had been explained to him and the leaflets he had been given. He completed a form giving the names, addresses and telephone numbers of his mother, sister and five friends he wanted to contact whilst in prison. The officer could not remember what time he had seen the man for Induction but thought that he had spent about 30-45 minutes with him.

36. According to the prison telephone records, the man tried to telephone his mother's mobile telephone several times between 9:16am and 9:43am, but was unable to make contact with her.

37. At 9:45am, he telephoned and spoke to his friend. He told his friend that he was in Norwich Prison, having assaulted his partner again. He asked his friend to tell his mother later that he was there and that he had written a letter to her. He added that he would also write to his friend.

38. After speaking to his friend, the man had an interview with an Assistant Chaplain, as part of his induction. It is a requirement that a Chaplain sees all newly-arrived prisoners within 24 hours.

39. The man told the Assistant Chaplain that he had argued with his mother before leaving on holiday with nine friends and had driven her car to Norfolk on Saturday 2 July, despite not having a valid driving licence or car insurance. Soon after arriving at the caravan park, he and his friends had begun to drink heavily and he became quite drunk. As a result, he was somewhat unclear about what had happened next, but believed that he had rowed with his partner and she had punched him in the mouth. He had retaliated by hitting her across the face and had run away.

40. The man speculated that he had probably lost his girlfriend for good. He spoke about saving up his money for a holiday and ending up in prison only a few hours after his holiday had started. He thought he

might receive between 12 and 18 months imprisonment and remarked that he would miss the beginning of the football season.

41. The Assistant Chaplain described the man as open and talkative. He had been pleasant to talk to and had spoken freely. He had not seen any signs that the man intended to harm himself.

42. The man tried to telephone his mother again at 10:06am without success. Lunch was served between 12:00 and 12:30pm. Like all the other prisoners in the YOI the man ate his lunch in his cell. An officer observed the man laughing and joking with other prisoners at lunchtime and thought that he seemed to be getting on well.

43. After lunch, as F1 landing was preparing to receive new prisoners, the man moved cells because his induction had finished. An officer took him to G2 landing (which is on the first floor of G wing) where he was allocated a single cell, G2-19. He was not sure what time he was moved but he thought it to be around 2:30pm.

44. The cells in G wing which face the perimeter wall have a metal grille, perforated with large holes, fitted to the inside of the windows. It is possible to see out of the windows but the grilles do reduce the amount of light available and lend a claustrophobic air to the cells that have them. My investigators were told that the grilles were fitted to stop prisoners retrieving contraband that is thrown over the perimeter fence. Cells in F wing do not have the grilles as they are away from the fence.

45. The landing officer in charge of G2 that afternoon said he could not remember what time the man had arrived on his landing but thought that it was late afternoon, towards the end of his shift, which was due to finish at 4:45pm. In interview with my investigators an officer said that, a little while after the man had placed in his cell, he went to introduce himself to him and asked him if he had any immediate problems that needed to be dealt with. The man said that he did not. Asked by my investigators whether the man had asked for single cell, the officer explained that there is normally a waiting list for single cells but, as it happened, there were no names on the list and the man seemed suitable for a single cell. The officer explained to the man that if he had any problems, especially with bullying, he should report it to a member of staff as they should deal with it. He told my investigators that new prisoners, unfortunately, sometimes receive verbal abuse from other prisoners at night time after they are locked up for the evening.

    The man said he said he was fine, there were no problems. The officer noted that he had good eye contact, he seemed better than most prisoners who come in their first time in prison, he seemed quite with it and there was no obvious signs of distress."

46. An officer said he had been shocked to learn of Paul's death, so he had asked a couple of prisoners whether the man had been verbally

abused that evening, but they said he had not. The feedback he received was that, due to the short time the man had spent on the landing, others did not know he was there.

