**IN THE SURREY CORONER'S COURT**
**IN THE MATTER OF:**

---

**The Inquests Touching the Death of Chrylin Angela Maria NORRELL-GOLDSMITH**
**A Regulation 28 Report – Action to Prevent Future Deaths**

---

| | |
|---|---|
| | **THIS REPORT IS BEING SENT TO:**<br><br>• The Rt Hon Chris Grayling MP – Lord Chancellor in relation to paragraph 5(1).<br>• The Governor of HMP Downview in relation to paragraphs 5(1) and 5(2).<br>• The Chief Executive of the Surrey and Borders Partnership NHS Foundation Trust in relation to paragraphs 5(2), 5(3) and 5(4).<br>• The Chief Executive of Virgin Care in relation to paragraphs 5(2) and 5(4). |
| 1 | **CORONER**<br>Richard Travers HM Coroner for Surrey |
| 2 | **CORONER'S LEGAL POWERS**<br>I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009. |
| 3 | **INVESTIGATION and INQUEST**<br>The inquest into **Mrs Norrell-Goldsmith's** death was opened on the 2nd August 2013 and was resumed on 2nd October 2014 with a jury. It was concluded on 27th October 2014.<br>The jury found that the cause of death was:<br>1a – Hanging.<br>They concluded with the following verdict:<br>Cherylin Angela Maria Norrell-Goldsmith took her own life. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>At shortly before midnight on the 26th July 2013 Mrs Norrell-Goldsmith was found in her cell at HMP Downview. She was partially suspended by a ligature which had been attached to some exposed pipe work in the |

| | |
|---|---|
| | lavatory area within her cell. Assistance was summoned and CPR commenced. Paramedics later attended but despite continued effort on the part of those in attendance they were unable to revive her.<br>Mrs Norrell-Goldsmith had been in custody since the 1st March 2012 and had been on an ACCT for almost the whole of that time. In addition, she had had long periods of counselling and, at the time of her death, was receiving Dialectical Behavioural Therapy. She had been a prolific self-harmer whilst in prison and had been diagnosed as suffering from an Adjustment Disorder. There was substantial documentation in relation to her treatment and care. |
| 5 | <u>**CORONER'S CONCERNS**</u><br>During the course of the inquest the evidence revealed a number of matters that gave rise to concerns that circumstances creating a risk of other deaths will continue to exist in the future unless action is taken.<br><br>The **MATTERS OF CONCERN** are as follows:<br>1. <u>Open pipe work with the cell</u><br><br>Whilst it may not be possible to remove all potential ligature points within a cell, removal of easily accessible and obvious ligature points may serve to reduce the risk of self harm and suicide to vulnerable prisoners.<br><br>2. <u>Multi-Disciplinary Attendance / Input at ACCT Reviews</u><br><br>Consideration should be given to ensuring that all staff, including prison staff, healthcare staff and In Reach staff understand the importance of requiring and providing multi-disciplinary attendance, or alternatively, multi-disciplinary input at all ACCT reviews.<br><br>3. <u>Retention of Primary Source Data within the Phoenix Programme</u><br>Consideration should be given to ensuring that all primary source data (ie data provided by the prisoner to the therapist), should be kept either in hard copy format or by way of faithfully recoding all the detail contained therein on the prisoner's System One record.<br><br>4. <u>Recording Significant Medical Events on a prisoner's Non-medical Records</u><br>Consideration should be given to ensuring that all members of healthcare and In Reach staff working within a prison environment record all significant medical events that may impact upon a prisoner's risk assessment for self-harm or suicide in a |

place or manner that is readily accessible to the discipline staff at the prison, in addition to any entry made in respect thereof in the System One record.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.

7 **YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

8 **COPIES**

I have sent a copy of this report to the following:

1. The Lord Chancellor
2. The Chief Executive of the Surrey and Borders Partnership NHS Foundation Trust in relation to paragraph 5(3).
3. The Chief Executive of Virgin Care
4. The Governor of HMP Downview
5. The Interested Persons in the Inquest:
    - Mrs Norrell-Goldsmith's Family (Bhatt Murphy)
    - Mrs Norrell-Goldsmith's daughter [redacted]
    - SABP NHS Foundation Trust (Weightmans)
    - MOJ – (T.Sols)
    - [redacted]
    - [redacted]
    - [redacted]
    - Virgin Care
6. The Chief Coroner

9 **Signed:**

*Richard Travers*

| | |
|---|---|
| | **DATED this 27th October 2014** |