

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in September
2013, while a prisoner at HMYOI Glen Parva**

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 HMYOI Glen Parva in September 2013. He was 21 years old. I offer my condolences to his family and friends.

A review of the man's clinical care whilst in prison was undertaken. The prison cooperated fully with the investigation.

The man had been arrested for possession of an offensive weapon after threatening to cut his throat and was remanded to Glen Parva. It was his first time in prison. He had a history of mental health problems and had previously attempted suicide many times, including taking an overdose the week before his arrest. He had recently spent time in a psychiatric hospital. Glen Parva had been alerted to his risks when he arrived, but reception officers and the nurse who carried out his initial health assessment did not identify him as at risk of suicide or self-harm. It is difficult to see how they reached this conclusion, but this was rectified after a further assessment the next day and monitoring under suicide and self-harm prevention procedures began. The monitoring continued until 6 August. He frequently spoke about killing himself but said he would not do so in prison.

On the morning of 25 September, the man deliberately burned himself and suicide prevention procedures were restarted. That afternoon, his girlfriend ended their relationship and also told him that his grandfather had died. He was very upset about this, but his level of risk was not reviewed. Three days later, an officer noticed that he had made cuts to his legs. There was no further review after this additional act of self-harm. The next afternoon an officer found him hanging in his cell. Resuscitation was attempted and he was taken to hospital, but sadly he was pronounced dead shortly after arrival.

The man was evidently a very troubled young man and, while he had access to mental health services at Glen Parva, the investigation found that the identification and management of his risks were poor. Not all front-line staff were trained in suicide and self-harm prevention procedures, there was little continuity of case management, a lack of multidisciplinary involvement in case reviews and poor assessment of his level of risk, even after further acts of self-harm. As in many cases my office investigates, the staff relied too much on his personal presentation and assurances that he did not intend to kill himself rather than his known risk factors. On the day he died I am concerned to note that the staff did not monitor him in line with the required frequency.

There are clearly lessons for Glen Parva to learn from this tragic case about the management of risk when receiving new prisoners and adhering to the requirements of the suicide and self-harm prevention procedures. In addition, the investigation identified a need for improved emergency procedure, a matter I have raised before.

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.

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SUMMARY

1. The man was arrested for possession of an offensive weapon in a public place on 13 June 2013 and remanded to HMYOI Glen Parva. He had threatened to cut his own throat. He had mental health problems and said he had previously attempted suicide over 30 times. He was 21 years old and it was his first time in prison.
2. The man arrived at Glen Parva with a suicide and self-harm warning form from the courts which identified his risk. None of the officers in reception began suicide and self-harm prevention procedures. The nurse who completed the initial health screen recorded that he had a history of self-harm and mental health problems and had recently spent time in a psychiatric hospital. She had received no training in suicide and self-harm procedures and, in spite of his considerable risk factors, she did not assess him as at risk of suicide and self-harm.
3. At a secondary health screen the next day, his risks were recognised and staff initiated monitoring under suicide and self-harm prevention procedures which continued until 6 August. Throughout his time at Glen Parva, the man was open about his continued suicidal thoughts. The staff appear to have accepted his assurances that he would not kill himself in prison, without balancing this against his known risk factors. He said he had the support of his girlfriend.
4. On 25 September, the man cut himself and said he was anxious about his release arrangements and some family matters. As part of his support plan, he was given telephone credit to speak to his family. That afternoon, he telephoned his girlfriend who ended their relationship and also told him that his grandfather had died. He was very upset, yet despite these significant events the staff did not review his level of risk. At an assessment the next day, he spoke openly about wanting to die and was upset throughout. This information was passed to the supervising officer on duty, who held a review on his own with him without involving staff from other disciplines such as healthcare. The supervising officer assessed him as low risk and set his next review for 2 October.
5. On 28 September, an officer noted that the man had made cuts to his legs. A nurse treated the cuts and noted he appeared low. There was no review of his risk to determine whether additional support was needed after this further act of self-harm. The supervising officer on duty that day said that he considered that the cuts were not new and therefore a review was not needed.
6. The man became more withdrawn after the news from his girlfriend but no one appeared to consider whether this had increased his risk of suicide or self-harm and whether this should have triggered a further review.
7. On the day of the incident the man was unlocked for an association period at about 3.00pm. He left his cell briefly to telephone his mother and was locked in again at 3.15pm. Although he was required to be checked at least every thirty minutes, it was not until 3.57pm that an officer found him hanging in his cell when she was locking up other prisoner. The last entry in his monitoring document was at 3.00pm. Prison and healthcare staff and paramedics when

they arrived attempted to resuscitate him. The paramedics took him to hospital but he was pronounced dead at 5.19pm.

8. We are concerned that some staff responsible for assessing prisoners had not received training in the Prison Service suicide and self-harm procedures and that, in spite of the man's history and clear risk factors, insufficient consideration was given to monitoring him when he first arrived. The investigation found a number of other inadequacies in the management of suicide and self harm prevention procedures at Glen Parva. Some documents were incomplete, case reviews were not always multidisciplinary, there was little consistency in case managers, staff did not always adhere to the required frequency of observations and case reviews were not held after an act of self-harm and a change in circumstances which should have identified potential heightened risk.
9. The investigation also found that Glen Parva's emergency procedures were not in line with national Prison Service instructions and some staff were unaware of the national guidance.