47. A prisoner who was in cell G2-18 next door to the man, told my investigators that on 5 July, when he returned from education classes in the afternoon, he noticed that someone new had moved into the cell next to his. It was about 4:00pm. He said that he greeted the mna through the cell door and asked him why he was in Norwich and the length of his sentence. He remembered that the man said he was there for assault after arriving on holiday and getting "banged up". He recalled that the man was chatty and lively. The prisoner said that it was not unusual for him to speak to new prisoners and he had chatted to the man for about 15 minutes before getting locked in his own cell. The cell to the other side of the man, G2-20, was empty as it was out of action.

48. At 4:09pm, the man managed to contact his mother by telephone. The conversation lasted just over four and a half minutes. He asked her whether a friend had visited her and told her that he was in prison. She replied that she had already been informed by a solicitor that he was in custody. The man asked his mother for his girlfriend's telephone number. His mother advised him not to contact his partner and that she would have nothing to do with him if he did. She said that she had spoken to his partner and that she had said she was frightened about him being released. They discussed whether the man could obtain a bail address.

49. The man told his mother that he had written to her and she should reply. His mother said that she had posted him some money, as she had already found out the address of the prison. The man asked his mother to ring his partner. She replied that she did not want to, but agreed to do so. The manl told his mother that he loved her and that he had to go back to his cell. She asked him if he was alright and he replied, "No it's fucking shit".

50. The evening meal was served in the YOI at about 5:30pm. Prisoners on F wing collected their meals first, then G wing at about 5:50pm. There is no dining room in the YOI, so individual meals are collected from a servery on the ground floor and eaten in cells. There was no association amongst prisoners on G wing that evening, so they were locked in their cells after collecting their evening meal until the next morning. The prisoner in the cell next to the man said he did not see him going for his meal, but at some point after they were locked in they spoke to each other through their cell windows. They talked about where he was from and his holiday. The prisoner was unable to say at what time he had last spoken to the man. Having missed out on association the previous night, the man now faced the prospect of being locked in his cell again for a second consecutive evening.

51. All the prisoners on G wing were locked in after the evening meal was served. An evening patrol officer for G wing told my investigators that he had been working on G3 landing that afternoon and had not had any contact with the man. He could not actually remember the evening of 5 July very clearly and could only say what would normally happen on evening duty rather than what he remembered occurring. He described his duties as evening patrol officer to carry out a roll check, respond to cell bells and answer any queries or requests from prisoners.

52. The patrol officer thought that G wing prisoners were finally locked in at about 6:10pm. He said he would normally have answered cell bells and queries from prisoners for about 15 minutes before starting to count the wing at about 6:30pm. He did not remember the man and could not say whether he had rung his cell bell. There is no electronic system to record whether a cell bell has been activated.

53. After confirming at about 6:45pm that the number of prisoners he had counted tallied with the master roll board, the officer based himself in G1 office on the ground floor. There is no requirement to record in a wing diary what time the wing roll is checked or by whom.

54. This officer did not physically check the roll again. After association on F wing finished at about 7:30pm and the prisoners were locked in their cells, an officer who had been working on F wing and was going off duty at 8:00pm, went to the Communications Room and signed the Report of Locking Up to confirm the roll for F and G wings. The roll for the whole prison was declared correct at 7:56pm and the staff whose shifts finished at 8:00pm left the prison.

55. The patrolling officer was detailed a “late finish” which meant that he would remain on duty until the night officer arrived and took over duties at 9:00pm. The patrolling officer was unclear as to what exactly had happened that evening, but thought that he probably left the wing as the night staff arrived and waited at the main YOI gate for the overall prison roll to be correct. He was unaware that the man had been found hanging until he returned to the prison for his next shift.

56. The night officer told my investigators that his shift began at 9:00pm but he arrived at the prison some 25 minutes before. It was his second night on duty and the first set of nights he had done in the YOI. He said he arrived early so that he could find out from the day staff if there was anything he should be aware of. In the event, he could not remember what was said on handover. He said it was normal practice for night staff to check the roll and then the evening patrol staff could leave.

