

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in November
2013 at HMP Norwich**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man who was found hanging in his cell at HMP Norwich on 3 November 2013. He was 35 years old. I offer my condolences to his family and friends.

A nurse reviewed the man's clinical care. HMP Norwich co-operated fully with the investigation.

The man was in prison for a violent offence against a family member. He began an alcohol detoxification programme when he arrived in prison. This was his first time in prison and a nurse described him as anxious when he arrived. There were indications he had had previous contact with mental health services which do not appear to have been pursued. All of these are known risk factors for suicide and self-harm, but no one identified the man as being at risk and it is not clear that all of the risk factors were considered.

During his time at the prison, the man was described as quiet and reserved and he appears to have been withdrawn. At different times during October, two members of staff raised concerns about him but the officers who subsequently spoke to the man about these concerns concluded that he was finding it difficult to adapt to life in prison and did not consider that he was at risk of suicide or self-harm. Two referrals to the chaplaincy and mental health teams do not appear to have been recorded or acted upon. The man was eligible for release on home detention curfew on 4 November, the day after his death, but little had been done to progress his application. A note asking about this application was found in his cell after his death.

I am concerned that prison staff did not identify that the man might be in need of further support when he first arrived at the prison, when factors known to increase the risk of suicide and self-harm do not appear to have been taken into account. This is a matter I have raised with Norwich before. I am also concerned that two further opportunities to give the man the support he required were missed and, meanwhile, that the man's application for home detention curfew had not been processed appropriately.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2014

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SUMMARY

1. On 4 September 2013, the man was sentenced to eight months in prison for criminal damage and actual bodily harm. His victims were family members. It was his first time in prison and the reception nurse noted that he was anxious and withdrawing from alcohol.
2. On 1 October, a teacher was concerned about the man's state of mind and reported her concerns to prison officers who believed that he was withdrawn and finding it difficult to adjust to prison life. On 4 October, the man told an officer that he thought he might have been sexually assaulted by his cell mate while he was asleep, but he was not sure what had happened. He was moved to another wing so that he would not see his former cell mate. After discussion with the police, he decided not to press charges. A mental health nurse saw the man on 7 October, but none of the staff identified him as at risk of suicide or self-harm and in need of special monitoring and support.
3. Later in October, a substance misuse worker saw the man and although she did not consider him at significant risk of harming himself, she was concerned that he was very subdued and needed to talk to someone about his feelings. She said she had contacted the chaplaincy and mental health team but these referrals were not noted or followed up. The substance misuse worker also reported her concerns to a wing officer and noted them in the wing observation book. The wing officer spoke to the man but did not consider that he intended to harm himself.
4. The man was eligible for release on home detention curfew (subject to a suitable assessment) on 4 November, the day after his death. The process had been started, but further information requested from Suffolk Probation Trust was not obtained or chased up, which meant that the application had not been progressed as it should have been.
5. On 3 November, the man's wife visited him. An officer noted that he was quiet during the visit, but otherwise noted nothing unusual about the visit. That afternoon, the man collected his evening meal and was locked in his cell at around 5.00pm. He was found hanged in his cell during a roll check at 8.25pm. Officers and paramedics tried to resuscitate him but were unsuccessful.
6. We consider that the man should have been identified as at risk of suicide and self-harm when he first arrived at the prison and given appropriate support. Two further opportunities to offer additional support were missed when staff were concerned about him. Referrals to the chaplaincy and healthcare teams were not recorded effectively. A nurse attending the emergency was unable to locate the cell as she was new and unfamiliar with the layout of the prison. We make recommendations about these issues.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation. She invited anyone with relevant information to contact her and received a letter from the man's cell mate.
8. The investigator visited Norwich on 6 November. She went to the wing where the man lived and collected relevant records. She listened to some of the telephone calls the man had made. (Prisoners' telephone calls are automatically recorded and kept for a period of time. The prison was not routinely monitoring the man's calls.) She later interviewed staff and prisoners at Norwich and gave preliminary feedback about the investigation to the Governor.
9. NHS England commissioned a nurse to review the man's clinical care at the prison. She was given all the relevant documents to assist her review and attended some of the interviews with the investigator.
10. HM Coroner for Greater Norfolk District was informed of the investigation and provided the results of the post-mortem examination.
11. One of the Ombudsman's family liaison officers contacted the man's wife to explain the investigation and invite her to identify issues she wished the investigation to consider. She asked whether he had applied for, or discussed, being released on an electronic tag (home detention curfew).

