

PRESS RELEASE – WEDNESDAY 16 NOVEMBER 2005

**CORONER FINDS ‘SERIOUS FAILINGS AND FUNDAMENTAL FLAWS’
IN PROCEDURES IN HMP NORWICH FOLLOWING DEATH OF 20 YEAR
OLD ANDREW BARCLAY**

Following a critical narrative verdict returned by the jury at the inquest into the death of 20-year-old Andrew Barclay who died at HMP Norwich in 2003 the Coroner, William Armstrong, stated that there were “serious failings and fundamental flaws” in procedures in April 2003. He said that the response to discovering Andrew hanging was “uncoordinated, undirected and inappropriate” and that the lack of staff training was totally unacceptable. He also said that various lessons had come from the investigation into Mr Barclay’s death and that from what the governor of the prison had said at the inquest that improvements had been made which was encouraging. He went on to say however, that there are still far too many people dying in prison custody and that deaths in custody are of public concern and it is important that they are independently investigated and that lessons are learned.

Deborah Coles, Co-Director of INQUEST, said: “Yet again an inquest into a death in prison has resulted in highly critical comments from the Coroner and jury about the failure by the prison service to protect the right to life of a prisoner in its care. INQUEST is concerned that there are no effective mechanisms to ensure that lessons are learned across the prison estate following a death in custody.”

Andrew, who had arrived at the prison on 14 February 2003, was found hanging in his cell by a prison officer as he opened the cells for morning unlock on 24 April 2003.

The Prison Service’s own internal investigation report completed in September 2003 raises a number of serious concerns about the circumstances of Andrew Barclay’s death. Key points include the lack of training received by clinical healthcare staff and their lack of basic medical training in CPR and general healthcare. Staff should also receive and understand guidance on initial screening of a person’s suicide or self-harm risk. This was confirmed by the jury’s verdict below.

1. Did prison staff have any reason to believe that Andrew Barclay was likely to self-harm or take his life?

No. Due to unsatisfactory communications and procedures within the prison

2. Once Mr Barclay had been discovered hanging;

a) Were attempts made to summon medical assistance to the cell as quickly as possible having regard to all the circumstances at the time?

Yes

b) Were ligature cutters brought to the cell as quickly as possible having regard to all the circumstances at the time?

No

c) Was an ambulance called as quickly as possible having regard to all the circumstances at the time?

No

3. Should a member of nursing staff on the morning of the 24 April 2003 have;

a) Provided mouth to mouth resuscitation?

Yes

b) Conducted chest compression until paramedics arrived

Yes

Notes to Editors

INQUEST has worked closely with Andrew's father John Barclay since the tragic death of his son. This inquest is the first opportunity that Andrew's family have had to find out the circumstances of Andrew's death over two and a half years ago. In 2003 John was one of a number of families who gave evidence to the Parliamentary All Party Joint Committee for Human Rights as part of their inquiry into deaths in custody. Despite the nature of his son's death in prison John has been refused public funding for the inquest. This is in stark contrast to the Prison Service whose legal team is paid for out of the public purse.

The family of Andrew Barclay were represented by INQUEST Lawyers Group members Nick Stange (Garden Court North Chambers) instructed by James Bell (Christian Khan Solicitors).

Self-inflicted deaths at HMP Norwich 2000-2005					
Name	DateOfDeath	Status	Ethnicity	Age	Cause of death
Simon Smith	30/09/2005	Convicted	UK White	40	Hanging
Paul Jones	05/07/2005	Convicted	UK White	20	Hanging
James Fadden	11/06/2005	Remanded	UK White	28	Hanging
Raymond Goodwin	27/09/2004	Remanded	UK White	44	Hanging
Benjamin Gibson	25/08/2004	Convicted	UK White	19	Hanging
Kingsley Llewellyn	14/03/2004	N/A	Black Caribbean	29	Hanging
Benjamin Townsend	21/06/2003	Convicted	UK White	19	Hanging
Andrew Barclay	24/04/2003	Convicted	UK White	20	Hanging
Nicholas Brownlee	02/01/2003	Convicted	UK White	29	Plastic bag over head
Ryan Edmunds	17/08/2002	Remanded	UK White	20	Hanging
Wayne Rowan	25/12/2001	Convicted	UK White	27	Hanging & bag over head
Carl Dale	20/09/2001	Remanded	UK White	43	Hanging
Philip Nixon	17/08/2000	Remanded	White	31	Hanging

Source – INQUEST Monitoring

INQUEST has ongoing concerns regarding the number of young offenders taking their own lives in prison. Andrew was one of twelve people who died in 2003 aged 21 and under.

INQUEST is the only non-governmental organisation in England and Wales that works directly with the families of those who die in custody. It provides an independent free legal and advice service to bereaved people on inquest procedures and their rights in the coroner's courts.