THE INVESTIGATION PROCESS

10. The investigator issued notices to HMYOI Glen Parva, informing staff and prisoners of the investigation and inviting anyone with relevant information to contact him. No one responded.
11. The investigator visited Glen Parva on 1 October 2013. He met the Governor and visited the wing where the man had lived. He spoke to staff and collected relevant documents. He interviewed 19 members of staff in December.
12. NHS England appointed a clinical reviewer to assess the standard of medical treatment that the man had received at Glen Parva. The clinical reviewer and the investigator jointly interviewed key healthcare staff.
13. We informed the local Coroner of the investigation, who provided a copy of the post-mortem report. A copy of this report has been sent to the Coroner.
14. One of the Ombudsman's family liaison officers telephoned the man's mother on 28 October to explain the investigation process and invite her to identify any relevant issues she wished the investigation to consider. His mother said that she and her son's father were concerned about whether he had received the appropriate treatment and medication for his mental health problems and whether the levels of observations were appropriate.
15. Following the issue of the draft report the legal representative acting on behalf of the man's family submitted a written response to our findings. The points raised have been dealt with in separate correspondence and have not led to any factual changes within the final report.

HMYOI GLEN PARVA

16. HMYOI Glen Parva holds up to 800 convicted and unconvicted young adult male prisoners aged between 18 and 21. There are ten residential units each holding up to 80 prisoners. Leicestershire Partnership Trust delivers primary mental health services and Northamptonshire Primary Care Trust provides in-reach (acute) mental health services.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons' most recent inspection of Glen Parva was an unannounced short follow-up inspection in July/August 2012. At the previous inspection in 2009, inspectors had found failures in the operation of the personal officer scheme and deficiencies in the suicide and self-harm prevention procedures, Assessment, Care in Custody and Teamwork (ACCT). Few ACCT reviews were multidisciplinary and there was little evidence that personal officers played any significant role in supporting prisoners at risk. The inspection in 2012 found that ACCT reviews were appropriately multidisciplinary, with representation from the mental health team.

Independent Monitoring Board

18. Each prison 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 most recent report for the year ending November 2013, the IMB at Glen Parva noted that there had been a marked increase in suicide and self-harm monitoring. There was a good range of services to promote the physical and mental health of prisoners. Those with mental health problems had access to professional care and counselling and support services were generally available, often provided by the chaplaincy.

Previous deaths at Glen Parva

19. Since 2011, there have been five self-inflicted deaths at Glen Parva. We have made previous recommendations about the operation of ACCT and emergency response procedures and these issues arise again in this report.

Assessment Care in Custody and Teamwork (ACCT)

20. 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 carried out 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 caremap 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 caremap have been completed. If there are further acts of self-harm, a multi-disciplinary review must be held and changes to the level and frequency of monitoring considered.

KEY EVENTS

21. The man was remanded to HMYOI Glen Parva on 13 June 2013, charged with possession of an offensive weapon in a public place with which he had threatened to cut his throat. He was 20 years old and this was his first time in prison.
22. A nurse completed an initial health screen and noted that a suicide and self-harm warning form had arrived with the man, which indicated that he had mental health problems and a history of self-harm and attempting suicide. They discussed his medical history and she referred him to the prison GP and mental health services, for a review of his medication and treatment. She recorded that he appeared settled and stable in his mood and he denied having current thoughts of self-harm or suicide. Arrangements were made to contact his community GP in order to confirm his prescribed medication.
23. The nurse told the investigator that she had considered the man's presentation as well as his history and identified no immediate risks. She had started working at Glen Parva in August 2012 but she had never been given any training in ACCT suicide and self-harm prevention procedures, despite her frontline role and a requirement to attend ACCT case reviews. Officers working in reception did not identify him as a risk of suicide and self-harm and there is no evidence that they considered his risk factors or discussed the information in the self-harm warning form with him or with the nurse.
24. On 14 June, the acting Head of Healthcare and previously Head of the mental health team conducted a mental health assessment. The man told her that he had been involved with community mental health services and had spent time in a psychiatric unit (the Bradgate Unit) in Leicester, as a voluntary patient. He spoke openly about his self-harm and said that he had attempted suicide over 30 times, including taking an overdose a week before his arrest. He said that he was always planning suicide but was impulsive in his attempts.
25. The acting Head of Healthcare said that the man had indicated that he had had thoughts about harming himself most of that day. When she explored this with him she believed that they were fleeting rather than active thoughts of suicide and she felt that there was nothing to indicate that he had any immediate intentions or plans to kill himself. He had been very open about his thoughts and she believed that he would tell her if his thoughts of suicide were stronger, as he was so open and transparent about his mental health problems.
26. Because of the man's mental health and history of suicide attempts and self-harm, the acting Head of Healthcare started ACCT procedures. She said that she felt that he was an increased risk, because of his suicidal thoughts and because it was his first time in prison. She thought ACCT monitoring would provide him with additional support and make staff more aware of his needs as he might find it difficult to cope with this new experience.
27. An officer carried out an ACCT assessment at 4.40pm that afternoon. The man told her that he had tried to take his own life over 30 times, mostly by taking overdoses or by cutting himself. He spoke about his mental health issues and feelings of hopelessness and said that he was keen to engage with the mental

health team. When asked about support in the community, he spoke about his girlfriend of five months.