HMP & YOI NORWICH

12. HMP & YOI Norwich is a multi-function prison which predominantly serves the courts of Norfolk and Suffolk. The prison holds up to 769 men. There is a healthcare centre which provides 24-hour nursing cover and a dedicated unit for older prisoners.

HM Inspectorate of Prisons

13. In the report of an inspection of Norwich in August 2013, inspectors noted that not all newly arrived prisoners were interviewed on their first night to identify risk and they were not assured that all prisoners received a full induction. They were concerned that staffing levels on A wing, which handled first night and induction and also prisoners requiring detoxification and those on remand, were inadequate. Staff had too little time to manage prisoners in crisis or feeling anxious during their early days in custody. Levels of violence were relatively high and inspectors said that too many prisoners said their isolation and anxieties about safety led them to self-harm. There were serious weaknesses in case management and planning for prisoners regarded as at risk of suicide and self-harm. Listeners (prisoners trained by Samaritans to provide confidential emotional support to fellow prisoners) said they did not feel supported by staff. Inspectors found that relationships between staff and prisoners were reasonable, but were sometimes superficial and prisoners found it difficult to get basic issues sorted out. Inspectors noted some significant delays with managing home detention curfew (HDC) applications. Most delays were caused by late reports from community offender managers, but delays were not pursued.

Independent Monitoring Board

14. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its latest annual report to the end of February 2013 the IMB was concerned about the effect of staff shortages and sickness on the prison regime. The IMB noted that the personal officer scheme did not work well and that wing officers did not know their prisoners. ACCT documents did not indicate quality interactions with prisoners. The IMB recognised that reception staff were welcoming but considered that the reception building was an austere introduction to prison life for more vulnerable prisoners arriving at Norwich. The IMB was concerned that some recommendations from Prisons and Probation Ombudsman's reports into death in custody were repeat recommendations and intended to monitor implementation more closely.

Previous deaths at Norwich

15. As Norwich has a special unit for elderly prisoners, there has been a relatively high number of deaths at the prison, mostly of prisoners who were terminally ill. In relation to self-inflicted deaths, we have previously made recommendations about the need to improve the identification of prisoners at

risk of suicide and self harm, particularly when they first arrive at the prison. We repeat a recommendation about this in this report.

Assessment, Care in Custody and Teamwork (ACCT)

16. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the care map have been completed.

KEY EVENTS

17. On 4 September 2013, the man was sentenced to eight months in prison for criminal damage and actual bodily harm. The victims were other members of his family. It was his first time in custody.
18. A nurse completed a first reception health screen when the man arrived at Norwich. He noted that it was the man's first time in custody and that he was anxious, but he did not think that the man would harm himself. The nurse said, when interviewed, that he attributed the man's anxiety to it being his first time in prison and not knowing what to expect. The nurse said that he had spent some time reassuring the man and telling him what prison life was like. The man said that he did not have any medical issues and his community GP faxed a summary to the prison which confirmed this. The man said he was homeless and told the nurse that he frequently drank alcohol. He was monitored for alcohol dependency and, as a precaution, was prescribed medication for six days to ease any symptoms of alcohol withdrawal. The nurse recorded that the man had previously seen a psychiatrist, but, when interviewed, he could not recall what the man had told him. There is no record of an officer in reception assessing the man's risk of suicide and self-harm and no evidence of a first night assessment.
19. On 5 September, the man was categorised as a Category C prisoner. The algorithm used to help determine the appropriate security category (which considers current and previous offending history) indicated that the man could be category D and suitable for an open prison. However, a member of staff from the prison's Offender Management Unit decided to over-ride the algorithm and made him a category C prisoner. Although she wrote on the form that the man had a pattern of escalating offences, she told the investigator that she had based her decision on the man having a restraining order against a family member. Because of this, she considered he was not suitable for an open prison until he had a period of assessment in closed conditions.
20. The man was eligible for release on 4 November on home detention curfew. (HDC, also known as "tagging" because offenders released under the scheme are required to wear an electronic tag to monitor their compliance.) The application process was started on 6 September and a suitability assessment was completed on 10 September. The man needed to get accommodation from BASS (a service which provides accommodation and support for those who would normally be living in the community on bail or HDC licence but do not have a suitable address).
21. On 18 September, the prison faxed the Suffolk Probation Trust in Ipswich and asked whether it would be appropriate to release the man to the Ipswich area. No response was received from the Probation Trust and this was not chased up. This meant that an HDC board was not convened to decide whether the man could be released on HDC. (The man had filled out a form dated 4 November asking for an update about his HDC application, which was found in his cell after he died).