57. The officer said he checked to see if anyone had been identified as at risk and then began to count the landings. As he got to cell G2-19, he noticed that the transparent observation panel in the door had been

covered from the inside. He thought that he probably kicked the door to get a response from the prisoner inside but did not hear anything. The officer said that from time to time prisoners did cover their observation panels and it was normal to elicit a response from the occupant and ask them to remove the covering.

58. The officer telephoned Operational Support Grade (OSG) who was also on night duty on F wing and asked him to come over to G wing so that they could unlock the door to cell 19, as he said it was not the practice to open cells at night time with only one member of staff. At about 8:53pm, the officer unlocked the cell and saw the man hanging in front of his cell window. The ligature had been made from a bed sheet and was threaded through holes in the right hand side of the window grille to form a horseshoe shape.

59. The officer contacted the Communications Room by radio to ask for immediate medical assistance saying "Code 1 Code Blue". He explained to my investigators that Code 1 meant "presumed dead" and Code Blue meant "not breathing" and that the code system had recently changed. The OSG said at interview that he radioed for assistance. However, the Communications Room incident log shows that the message was in fact received from the officer.

60. The officer said he pushed a table under the man to try to support his weight and then climbed on it to remove the ligature from around his neck. The OSG held the man's legs and helped him place the man on his bed. The officer used a Vent Aid, a plastic mouth piece, to try to resuscitate the man by blowing air into his mouth, but he did not think that air was getting past his throat. The Vent Aid was an item that he chose to carry, but was not standard issue. The officer then began Cardio Pulmonary Resuscitation (CPR). The officer described the man's appearance as having a poor pallor. He had very dark bruising around his neck and his skin was cold to the touch. He did not respond to attempts to revive him.

61. At 8:53pm, the Communications Room put out a radio message asking for urgent medical assistance. It was acknowledged by two Healthcare staff carrying the radio call signs Hotel 1 and Hotel 6 and by the Night Orderly Officer.

62. The OSG told my investigators that the officer radioed for medical assistance again, as no-one had turned up. Shortly afterwards, a nurse arrived. A nurse arrived at the man's cell at 8:57pm. She had been on duty in the Healthcare Centre and was Hotel 1, the designated night duty response nurse for the Healthcare Centre and F and G wings. She explained at interview that, although she knew she had been asked to attend a "Code Blue", she did not know exactly what sort of situation she would be facing. She did not take any medical equipment with her, as there was an emergency bag in the treatment room in the YOI. She was escorted to G wing by an officer as she was

not carrying door keys. She did not take a defibrillator with her as she was not trained to use it.

63. When the nurse arrived she said she saw the officer and the OSG administering CPR. The man's skin looked greyish blue and he did not appear to be responding. The nurse said she asked for an emergency bag to be brought. She did not recall which member of staff brought it, but only one member of staff left the cell. The OSG said he brought up a First Aid Box from the treatment room which is situated on the ground floor. The officer said he went to get a portable resuscitation kit from the treatment room then returned to the cell and continued administering CPR with the nurse.

64. The nurse asked the officers if they had called an ambulance and when they replied that they had not, she asked for one to be called. In fact, according to Norwich's Incident Log sheet, a 999 emergency call for an ambulance had already been placed by another officer at 8:53pm. The East Anglian Ambulance Trust Agency Incident Report records the time of the request as 8:55pm.

65. A Senior Officer (SO) was the Night Orderly Officer in charge of the prison on 5 July. He said he heard a radio message at about 8:55pm that there was an emergency in the YOI. He went to the cell and took over resuscitation attempts from the officer that had found the man.. The SO said about two minutes after he arrived, another nurse appeared and took over from him. The SO then assumed his role as the incident manager co-ordinating officers to escort the police and ambulance crew, making sure that an occurrence log of events was being kept, staff on the scene had been supported, and that appropriate senior managers were being kept abreast of what had happened.