28. The first case review after the ACCT assessment should take place within 24 hours of the opening of the ACCT and, ideally, immediately after the assessment. However, the man's case review did not take place until 16 June, two days after it had been opened. A Supervising Officer (SO) chaired the review and the primary mental healthcare team leader also attended. The SO noted that he answered all the questions openly and that he said he had no self-esteem or feelings of self-worth. When asked about thoughts of self-harm, he said that he would not try to take his life in custody as it would be unfair on staff. However, he added that he would not tell anyone if his mood deteriorated. Because of these comments, the SO increased the frequency of his observations from hourly to three an hour.
29. The SO explained that when she first met the man it was clear that he had no self-esteem. He had said that he had no reason to go on, but would then contradict himself and talk about things he was looking forward to. She said she saw him on the wing several times after the ACCT review and when she asked how he was doing, he told her that he was good and looking forward to getting out. She said that she had noticed an improvement in him since the initial case review. She could not explain the reason for the delay in holding the initial review, which she acknowledged should have been within 24 hours of the ACCT being opened.
30. After the first case review, the man was referred again to the mental health in-reach team and the SO completed a caremap outlining actions to be taken to help him over his period of crisis. These included the referral to the mental health in-reach service, provision of some in-cell activities to keep him occupied and arranging an appointment with the GP to discuss his medication. He had previously been prescribed fluoxetine for depression and zopiclone to help him sleep. The caremap indicates that these actions were completed the same day. The caremap was not updated with any further actions at future case reviews.
31. Arrangements were made to inform the community mental health team and request information to plan the man's ongoing care. He was referred to the prison GP for a medication review that afternoon as he had not had his prescribed medication for around two days, although the medication had been recorded when he arrived.
32. A prison GP saw the man later that day and noted that he had a history of depression and borderline personality disorder. He re-prescribed fluoxetine, which he had been given in the community. He told the doctor that he had no current thoughts of self-harm and felt supported.
33. A follow up with the mental health team and an ACCT review both took place on 18 June. The next day a nurse from the mental health in-reach team assessed the man in response to the initial referral when he arrived. The nurse explained that the purpose of the assessment was to ensure that he required the support of the secondary mental health service and that he stayed safe and well in custody. He was aware of his past self-harm, that he had been under the care of the community mental health services and that his offence involved

taking a knife to a public place and threatening to kill himself by cutting his throat. The nurse noted that as he had already been diagnosed with borderline personality disorder and depression, he automatically fell within the remit of the secondary mental healthcare team.

34. On 20 June, a visiting psychiatrist assessed the man. The psychiatrist explained that he had been asked to provide an opinion on whether his problems were indicative of a formal mental illness or whether he had other emotional mental health problems. The psychiatrist considered that he presented as straddling somewhere in between the two categories. He did not have a very clear-cut formal mental illness which took away his mental capacity or which could have affected his understanding of reality, but equally he had previous experience with the secondary mental health services in the community which indicated longstanding problems and this was significant enough for the involvement of the secondary mental health team.
35. The psychiatrist added that the man had a range of personality problems or aspects of personality disorder which, as a young person, would continue to evolve. He said that his family dynamics seemed to impact significantly on his overall mental state. In view of this, he decided that the in-reach team should continue to monitor him and arrangements would be made to have his care transferred to community services to ensure his ongoing care after his release. He would also continue his medication. He said that the mental health in-reach team should continue to monitor him as required.
36. ACCT case reviews were held weekly until 6 August. During this period, six different case managers chaired the ten separate reviews. A member of the mental health team attended six of the ten reviews. The man did not self-harm during this period, but at reviews he still said he had frequent thoughts of suicide and self-harm, although he maintained that he would not act on these thoughts at Glen Parva. Each review indicated that his level of risk was low, despite his repeated and continuing thoughts of self-harm. Staff ticked the ACCT document to indicate that the care map had been updated and reviewed, but there is no other evidence that this was the case. On 11 July, he attended court and was sentenced to 35 weeks in prison. When he returned to Glen Parva, an ACCT review was held during which he said that he felt better that there was 'an end in sight'.
37. On 15 July, a member of the mental health team went to see the man at the request of wing staff who were concerned that he was distressed. He told the nurse that he was feeling down and disturbed because he kept thinking about his daughter, who he was not allowed to contact under the terms of a restraining order. He told her that he had recently been sentenced. He said that he 'felt like smashing his head through a window' and had some thoughts of hanging himself. However, when she questioned this, he said that acting on these thoughts would not help him and spoke of his girlfriend as a protective factor. He told her that he felt unable to express his feelings to his cellmate or cry in front of him as he did not understand his difficulties in managing situations.
38. The nurse believed that the man's main problem was missing his daughter and that he was upset because he could not have contact with her. She described him as very chaotic, in a lot of distress and it was as though his head was too

full of thoughts that he just could not manage. They discussed ways of managing his feelings but he said he felt uncomfortable doing things such as relaxation or breathing exercises in front of his cellmate. She said that she considered his risk of self-harm and asked him whether he thought there was a need for him to go to a safer cell because of his distress. (Safer cells are cells designed to minimise ligature points compared to those in standard cells.) He said he did not feel he needed this safeguard, but believed that he would be better able to manage his problems if he left his current cell because of his cellmate.