22. The man enrolled on a business studies course and classes were run twice a week for three weeks. The teacher described the man as very quiet and said he would only contribute to the class if asked a direct question. She thought he was uncomfortable about being in prison. The purpose of the course was to look at business ideas. The man said he knew about dogs and might work with them when he was released.
23. On 1 October, the teacher became concerned that the man was showing physical signs of distress by shaking and blanking out others. He told her that he was being set up for something and that he did not think he would get out of prison alive, but would not clarify what this meant. The man made references to “them” listening to him. He agreed that he would speak to someone about this. The teacher spoke to her manager and she telephoned the man’s wing to report this, wrote an entry in his prison record case notes and submitted a security information report. The next day the security office asked an officer who was working on the man’s wing (F wing) that day, to speak to him. The officer spoke to the man for five to ten minutes but did not think he was at risk of suicide or self-harm. The man told him he had been feeling down, but was dealing with it and that he got on with his cell mate. The officer felt the man was going through the process of adjusting to prison and that he was shy and quiet. He did not think it necessary to open an ACCT. The officer rang the security office to tell them of his conversation with the man but did not record this in the man’s case notes on his prison record.
24. On 4 October, the man told another officer he thought he might have been sexually assaulted by his cell mate two nights earlier. He said that he had woken up about 2.00am and his cell mate was standing next to the bed. The television was on and his blanket was on the floor. The man said he could not recollect any specific contact by his cell mate but felt some discomfort in his scrotum. A GP examined him and could not find any physical evidence of forced physical contact and there were no bruises or cuts. The police interviewed the man but he decided not to press any charges. He was moved to another wing (G wing) as soon as he made the allegation so that he would not come into contact with his former cell mate.
25. A mental health nurse saw the man three days later, on 7 October, at the request of an officer who felt he was isolating himself and not talking to anyone. The mental health nurse said the man was eating his lunch when she visited and, although he appeared anxious, told her he had no intentions of harming himself and was happy to be moving into a single cell later that day. He moved into his own cell on G wing that afternoon.
26. When the business course finished, the man decided to do an IT course, which has more independent study than classroom-based discussion. Prisoners on the course are allocated an IT mentor – a prisoner who is experienced in IT and who can offer advice and help. The man’s mentor described him as very quiet and said that it was hard to get anything out of him. He said the man was often monosyllabic and that he tried to encourage

and motivate him, but it was difficult. The man told his mentor he felt unsupported by his family and he did not speak about his wife.