66. The second nurse also responded to the radio message for medical assistance. She had been working in the main adult prison, across the road from the YOI, and had just finished her shift but decided to offer her assistance. She arrived at G2 landing at 9:00pm. She did not take any equipment with her, but said that when she got to the man's cell the resuscitation bag was already there. She took over chest compressions from the SO.

67. Norwich's records indicate that an ambulance arrived at 9:04pm (East Anglian Ambulance Trust Agency record the time they arrived at the scene as 9:02pm.) The two paramedics took over from the nursing staff treating the man, but when he did not respond, they stopped at 9:10pm and declared him dead.

68. Norfolk police were informed at 9:20pm that there had been a death. After examining the man's cell and taking statements, they were satisfied that no third party had been involved.

69. An undated handwritten letter addressed to the man's mother was found on the floor of his cell by the SO.

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70. A notice from the Governor was displayed informing staff and prisoners of the man's death. In addition, the Assistant Chaplain held prayers and a minute of silence on the exercise yard for F and G wings. Afterwards, he was asked for two bereavement cards which prisoners signed and were sent to the man's mother.

Contact with the deceased's family after his death

Norwich's efforts to inform the family of the death

71. The duty governor on-call on the evening of 5 July was informed at 8:58pm by the Communications Room that the man had been found. He arrived at the prison at 9:15pm.

72. On the man's arrival at Norwich, he had named his mother as his next-of-kin. His mother lives in Lancashire. The duty governor commendably decided that it would be preferable for a governor at a prison near to her address to visit her and break the news of her son's death rather than the police. Having consulted a map of Prison Service establishments, he thought that HMP Garth, in Leyland, seemed appropriate and he contacted them at 11:04pm.

73. The duty governor at Garth, returned the call at 11:08pm. He declined to contact the family on the grounds that HMP Kirkham was nearer to her address. Garth is approximately 18 miles from away.

74. Norwich's duty governor then spoke to the duty governor at Kirkham, at 11:31pm. Kirkham was not happy with the request and refused. Kirkham is approximately 22 miles from where the mother lived by the shortest route.

75. At 11.46pm, Norwich's duty governor then telephoned HMP Preston, just under 14 miles from the family home by the shortest route. He spoke to the duty governor explaining that - as far as he understood - there had been a directive from Prison Service Headquarters to all Governors endorsing the use of governors to inform families of a death rather than the police. Preston's governor was unaware of such a policy, but nevertheless agreed to visit the mother with the prison Chaplain to break the news of her son's death. He had asked Lancashire police whether they would accompany him but they said they did not have an officer available. As he lived some distance from the prison, he was unable to make contact with the mother until 2:30am on 6 July. The Governor of Norwich made contact with the mother later that day and has continued to act as the prison's Family Liaison Officer.

76. One of my Family Liaison Officers and the Senior Investigating Officer, visited the family, to discuss any issues they wished to raise.

77. The mother was concerned that she appeared to have been given conflicting information about the time her son was last seen when he was locked up for the evening. She said she had been told her that her son had been locked up for the evening at about 6:30pm but she had also heard that lock up time was 8:30pm. She said her son was not the type of person to take his own life and that it must have been an attempt to get attention or a prank that went wrong. She was concerned that he was in a cell by himself and found it hard to accept that he could have made a ligature to hang himself.

78. She felt that the governor who had told her of Paul's death had been very supportive.

Contact with the man's father

79. The man's father, contacted my office and asked to meet my investigators. He said that he and the man's mother had divorced some years ago and she did not wish him to have contact with his son, although his son had visited him regularly during his teenage years and in the12-18 months prior to his death and he had telephoned occasionally.

80. He and his wife said they had experienced difficulty finding out from Norwich what had happened to their son, as Norwich appeared reluctant to disclose any information to them. Eventually, they had to ask a solicitor to send a fax to the Governor confirming the father's identity. This had caused them some distress.