39. The nurse said that she discussed the man's problems with the unit manager and what they would do to support him including whether a single cell would help. They looked at alternative coping strategies, using in-cell activities such as word searches, dot to dots and colouring mazes, as a distraction and she provided them. They also discussed the risk factors associated with him being subject to ACCT monitoring, feeling in distress and being in a cell on his own. She said that they needed to be cautious about putting him in a cell on his own where no one could alert staff if he was finding it difficult to cope, although he had repeatedly assured them that he would press his cell bell if he needed to and that he would use the strategies that they had discussed.
40. The nurse said they agreed to give the man the benefit of the doubt and allocated him a single cell but they increased the frequency of his ACCT observations from every two hours to hourly and made it clear that if he felt unsafe or it did not work out he could move back to a shared cell. He spent about a week in a single cell and then agreed to share again. She said that she had had no ACCT training although she had worked at the prison for over four years. Training planned as part of her original induction had never taken place.
41. A SO held an ACCT review with the man on 26 July, the first she had chaired since the initial review on 16 June. She felt that he had improved immensely since they had last met and he raised the possibility of the ACCT monitoring ending. However, it was agreed to keep the ACCT open for a longer period to check that his medication was at the correct level as it had recently been changed. He was reported to be looking forward to his release and thinking about his future. He said that he had not had any thoughts about self-harm for over a week.
42. During his time at Glen Parva, the man had frequent contact with members of the chaplaincy team. On 27 July, the Roman Catholic chaplain spoke to him and recorded that when he visited the wing he was socialising with other prisoners and appeared to be engaging positively. He had been in contact with his girlfriend and did not report any problems.
43. On 30 July, a SO chaired the man's tenth ACCT review. He said that he felt flat but talking to his family helped to alleviate these feelings. The SO recorded that he would be given £2 telephone credit to enable him to contact his family. He did not express any thoughts of self-harm but the review decided that the ACCT plan should remain open.
44. On 6 August, another SO noted in the man's record that he had carried out an ACCT review and had decided that the ACCT monitoring should end. This review was not recorded in the ACCT documents and the prison could find no

record of it. He told the investigator that he had had no previous contact with him before 6 August, but he had read through the ACCT document and his wing record so he was aware of his issues. He was unable to account for the missing record of the review. He said he had been unable to get a representative from the mental health team to attend, so he had held the review with a member of the unit staff who happened to be in the office at the time. His entry in the record said that all those who attended the review had agreed to the closure of the document. He added that the man was happy for the document to be closed and he had explained to him that, if at any point he was unhappy, they would re-open the ACCT if necessary.

45. A SO carried out a post-closure ACCT review on 15 August. The man said that the problems that had led to the opening of the ACCT plan had not completely been resolved, but an appointment had been planned with the GP to discuss his treatment and how it made him feel. He said he was better able to cope with his thoughts of self-harm and had a new cellmate, which had helped. He told the SO that his girlfriend and unit staff continued to support him. He was working as a wing cleaner wing and said he had support for when he was released.
46. A nurse saw the man briefly on 2 September, while he was visiting the wing. He had told him that his medication no longer appeared to be working and he had problems sleeping. This affected his mood but he said that he had no thoughts of self-harm. The nurse noted that he looked visibly tired. The visiting psychiatrist was away that week so the nurse spoke to the pharmacy about changing his medication. They felt it would be too much of a risk to stop his medication, but decided to discuss it with the psychiatrist when he returned the next week. In the meantime, the mental health team in consultation with the pharmacist prescribed medication to help him sleep.
47. At 10.45am, on 25 September, the man pressed his cell call bell. An officer answered and found him very flustered. He showed him that he had deliberately burnt his arm with his cigarette lighter. The officer said that he could see that he urgently needed to talk so they spent some time talking together. He spoke about a number of issues, including his forthcoming release in two weeks time and the possible effect on his parents' relationship. He also talked about his daughter, with whom he was not allowed to have any contact.
48. The officer then took the man to the healthcare department for treatment and an ACCT document was opened. One of the immediate actions agreed by a SO was to issue £2 emergency telephone credit to enable him to contact his family. It was decided that he would be observed hourly until a full ACCT assessment took place.
49. That afternoon, the man telephoned his girlfriend who informed him that his grandfather had died and that she was ending their relationship. He was visibly upset and angry at the end of the telephone and pushed over a table tennis table before he went back to his cell. The SO went to his cell and he told him what his girlfriend had said. He was very stressed and emotional and apologised for his behaviour. The SO recorded in the ACCT document that he had a supportive cell mate and decided that he should be observed at least once every 30 minutes when he was locked in his cell.

50. When interviewed, the SO said that although the news of his grandfather's death and the end of his relationship with his girlfriend were additional significant events since the ACCT was opened earlier that day, he did not consider holding an immediate case review to discuss the implications and review the man's risk. He said that he had gone from being rock bottom to being angry and he felt that an ACCT review might have made things worse by making him go over it again. He thought he needed a chance to cool down and he would speak to him the next day.
51. The next day, 26 September, an officer spoke to the man for an ACCT assessment. She recorded that he was very upset about the breakdown of his relationship and said he would not be able to cope when he was released. He discussed his previous suicide attempts, as well as his current thoughts. He said that he wanted to die, but reiterated that he would not harm himself while in custody as he did not want his cellmate, with whom he got on well, to find him dead.
52. The officer said that during the assessment, the man was initially tearful, withdrawn and very fidgety and did not make eye contact. In the ACCT document, she underlined the statement about him saying he wanted to die. She said that this was not something she had done before but he was adamant and she felt that he meant everything he said. She therefore wanted to draw attention to it. She said he repeatedly said that he wanted to die and gave reasons for this. However, by the end of the assessment, she thought he was a lot brighter, but still stated that he wanted to die.
53. The officer spoke to a SO about the assessment and showed him what she had written in the ACCT document but she was unable to stay for the case review as she had to complete another assessment. The SO held a case review on his own with the man. Despite his repeated assertion that he wanted to die and his range of other risks, the SO recorded his level of risk as low.
54. The ACCT guidance describes low risk as when suicidal thoughts are fleeting and soon dismissed, there is no plan, few symptoms of depression, no psychotic mental illness, no self-harming behaviour, and the situation experienced is painful but not unbearable. The officer told the investigator that when she assessed the man she did not regard him as low risk.
55. The SO said that the man had been extremely emotional and repeatedly spoke about his grandfather's death. He said he had meant a lot to him but indicated that he would not apply to go to his funeral. He described him as on an 'emotional rollercoaster', going from being tearful to happy and calm and then when he thought about either his grandfather or his girlfriend, he would get emotional again. The SO said he had not considered asking someone from healthcare or from the mental health team to attend the review. Despite the change in circumstances the SO still considered that he was at low risk of self-harm.
56. That afternoon, a member of the chaplaincy team spoke to the man. He repeated what he had said to the officer about killing himself and said that he did not want to be released as he felt safer in prison. He thanked the chaplain for her visit and said he would appreciate a visit from the Roman Catholic

chaplain. The Roman Catholic chaplain went to see him the next day and found that he was in a generally low mood and agreed that they would visit the chapel on 4 October, the day of his grandfather's funeral, in order to say prayers and to light a candle for him.