27. On 15 October, a healthcare assistant saw the man to follow up the visit from the mental health nurse. He thought that the man was in good spirits and they talked about his release in January. The man did not mention anything about the possibility of early release under HDC. He told the healthcare assistant he would have no accommodation problems after he was released and that he received good support from his wife and family. The healthcare assistant had no concerns about the man or his mental health.
28. The man telephoned his father on 17 October and they spoke for ten minutes. The man said that he had wanted to check that his father was okay and that he worried about him. The man was tearful at times during the call. The man told his father that he might get released early on a tag but that he had not been assessed yet. He explained that if he did not get the tag he would be out in the New Year.
29. A substance misuse worker from the Rehabilitation for Addicted Prisoners Trust (RAPt) saw the man on 18 October to assess whether he needed support for drug or alcohol problems. The man told her that he usually drank two to four cans of lager a day. The substance misuse worker thought that the man was very subdued and appeared to be struggling with his feelings. He told her it was near the anniversary of his mother's death that he had spoken to his father and felt very low. The man said that he was not a great talker and that both he and his father were very private people. The man said he had spoken to members of the mental health team, but had told them that he did not have any problems. He said he did not want to harm himself, but the substance misuse worker was concerned about him. She did not open an ACCT document as she did not think he was at significant risk of self-harm at that time, but she thought that there was a potential risk of harm if he did not talk to someone about his feelings. After the meeting, she reported her concerns to one of his wing officers. She noted her concerns about the man in the wing observation book. She told the investigator that she had also rung the chaplaincy and contacted the mental health team about him.
30. The wing officer said that the substance misuse worker had told him she did not think that the man had any intentions of suicide or self-harm, but said that he would keep a close eye on the man over the next couple of days. The wing officer described him as a quiet young man who often kept to himself. He did not seem up and down in his moods, but was just quiet and appreciative of his privacy. He often spent association periods sitting alone in his cell watching television and did not mix with the prisoners on the rest of the landing very much. The wing officer continued to watch the man and felt there was nothing in his behaviour to suggest any intention of self-harm and therefore did not open an ACCT. The wing officer told the investigator that whenever he asked the man, he said that he was all right. He did not record any of his observations about the man in his prison record case notes or in the wing observation book.

31. The substance misuse worker said that she had spoken to the learning disability lead nurse when she rang the healthcare team to report her concerns about the man. The disability lead nurse said he did not remember receiving the call and that it would be usual practice in such circumstances for a message to be written in the communication book so that someone from the primary mental health team would go and see the prisoner. There was no message in the book and no note on the man's medical record. No one from the primary mental health team went to see the man as a result of the substance misuse worker's concerns.
32. The substance misuse worker saw the man again on 23 October. She felt he was more settled and much brighter than when she had last seen him. She gave him details of an alcohol agency in Suffolk in case he wanted help after release. The substance misuse worker said she had called the chaplaincy department again as she thought he needed support with his bereavement issues. The head of chaplaincy told the investigator that they did not get any telephone calls or referrals and there is no written entry about the man on 18 or 23 October in their daily journal, which is where they record telephone calls. When the investigator asked the substance misuse worker about this, she was adamant that she had made the calls. No one from chaplaincy went to see the man.
33. An officer on G wing described the man as very quiet. She said he did not socialise with other prisoners and spent most of his time in his cell. He would go outside during the exercise periods but usually walked around on his own. The G wing officer thought that other prisoners just left him alone because they thought that was how he wanted to be. She said she tried to engage the man in conversation but said he always give very short replies like "fine" and "okay".
34. The man spoke to his wife on the telephone on Friday 1 November. He told her his computer course had finished and that he would need to apply for another job in the prison the next week. He was worried about her planned visit on 3 November and whether her name would be on the visitors' list. He said that he was concerned about her and asked her if she was okay.
35. On Saturday 2 November, the man's IT mentor said the man walked around the exercise yard a few paces behind him. He thought that the man might have been trying to get his attention, but the IT mentor was busy talking to another prisoner about a personal matter and did not speak to him.
36. The man went to chapel on Sunday morning, 3 November. Another prisoner told the investigator that the man could not sit still that morning and kept moving about. After chapel, the man went to the exercise yard. He rang his wife at 11.00am and they spoke for a minute. The man checked that his wife was on the visiting list for the afternoon and told her he had been to chapel and would be having a shower before the visit.
37. The man's wife visited him that afternoon. An officer in the visits hall said the visit appeared normal and lasted for the whole two hour duration. Although

the man and his wife did not talk to each other all the time, the visits officer thought this was due to natural lulls in conversation and not because of any apparent argument or disagreement. The visit finished around 4.15pm and the man returned to the wing. (There were some letters in the man's cell from his wife questioning the future of their relationship and what they would do when he was released from prison).