81. My investigators asked the Governor about his contact with the father. The Governor said that the man had only named his mother as his next of kin and had not included his father's details amongst the names and addresses of those with whom he wished to be in contact. Clearly, relations between the parents were difficult and it would have been unethical for him to involve himself in their personal matters. He considered it best to deal with the mother as she had been named by the man as his next-of-kin and it was left to her to tell whom she wished.

Post Mortem and Clinical Review

82. A post mortem examination took place on 7 July. It found that three small abrasions on the man's neck may have been caused by the removal of the ligature by staff or the attempt by paramedics to resuscitate him. There were also four small bruises on his left foot. The pathologist concluded that the death was due to suspension and that there was no pathological evidence of a third party being involved.

83. A clinical review was carried out on behalf of Norwich Primary Care Trust. It concluded that the radio system of coded emergency messages was "inadequate and non informative" leading to nursing staff not attending an emergency with appropriate equipment. The emergency bag itself did not contain a defibrillator. It recommended that healthcare staff should receive annual refreshers in basic life support, which should include instruction on the use of an automatic external defibrillator. It commended the use of secondary health screening. Since this death, all medical emergency bags now contain lightweight oxygen cylinders.

Conclusions and Recommendations

84. This man appeared to all the staff who met him at Norwich to be a pleasant, open, chatty, jovial young man. He seemed to interact well with staff and prisoners alike considering that it was his first time in custody. From his entry into Norwich, officers were aware that he had not been in prison before and sought to put him at ease. Many of the staff he encountered were experienced at working with new and young prisoners and alert to signs of distress and vulnerability.

85. He told the Assistant Chaplain that he had probably lost his girlfriend and he said to an officer that he was nervous about being in prison as it was a new experience. He did not express any other worries to staff.

86. In contrast, in the unposted letter to his mother, he confessed to feeling frightened, expressed feelings of worthlessness and bewilderment at his violent behaviour towards his girlfriend and agreed that he needed to "see someone about [his] head". My investigators have interviewed all of the staff who came into contact with the man and have seen his prison records. Despite him saying in the letter that he needed help and had been told that something would be "sorted out", they have been unable to find evidence that he did express such sentiments to staff.

87. The officers of F and G wing who came into contact with the man come across as caring, dedicated and professional in their duties. It is understandable that this death after only a day in Norwich came as a shock to so many.

88. It is unclear why the man was unable to make a telephone on his first night at Norwich.

I recommend that Reception staff ensure that newly received YOI prisoners have the opportunity to use the telephone before the end of the day.

89. I regret that this man did not have association for the two consecutive evenings he was in Norwich. A system which provides for activity only every other weekday evening, and not at all on a weekend evening,

can only serve to emphasise the feelings of isolation felt by many prisoners. This is particularly true of young prisoners, and particularly at Norwich where insufficient work and activity places during the day mean that many prisoners spend all day, all evening and all night (apart from a period of exercise and to collect their meals) in their cells.

I recommend that newly received YOI prisoners should be able to have association within a day of arrival.

90. The induction staff to whom my investigators spoke were enthusiastic about their work. Induction in the adult prison is spread over two days and involves Insiders, who are prisoners trained to give newly arrived prisoners information on how the prison runs, the realities of coming into custody – information especially useful for those who have no experience of custodial life. However, in the YOI, induction lasts no more than a day (in this case, just a few hours), there are no Insiders, and the result is too many establishment policies and compacts being introduced at one time, leading to information overload. The process is too skewed towards the completion of written booklets and forms and is too rushed.

I recommend that the Governor reviews the operation of induction in the YOI with a view to expanding it from one day and harnessing the skills of staff to create a specific package tailored for young adults.

The Governor should consider the introduction of Insiders to the YOI.

94. After seeing this report at the draft stage, the Prison Service commented that "Insiders were introduced as an integral part of the new First Night Centre, however, Samaritan trained 'listeners' were available on each wing prior to the first night centre opening." I am pleased that, following this death, the Governor of Norwich has taken measures to improve the wellbeing of new prisoners.