57. The man did not collect his antidepressant medication on a number of occasions and records show that this became more frequent in the last two weeks of September. The primary mental healthcare team lead told the investigator that outpatient staff report to the relevant teams when people do not attend to collect their medication for three consecutive days as he had not done. They then arrange a review with the patient. She considered that not taking his prescribed medication could have affected his outlook and mood. There is nothing in his medical record to indicate that such a review took place or that anyone had flagged up that he had missed his medication.
58. The investigator asked the mental health nurse what action he would have taken if it had been reported that the man had not been collecting his medication. The nurse said that before medical records became electronic, drug administration was hand written and such prisoners were easily identified. He believed that with the electronic records there was no way of highlighting individuals and he did not recall being sent any tasks relating to him missing medication. However, other nurses told the investigator that 'tasks' are routinely sent to other departments on the electronic medical record, SystemOne, to raise a particular issue such as missed medication.
59. On 28 September, an officer noticed that the man had made cuts at the upper part of his thighs. The cuts had been made using a pair of nail clippers and he had scratched in abusive words. He was taken to the healthcare outpatient department and a registered mental health nurse examined him. She said that he seemed very low but denied any further intention of harming himself. He spoke about finding it difficult to come to terms with the death of his grandfather and the break up with his girlfriend. She was aware that he was subject to ACCT monitoring, so she had asked an officer to go back and collect the ACCT document. She wrote an entry in the ACCT record and left a message for the mental health in-reach team to see him as she was aware he was under their care.
60. The officer then took the man to speak to a SO, the unit manager. The SO told the investigator that he had regarded the cuts as historic as they had scabbed over. He therefore did not consider it necessary to convene an urgent ACCT review. In view of this, he made no changes to the level of assessed risk and did not increase the frequency of observations. The investigator suggested that regardless of whether the cuts had been made a day or so before, this was the first time this act of self-harm had been identified. The cuts were significant and should have prompted a review in line with ACCT guidance. On reflection, the SO agreed that this could have been handled better.
61. On Sunday 29 September, staff who knew the man well noticed that he appeared very withdrawn. An officer said that he and a colleague had collected his breakfast for him and had spoken to him a short time afterwards to make sure that he ate some of it. They had also taken him his lunch as he did not want to leave his cell.

62. At around 3.00pm, the officer said that the man and other prisoners on the wing were unlocked for a period of association. As the weather was still quite warm, the exercise yard was also open for prisoners to go outside. He and his colleagues were keen for him to leave his cell and get some fresh air so he went to his cell to ask if he wanted to go out. He had jumped straight up from his bed and said yes and that he had to make a few telephone calls.
63. The last entry in the ACCT document, at 3.00pm, indicated that the man was out of his cell on association. Telephone records show that he had telephoned his mother at 3.09pm and the call had lasted for a little under three minutes. During the call, he discussed his sister's new home. He apologised for not telephoning the previous day, but said that he had spent the day in bed. His mother asked if he needed any money, but he said that he had enough. He also told her to not worry about visiting as he would be released soon. He ended by reassuring his mother that he was all right. After the call, he asked to return to his cell. Staff told the investigator that it was not unusual for prisoners either to choose to remain in their cells or ask to go back to them during the association period, particularly if there was a particular film or a sports event that they wanted to watch. In that case the local rule is that the cell door has to be locked as prisoners are not allowed in each others' cells. A SO took him back to his cell shortly after 3.15pm and was the last person to see him alive.
64. The prescribed frequency of observations on the ACCT document remained at once every 30 minutes. The record indicates that this was not adhered to and there is no evidence that the man had been observed between his return to his cell and the end of the association period at 3.50pm. Although there was a requirement to check him every 30 minutes, throughout this period of ACCT monitoring, the time between entries varied between three hours and one hour. At night entries were made hourly.
65. At around 3.50pm, officers began locking prisoners in their cells. An officer went along landing 1, opening cell doors, while a colleague stood at the entrance to the landing. He did not know that the man had returned to his cell, but as he reached the cell, he looked through the observation panel before opening the door. He saw him with a piece of torn bedding tied around his neck, suspended from the grills over the cell window. The officer said that he was very low to the floor and described him as being almost in a 'press up position.'
66. The officer said that he immediately radioed for medical assistance and other staff said that they had heard a code blue emergency called (a code blue indicates that a prisoner is unconscious or has breathing difficulties) and then went into the cell and cut the ligature from the man's neck. He had hoped that he had only just done it and would still be alive. Another officer, who had been nearby, got to the cell very quickly and the two officers laid him on the floor. The first officer could not recall all his actions during the emergency, but he remembered that someone had asked him to call an ambulance and he had then radioed the communications room to check that this had been done.
67. A nurse was already in the unit to see a prisoner when she heard a code blue emergency call over her radio. She estimated that she arrived at the cell within 10 – 15 seconds. The unit manager, a SO, had also responded to the emergency call. The nurse explained that when she arrived, the man had just

been laid on the floor and the torn bed sheet was still around his neck. She said he was looked extremely grey and unresponsive. His body was warm but very cyanosed (a blue or purple colour of the skin caused by low oxygen saturation). She said her first action was to ensure that an ambulance had been requested and to check that other healthcare staff responding were bringing the full emergency kit, including a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest).