38. At Norwich, the last meal of the day is served from 4.45pm to 5.15pm on a Sunday. After the man collected his food, he asked the G wing officer to open his cell. The officer remembered commenting to him about his meal in order to try and elicit a response from him, but he did not reply. She locked him into his cell and continued locking up the rest of the wing. She and the visits officer were based on F & G wings that evening.
39. An Officer Support Grade (OSG) was on the night shift. He began a roll check of all prisoners around 8.20pm and reached the man's cell 2-18, just before 8.25pm. He looked through the observation panel and thought the man was standing at the window with the curtain drawn behind him. The man was not moving so the OSG asked if he was okay. When he got no response he looked closer and saw that the man was facing the door with the curtain in front of him. He saw blood on his T-shirt and knew that something was very wrong. The OSG radioed a code blue emergency, which automatically prompts the control room to call an ambulance. The ambulance report records the call at 8.24pm (the prison timings are a few minutes after this).
40. The G wing officer and the visits officer heard the call, ran upstairs and arrived within 30 seconds. They opened the cell door and saw the man hanging from the window, with a ligature made from a bed sheet around his neck. He had also cut the left side of his neck. The visits officer cut the ligature and laid the man on the floor. The G wing officer started chest compressions. The officers described him as cold, with pale and grey skin and they thought he might have been dead for some time. The visits officer tried to give rescue breaths but could not see the man's chest rising and so stopped after a few attempts.
41. A nurse was based in the healthcare centre on the same side of the prison as G wing. She took emergency equipment with her in response to the code blue, but was delayed by about five minutes because she was unsure how to get to the cell, once she got to G wing. An officer went to find her and took her to the cell. When the nurse got there, a defibrillator (a life-saving device that gives the heart an electric shock in cases of cardiac arrest) which had been brought from the wing office had been attached to the man. However, it instructed not to administer a shock and to continue cardio-pulmonary resuscitation.
42. The first paramedic responder arrived at 8.31pm and used his own defibrillator and resuscitation attempts continued. A second paramedic car arrived four minutes later and at 8.37pm, an emergency ambulance arrived. The paramedics continued to attempt resuscitation but were unsuccessful. They stopped at 8.54pm and declared that the man had died.

43. A hot debrief was held for the staff involved and managers then the next day and offered further support if required. The nurse said she was unable to have clinical supervision as her supervisor had left Norwich.
44. After the man's death, some prisoners told the G wing officer that after the visit from his wife on 3 November, the man had tried to sell his wedding ring to other prisoners.

Informing the man's family

45. The man's next of kin was his wife and the prison family liaison officer and the duty governor went to her home and broke the news of his death just after 1.00am on 4 November. The family liaison officer visited again that afternoon and also went to see the man's father. The prison offered a contribution towards the funeral expenses.

Post-mortem

46. The post-mortem examination report indicated that the man died from hanging. He had a 3cm cut to his neck just below the place where the ligature had been.

ISSUES

Assessment of risk of suicide and self-harm

47. The man was convicted of a violent offence against a family member, this was his first time in custody, and he began a limited alcohol detoxification programme when he arrived. He also told the nurse in reception that he had seen a psychiatrist which would have indicated some previous mental health problems. All of these are known factors which increase the risk of suicide and self-harm. The nurse also noted that the man appeared very anxious, although he attributed this to it being his first experience of prison. We consider that there were sufficient indicators of risk when the man first arrived which should have led to an ACCT being opened.
48. It appears that too many members of staff overlooked the static risk factors and put too much importance on the man's presentation when they spoke to him. As a result, he was not offered support under ACCT procedures when he first arrived, and several further opportunities to offer him effective support were missed, such as when his teacher and the substance misuse worker were concerned about him. His teacher was not ACCT trained but discussed him with her supervisor who did not open an ACCT and neither did the substance misuse worker. Both passed their concerns on wing staff who did not open an ACCT either. We are also concerned that referrals to assess and support the man do not seem to have been noted or actioned.
49. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We consider that more weight should have been given to the known risk factors in comparison to how staff thought the man presented.
50. We made a recommendation about this issue, following an investigation of a death at Norwich earlier in 2013. In its response, the prison said that they had introduced a new risk assessment form for reception staff to help them identify the known risk factors of newly-arrived prisoners. The prison said that the form focussed on key triggers to self-harm/suicide alongside factors such as mental health issues, current offence, length or potential length of sentence and general presentation. We were told that a full list of triggers for increased risk is available in reception and the medical screening room.
51. While it appears that some action has been taken to improve the assessment of risk when prisoners arrive at Norwich, we believe that the man's death shows that the measures are not sufficient to provide adequate protection and ensure that staff consider all the known risk factors when assessing a prisoner's risk of suicide and self-harm, either in reception or subsequently.