95. Some cells in G wing have perforated window grilles on the inside. Not only do they lend the cells a claustrophobic and oppressive air but, as this man sadly demonstrated, they provide an obvious ligature point.

I recommend that the Governor gives consideration to the internal grilles being removed and to what measures can be taken to make the cells safer.

96. The systems for recording roll checks on F and G wing are inadequate. There is a clear disparity between the time when the roll was checked on the evening the man died and the time the numbers were given in. A physical roll check of prisoners should have taken place just before the actual numbers were given in, not up to an hour and a half before. The post mortem does not indicate how long the man was dead before he

was found. From the officers' and nurses' description of the man's physical appearance, he might have been dead when the patrol officer was still on the wing, but before the roll was declared correct at 7:56pm. It is also possible that he died in the period afterwards.

I recommend that the Governor issues clear instructions to staff on the importance of conducting physical roll checks of prisoners immediately before the roll is submitted.

I recommend that all roll checks should be properly recorded in an auditable document.

97. At interview the evening patrol officer, was unable to recall any details of the evening the man died. The officer on nights who found the man hanging, was unable to recall whether or not he had received a handover from the patrol officer before taking over duties on G wing. This absence of information has meant that I have been unable to clarify the exact events between the time the man last spoke to the fellow prisoner and when he was found by the night officer. The family is distressed, understandably, by this unsatisfactory lack of detail. I am heartened to learn that, since this death, the Governor of Norwich has put in place a system of signed written handovers between shifts.

98. Prison Service Order 2710 – Follow up to deaths in custody states:

> "The decision on how to inform next of kin should take into account individual circumstances, especially distance from the establishment. However, unless inappropriate for geographical reasons … it is recommended that unless there are very good reasons not to do so, notification should be made in person by a visit to the next of kin by the governor … and chaplain/other religious leader."

99. I have recommended in previous investigations into deaths at Norwich that the Prison Service rather than the police should, wherever possible, inform the family of their loved one's death. It may be that the duty governor at Norwich understood that this was a national recommendation to all governors. The importance of treating a bereaved family with maximum respect cannot be overstated. However, I am conscious of the difficulties that may arise at night. It is not unreasonable for a governor at one prison to ask a governor at another to visit a family and inform them of a death during working hours. However, at night time there is a much reduced number of staff on duty in prisons and a duty governor may need to be on standby to handle any unforeseen incidents that occur at their own prison. Nevertheless, in this case the alternatives (the mother being telephoned with news of her son's death, being told by the police who would not have detailed information or knowledge of prisons, or delaying until the next day and risking that she might have already heard by other means) were not desirable. In the event, Lancashire police said they did not have an officer available to accompany the visit to the family and the task was left for the Prison Service to manage in its entirety.

100. Breaking news of a bereavement in another prison needs to be handled with great sensitivity. However, I am aware of several cases where it has been carried out successfully, sensitively and professionally. Norwich's duty governor went to considerable effort to ensure the mother was told appropriately of her son's death. In fact, Garth, the first prison contacted, is only three miles nearer to her home than Preston and whilst I understand the difficulties of making arrangements at night, I am disappointed that governors at two prisons only a few miles apart felt that they could not perform this task. The fact that the mother was very appreciative of being told of her son's death in person, makes Preston's willingness to agree to this difficult undertaking all the more commendable along with the efforts of Norwich's duty governor to make the arrangements.

I recommend that a copy of this report is sent to the Governor of Preston and his attention drawn to my comments concerning the important role his establishment played. A further copy should be sent to the Prison Service Area Manager for the North West.

101. The emergency codes of Code Blue and Code Red were introduced in June 2005 because the previous system was not specific enough. The first nurse said that, although she knew that she was responding to a medical emergency, she did not know that the man had been found hanging until she arrived at his cell.

I support the clinical review recommendation that there should be a review of whether the emergency codes are sufficiently detailed.

102. Finally, it is a matter of concern that a defibrillator was not part of the emergency equipment taken to an incident and that the designated night duty nurse, did not know how to use one. The clinical review also raises this as an issue.