68. The SO removed the sheet from around the man's neck and began cardiopulmonary resuscitation (CPR) which he continued until other nurses arrived with a defibrillator. The nurse said that this only took a few minutes as the healthcare department was only a short distance away. She attached the defibrillator to him, which indicated that no shockable rhythm had been detected and instructed CPR to continue. This continued until the paramedics arrived. All the time the defibrillator indicated there was no detectable heart rhythm.
69. Records show that the prison requested an ambulance at 4.00pm, which arrived at 4.15pm. The paramedics, who were also accompanied by an emergency GP, connected their own defibrillator to the man but obtained no output. The nurse said that she had expected paramedics to ask her to stop the resuscitation attempts but they asked her to continue. At 4.39pm, the paramedics took him to the accident and emergency department at hospital and arrived at 4.55pm.
70. At 5.00pm, the prison's duty manager contacted the Governor, who was at home. She instructed staff to inform the man's family that he had been admitted to hospital and advise them to go to the hospital as soon as possible. The prison called his family at 5.10pm. However, at 5.20pm, the hospital informed prison staff that he had suffered a cardiac arrest and had been pronounced dead at approximately 5.19pm.
71. When the prison first telephoned the man's family, he was still alive. However, when staff learnt that he had died a short while later they decided that it would be better not to telephone his family again but to inform them of the sad news in person once they got to the hospital.
72. The Governor, who lived a short distance away, stopped at the prison at 5.55pm on her way to the hospital, to get an update on the man's condition. She was informed that he had died and so went immediately to the hospital to meet his family. When she arrived, she first met the police and arranged to inform his family, but then learnt that hospital staff had already told them that he had died. When the family arrived at the hospital, she spent some time with them. They were understandably upset and she tried to explain the events as they were known to her at that time.
73. The prison then appointed a family liaison officer, who remained in contact with the man's family and offered assistance towards his funeral expenses in line with national guidance. The Governor and the family liaison officer attended the funeral, which took place on 14 October.

ISSUES

Medical care

74. The clinical reviewer completed a review of the man's clinical care at Glen Parva. He concluded that the primary physical healthcare and both primary and secondary mental healthcare was in line with that provided in the community. He found that individual healthcare workers and teams worked in accordance with good medical practice. However, access to information across various teams was a problem due to the mix of hand written documents, such as ACCT plans, as well as electronic personal and medical records. He noted that, while relevant information was recorded, key information, such as ACCT reviews, was not always available to all staff.
75. The clinical reviewer found that while the man was at Glen Parva there was no system for reporting non-compliance with medication. We understand that this issue has since been addressed and staff dispensing medication now report all patients' non-compliance with their medication regime to the relevant prescriber.

Assessment of the risk of self-harm

76. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), and PSI 74/2011 both list a number of risk factors and potential triggers for self-harm and suicide. These include early days in custody, previous self-harm, first time in custody, being charged with a violent offence and a history of mental health problems. PSI 74/2011 requires new prisoners to be interviewed in reception to assess the risk of self-harm and expects all staff to be alert to the increased risk of suicide/self-harm posed by prisoners in those categories and act appropriately to address any concerns, including opening an ACCT if necessary.
77. The nurse who conducted the man's initial health screen on the day he arrived at Glen Parva was aware of his mental health and history of self-harm and had also received a suicide and self-harm warning form. In spite of this, she indicated that she had no concerns about his immediate well-being and considered it unnecessary to begin suicide and self-harm prevention procedures. With the range of evident serious risk factors that he presented, it is very difficult to see how she reached that conclusion. He had just been arrested in circumstances where he had threatened to kill himself, he had attempted suicide just the week before and had many previous such attempts, and he was a young man experiencing his first time in prison. These risk factors should also have been evident to reception and first night officers.
78. The investigation found that reception officers and the first night induction officer did not appear to assess the man's risk of suicide and self-harm. The onus seems to have been placed on the nurse in reception and we are concerned that other staff did not see this as part of their responsibility. Although in this case the officers passed available information to the nurse, it is often the case in prison receptions that healthcare staff do not have all the information about a prisoner and their risk factors on which to base a fully considered assessment of risk. All staff need to be vigilant for indicators of risk and open an ACCT when indicated.

79. It seems that in assessing the man's risk of self-harm, the nurse relied heavily on his statement that he had no such thoughts at that time. Equally, reception staff appear to have taken no action based on the suicide and self-harm warning form or recorded any of the numerous potential triggers. In previous cases, we have been critical of prison staff in general placing too much reliance on what the prisoner tells them and ignoring the weight of other risk-related information. We consider that staff should have given more weight to his known risk factors, including the circumstances of his offence in which he had threatened to cut his throat, his mental health history and past self-harm behaviours. They could have then considered conducting the initial assessments of the suicide and self-harm prevention procedures to determine whether he required additional monitoring or support. We therefore make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular, this should ensure that reception and first night staff:

- **Have a clear understanding of their responsibilities and the need to share all relevant information about risk;**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other sources;**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