Other than the reliance on the man's assertion that he did not intend to harm himself, there was no record to indicate what factors had been considered when it was decided he was not at risk of suicide and self-harm and to explain why an ACCT was not opened. We repeat our previous recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines. This should include ensuring that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of self-harm or suicide, not just their presentation. Where there are significant risk factors and suicide and self-harm prevention procedures are not started, decisions and reasons should be clearly documented.

52. During his time at the prison, two members of staff raised concerns about the man's presentation. His teacher became concerned about him on 1 October when she observed him in physical distress. An officer saw him the next day and thought that the man was quiet and shy but was now adjusting to prison. He did not make any entries in the man's prison record about this. The man alleged that he might have been sexually assaulted a few days later. He was moved wings as a result but not given any other support. The substance misuse worker saw him on 18 October and thought that he was very subdued. She said that she reported this to an officer, the chaplaincy and the mental health team. The man also mentioned that the anniversary of his mother's death – a possible trigger for suicide and self-harm – was approaching.
53. We are concerned that several members of staff saw signs that the man was not coping with prison, but that none of them took the initiative to ensure that he was properly supported. It is impossible to say whether this support would have changed the outcome for the man. However, we believe that he should have received more support, especially when he thought that he might have been sexually assaulted and when he mentioned the anniversary of his mother's death. Almost everyone we spoke to about the man described him as quiet, shy and withdrawn. This is a common presentation of someone who is not coping with prison, yet staff did not act decisively enough to support him.
54. We are also concerned that several messages about the man's potential vulnerability do not seem to have been actioned effectively. In particular, the substance misuse worker said that she called both the chaplaincy department and the healthcare team about the man. However, there is no record of these calls. When we interviewed the substance misuse worker, she gave us sufficient detail for us to be confident that these conversations did take place. It is important that such referrals are recorded and followed up. We also note that the wing officer did not make an entry in the man's prison record when he spoke to him on 1 October after the teacher had become concerned about him, so this information would not have been available to any of his colleagues. We make the following recommendation:

The Governor should ensure that all information about a prisoner's vulnerability is appropriately recorded and actioned and that all staff are

aware of their responsibilities to keep prisoners safe and begin ACCT procedures when it is apparent that a prisoner is finding it difficult to cope and is at risk of suicide and self-harm.

Home Detention Curfew

55. The man was eligible to be released on home detention curfew the day after he died. Although the prison started the process on 6 September, they did not receive a reply to a fax on 18 September to Suffolk Probation Trust and never followed this up. This meant an HDC board was not convened to decide whether the man could be released. HDC boards are held once all the relevant documentation has been received and should be held before the eligibility date, the date when a person can be released under the scheme.
56. On 4 November, the man completed a form asking what was happening with his HDC application, which was found in his cell after he died. From the telephone calls he made it appears that he was not fully aware of the HDC process or kept informed about his application.
57. The man was serving a short sentence which meant that the turnaround for processing the HDC application was tight. He did not have an offender manager in the community, so there was no named individual for the prison to liaise with. There was also no one designated at Norwich to deal with the man's application, as the casework team responsible has groups of staff assigned to each application. In this case, no one took responsibility for ensuring that the man's application was completed promptly. At the time of the man's death it had been almost seven weeks since the request to Suffolk Probation Trust was made. We note that at the time of the August inspection of Norwich, inspectors were concerned that out of a sample of 31 successful HDC applications, only five had been released on their eligibility date and most delays were caused by late reports from offender managers in the community. Inspectors noted that there was no protocol for pursuing such delays. We make the following recommendation:

The Governor should ensure that there is an efficient process for managing home detention curfew applications to enable suitable prisoners to be released as close as possible to their eligibility date and that missing information is chased effectively.