I support the recommendation that the Governor and the Primary Care Trust consider the provision and training to staff in the use of defibrillators and annual refreshers in basic life support.

The Prison Service's response to my report

103. I sent the Prison Service a copy of this report at the draft stage. They did not identify any factual inaccuracies and have produced an action plan which I have included overleaf.

No	Recommendation	Accepted/Partially accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	I recommend that Reception staff ensure that newly received YOI prisoners should have the opportunity to use the telephone before the end of the day.	Accepted	The dedicated First Night Centre with extended opening hours for all new receptions will ensure delivery of this objective.	30 April 06	
2	I recommend that newly received YOI prisoners should be able to have association within a day of arrival.	Accepted	The dedicated First Night Centre with extended opening hours for all new receptions will ensure delivery of this objective.	30 April 06	
3	I recommend that the Governor reviews the operation of induction in the YOI with a view to expanding it from one day and harnessing the skills of staff to create a specific package tailored for young adults.	Accepted	New Work Profiles are being introduced which will facilitate the expansion of the Induction Programme.	31 May 06	
4	The Governor should consider the introduction of Insiders to the YOI.	Accepted	The dedicated First Night Centre with extended opening hours for all new receptions will ensure delivery of this objective. Insiders are based within the Centre.	30 April 06	
5	I recommend that the Governor gives consideration to the internal grilles being removed and to what measures can be taken to make the cells safer.	Accepted	A scheme of work is already in place to reduce the number of potential ligature points in Y.O.I. cells. A review will take place of the cost and practical implications of removing these particular grilles.	30 Jun 06	
6	I recommend that the Governor issues clear instructions to staff on the importance of conducting physical roll checks	Accepted	Clear instructions will be published.	30 April 06	

	of prisoners immediately before the roll is submitted				
7	I recommend that all roll checks should be properly recorded in an auditable document.	Accepted	An auditable document is now in place	Completed	
8	I recommend that a copy of this report is sent to the Governor of Preston and his attention drawn to my comments concerning the important role his establishment has played. A further copy should be sent to the Prison Service Area manager for the North West.	Accepted	Copy of report forwarded for action to: 1. The Prison Service Area Manager for the North West 2. The Governor of HM Prison Preston	Completed	
9	I support the clinical review recommendation that there should be a review of whether the emergency codes are sufficiently detailed.	Accepted	The emergency codes were adopted as a consequence of previous recommendations. It is accepted that detailed guidance will need to be issued personally to all Health Care Staff to support the existing Governor's order	30 April 06	
10	I support the recommendation that the Governor and the Primary Care Trust consider the provision of training to staff in the use of defibrillators.	Accepted	All Health Care Staff (nursing staff and Health Care Officers) will receive training.	31 December 06	

Summary of recommendations

- **I recommend that Reception staff ensure that newly received YOI prisoners should have the opportunity to use the telephone before the end of the day.**

- **I recommend that newly received YOI prisoners should be able to have association within a day of arrival.**

- **I recommend that the Governor reviews the operation of induction in the YOI with a view to expanding it from one day and harnessing the skills of staff to create a specific package tailored for young adults.**

- **The Governor should consider the introduction of Insiders to the YOI.**

- **I recommend that the Governor gives consideration to the internal grilles being removed and to what measures can be taken to make the cells safer.**

- **I recommend that the Governor issues clear instructions to staff on the importance of conducting physical roll checks of prisoners immediately before the roll is submitted.**

- **I recommend that all roll checks should be properly recorded in an auditable document.**

- **I recommend that a copy of this report is sent to the Governor of Preston and his attention drawn to my comments concerning the important role his establishment has played. A further copy should be sent to the Prison Service Area manager for the North West.**

- **I support the clinical review recommendation that there should be a review of whether the emergency codes are sufficiently detailed.**

- **I support the recommendation that the Governor and the Primary Care Trust consider the provision of training to staff in the use of defibrillators.**