Management of the ACCT process

80. Staff began ACCT procedures on 14 June, the day after the man arrived. He was open about his intent to end his life when he spoke to various members of staff, but he also said that he did not intend to harm himself while in custody. It seems that when considering his risk staff placed a lot of emphasis on these verbal assurances and less on his history, known risks and previous behaviour. We are concerned that neither the nurse who assessed him at reception nor the nurse who later conducted a mental health assessment while he was subject to ACCT monitoring, had been trained in ACCT procedures.
81. In spite of the man being under the care of the mental health team, ACCT case reviews between 14 June and 6 August were not always multidisciplinary, although mental health staff attended six of the ten recorded reviews. Despite his significant mental health problems, there is no evidence that any advice was sought from healthcare staff beforehand when they were not present at reviews. Prison staff would therefore have been unaware of relevant information about his risk from healthcare records.
82. There was little consistency of case management with six different managers chairing a total of 11 case reviews for the two separate periods of ACCT monitoring during the man's time at Glen Parva. Most of the managers had no previous knowledge of him before chairing his reviews. The investigator was told that on any one day there might be up to 40 ACCT documents open in the

prison and it would be the responsibility of one duty supervising officer to hold any reviews scheduled for that day, including those on different residential units. PSI 64/2011 requires that a case manager is appointed at the first case review. Where possible, the case manager should chair subsequent ACCT case reviews. The duty manager approach does not appear to help continuity of case management.

83. Following sight of the draft report the prison responded to say that the process at Glen Parva was that every prisoner on an ACCT is allocated a named Case Manager. The Case Manager is required to book reviews on dates that they are on duty. If this does not happen, due to sick or annual leave then it is the responsibility of the Orderly Officer that day to ensure an alternative Case Manager facilitates the review. The prison said that any such reviews would be spread evenly and not the responsibility of one person. While we understand that this may now be the practice at Glen Parva and welcome this, at the time of the investigation the evidence provided, would suggest that this process was not in operation or not operating effectively.
84. After an investigation at Glen Parva in 2011, we raised the issue of continuity of the case manager role to enable a consistent assessment of risk. The Prison Service accepted the related recommendation and undertook to issue a local instruction requiring case managers to book reviews for when they are on duty. They intended to monitor consistency through weekly managers' and safer prisons team ACCT audit checks. This does not appear to have been done.
85. A SO ended the first period of ACCT monitoring on 6 August. He noted his decision on the man's record but there is no evidence of a case review in the ACCT document to explain the basis of the decision or who else, if anyone was present at this review. Despite requests by the investigator, no record of the case review had been found.
86. We are concerned that ACCT reviews were not considered at times when there were apparent concerns that the man's risk of suicide and self-harm had increased, such as when on 25 September, his girlfriend told him their relationship was over and that his grandfather had died. On Saturday 28 September, an ACCT review was not held when an officer noticed he had cut his legs. While Prison Service guidance does not state that an ACCT review should be conducted after each act of self-harm, it advises that all acts of self-harm should be managed under the ACCT process and that a review should be held if there are concerns about increased risk such as an additional act of self-harm or because of information received. We consider that where there is a further act of self-harm or significant event happens during a period of monitoring, a multi-disciplinary case review should be held to review the risk and put in place appropriate support.
87. Although the man continually reported thoughts of suicide throughout his time at Glen Parva and had a range of known risk factors for suicide, staff consistently appeared to underestimate his level of risk. At all but one ACCT review he was considered low risk and on the other he was considered 'raised.' An example of this is when an officer conducted an ACCT assessment on 26 September he said that he wanted to die. The officer underlined this statement in her note of the assessment to draw attention to it yet the SO recorded his risk of self-harm as 'low.' The SO held the review with no other staff present,

which is itself very poor practice and unlikely to lead to a considered view of the level of risk. There is no evidence that he explored the man's comments about wanting to die.

88. No one appeared to have identified that there had been a clear change in the man's behaviour and mood. When he self-harmed in September this was the first at the prison and he had been so withdrawn that wing staff had collected his meals for him. Yet it appears that the staff did not consider these factors as significant in relation to his mental health or take sufficiently into account the loss of his protective factors, notably the break-up of the relationship with his formerly supportive girlfriend and the effect of the death of his grandfather. A multi-disciplinary review after his self-harm on 28 September would almost certainly have identified the potential triggers of his most recent self-harm and that his most important protective factor had been removed. If the procedures had been followed correctly, these significant points should have led to an increase in his level of risk and how he was managed including the frequency of observations.
89. It is also concerning that officers did not always follow the required frequency of observations. From 25 September, observations were set at half hourly but the entries on the on-going record show that staff did not adhere to the frequency specified and the timing of entries fluctuated greatly, with gaps of up to 3 hours between entries. The content of the entries did not indicate that the man had been checked between these times. On the day of the incident the last ACCT entry was at 3.00pm. In spite of the requirement for ACCT observations every 30 minutes, there had been no further entry when he was found hanging at 3.50pm a gap of 50 minutes. The unit manager locked him in his cell at 3.15pm but there is no entry in the ACCT record or anywhere else to say what his mood was like at the time.
90. It is evident from the investigation that there were a range of failings in the operation of ACCT procedures at Glen Parva which were not effective in supporting and protecting the man. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **Ensuring that all staff receive training about the ACCT procedures;**
- **Holding multidisciplinary case reviews attended by all relevant people involved in a prisoner's care; where this is not possible advice should be sought and documented as part of the review;**
- **Completing ACCT documents fully and accurately, including following the prescribed level of observations and recording them;**
- **Conducting an ACCT review whenever there is a clear sign that risk has increased;**
- **Considering all known risk factors when determining the level of risk of self-harm and considering all potential trigger factors; and**
- **Ensuring continuity of case manager, whenever possible.**

Emergency response

82. PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for governors to have a protocol to provide

guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies.