The emergency response

58. The man was cut down quickly when he was found, officers began resuscitation efforts and an ambulance was called immediately. However, the nurse on duty took over five minutes to arrive with emergency equipment as she did not know where the man's cell was on the wing.
59. While we are satisfied that this delay did not affect the outcome for the man, nurses need to be confident in their knowledge of the lay out of the prison so that they can respond quickly to emergencies when that is their designated role. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all nurses who are required to attend emergencies are familiar with the layout of the prison.

RECOMMENDATIONS

1. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines. This should include ensuring that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of self-harm or suicide, not just their presentation. Where there are significant risk factors and suicide and self-harm prevention procedures are not started, decisions and reasons should be clearly documented.
2. The Governor should ensure that all information about a prisoner's vulnerability is appropriately recorded and actioned and that all staff are aware of their responsibilities to keep prisoners safe and begin ACCT procedures when it is apparent that a prisoner is finding it difficult to cope and is at risk of suicide and self-harm.
3. The Governor should ensure that there is an efficient process for managing home detention curfew applications to enable suitable prisoners to be released as close as possible to their eligibility date and that missing information is chased effectively.
4. The Governor and Head of Healthcare should ensure that all nurses who are required to attend emergencies are familiar with the layout of the prison.

ACTION PLAN:

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines. This should include ensuring that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of self-harm or suicide, not just their presentation. Where there are significant risk factors and suicide and self-harm prevention procedures are not started, decisions and reasons should be clearly documented.</p>	Accepted	<p>A list of identified potential risks and triggers to self harm/suicide, as set out in PSI 64/2011, is available in Reception and the medical screening room in order for both reception and healthcare staff to refer to when assessing new receptions.</p> <p>Newly received prisoners are asked if they have any current thoughts of self-harm/suicide and whether or not they have a history of self-harm or suicide attempts. ACCT trained prison and nursing staff will make an assessment of potential risk of harm using this information and any available recorded risk related information, recording a summary the information available on NOMIS and SystemOne or within an ACCT if one is opened. If they have any concerns regarding the prisoner's risk, they will make an urgent referral to mental health. Returning prisoners whose status changes at court are also seen by staff, prior to returning to their cells, assessed for risk of harm and a summary of any new risk related information is recorded on NOMIS and SystemOne or within an ACCT if one is opened.</p>	Complete	

2	<p>The Governor should ensure that all information about a prisoner's vulnerability is appropriately recorded and actioned and that all staff are aware of their responsibilities to keep prisoners safe and begin ACCT procedures when it is apparent that a prisoner is finding it difficult to cope and is at risk of suicide and self-harm.</p>	Accepted	<p>Steps will be taken to ensure that all staff are conversant with ACCT procedures and understand their responsibilities when a prisoner is considered to be a risk of self harm or suicide.</p> <p>Staff will also be reminded about actioning referrals and updating NOMIS case notes with concerns about prisoners, including decisions surrounding the appropriateness of opening ACCT.</p> <p>This will take the form of training, briefings, bulletins and literature.</p>	Oct 2014	
3	<p>The Governor should ensure that there is an efficient process for managing home detention curfew applications to enable suitable prisoners to be released as close as possible to their eligibility date and that missing information is chased effectively.</p>	Accepted	<p>HDC eligibility date is prescribed by sentence length and offence. This is an administrative process that is activated by NOMIS when the calculation is entered on the system.</p> <p>The exception to this is when offenders are sentenced to 12 weeks or less. This is not recognised by NOMIS, therefore staff and administrators activate the process when completing the sentence calculation.</p> <p>Supervisory checks on both processes are completed by the hub manager.</p> <p>Should a probation report be outstanding from external probation trust/NPS area, a "chase" is made, and if this is not received within 7 working days, the Senior Probation Officer at HMP Norwich contacts their counterpart at the</p>	Ongoing	

			relevant trust/NPS area or relevant Community Rehabilitation Company to ensure the report is provided to HMP Norwich as soon as possible.		
4	The Governor and Head of Healthcare should ensure that all nurses who are required to attend emergencies are familiar with the layout of the prison.	Accepted	Head of Healthcare will ensure that all nursing staff (during their induction at HMP Norwich), will be afforded the opportunity to familiarise themselves with the establishment.	July 2014	