83. The officer correctly called a code blue emergency at 3.57pm, when he found the man hanging. During the emergency, one of the other staff asked him to contact the control room to request an ambulance, which was called at 4.00pm. One of the requirements of the national guidelines is that an ambulance should be called automatically as soon as a code blue call is received. The staff appeared to be unaware of the national instructions and this requirement. The nurse was not confident that an ambulance had been called and checked this and also reminded other healthcare staff to bring a defibrillator which she said was often forgotten in emergencies.
84. Glen Parva's suicide and self-harm prevention strategy, issued in June 2013, says, "The Duty Manager will attend the scene of each incident, assess the situation and on advice of an on scene Healthcare staff request the communication room to call an ambulance. Where an ambulance is called arrange for staff (OSG/Discipline) to meet ambulance at the gate and afford it speedy access to the scene". In a recent PPO report, issued after his death, we drew attention to the need for Glen Parva to issue a local emergency response code protocol.
85. We are concerned that in spite of our previous recommendation, Glen Parva has yet to comply with the mandatory requirement of PSI 03/2013 to ensure that all staff have clear guidance about what to do in a medical emergency. In addition, the guidance contained in the suicide and self-harm prevention strategy is not compliant with the national instructions as it specifies that a duty manager and a member of healthcare must attend an emergency incident before a decision is made about calling an ambulance. There is no evidence that the short delay in calling an ambulance affected the outcome for the man, but the call was not immediate, as required under Prison Service guidelines. We therefore make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Glen Parva has a Medical Emergency Response Code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

RECOMMENDATIONS

1. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular, this should ensure that reception and first night staff:
 - Have a clear understanding of their responsibilities and the need to share all relevant information about risk;
 - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other sources;
 - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

2. The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - Ensuring that all staff receive training about the ACCT procedures;
 - Holding multidisciplinary case reviews attended by all relevant people involved in a prisoner's care; where this is not possible advice should be sought and documented as part of the review;
 - Completing ACCT documents fully and accurately, including following the prescribed level of observations and recording them;
 - Conducting an ACCT review whenever there is a clear sign that risk has increased;
 - Considering all known risk factors when determining the level of risk of self-harm and considering all potential trigger factors; and
 - Ensuring continuity of case manager whenever possible.

3. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Glen Parva has a Medical Emergency Response Code protocol which:
 - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
 - Ensures staff called to the scene bring the relevant equipment; and
 - Ensures there are no delays in calling, directing or discharging ambulances.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	<p>The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular, this should ensure that reception and first night staff:</p> <p>a) Have a clear understanding of their responsibilities and the need to share all relevant information about risk;</p> <p>b) Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-</p>	Accepted	<p>Guidance has already been produced and made available to appropriate staff.</p> <p>This guidance will be reviewed and updated if appropriate.</p> <p>The way in which this guidance is communicated will be reviewed.</p>	<p>Complete</p> <p>30.06.14</p> <p>30.06.14</p>	

	<p>harm, including information from suicide and self-harm warning forms, PERs and other sources;</p> <p>c) Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.</p>		<p>Training will be facilitated for First Night and Reception staff.</p> <p>Training will be facilitated for Healthcare staff.</p>	<p>30.09.14</p> <p>30.09.14</p>	
2	<p>The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <p>a) Ensuring that all staff receive training about the ACCT procedures;</p> <p>b) Holding multidisciplinary case reviews attended by all</p>	Accepted	<p>a) All staff will receive a basic Safer Custody training as part of their induction</p> <p>All staff will complete the full Introduction to Safer Custody Training on the first training day after they start work at HMYOI & RC Glen Parva</p> <p>All staff with prisoner contact will receive refresher training. Once every 3 years for operational staff and once every 2 years for other staff with prisoner contact.</p> <p>Where local monitoring identifies an establishment training need linked to ACCT, training will be delivered through a full staff briefing followed up with a PowerPoint presentation e-mailed to all staff.</p> <p>B) Weekly management checks will monitor whether case reviews are multidisciplinary attended by all relevant people.</p>	<p>30.05.14</p> <p>30.05.14</p> <p>31.12.14</p> <p>30.06.14</p> <p>Complete</p>	

<p>relevant people involved in a prisoner's care; where this is not possible advice should be sought and documented as part of the review;</p> <p>c) Completing ACCT documents fully and accurately, including following the prescribed level of observations and recording them;</p> <p>d) Conducting an ACCT review whenever there is a clear sign that risk has increased;</p> <p>e) Considering all known risk factors when</p>		Where issues are identified the manager completing the check will raise this direct with the Case manager.	Complete	
		Safer Prisons Unit will monitor all weekly management checks and circulate guidance where common issues are identified.	Complete	
		C) Daily ACCT checks, completed by an allocated unit member of staff will be completed	30.06.14	
		Weekly management checks will be completed.	Complete	
		Where issues are identified the manager completing the check will raise this direct with the Case manager.	Complete	
		Safer Prisons Unit will monitor all weekly management checks and circulate guidance where common issues are identified.	Complete	
		D) NTS to be published making clear that an ACCT review must be conducted when there is evidence that the risk has increased.	30.05.14	
		Suicide and Self-harm strategy to be reviewed to ensure it makes this requirement explicit.	30.06.14	
		E) Guidance will be produced on determining the level of risk a prisoner is at.	30.06.14	
			30.09.14	

	<p>determining the level of risk of self-harm and considering all potential trigger factors; and</p> <p>f) Ensuring continuity of case manager whenever possible</p>		<p>Training will be delivered to ACCT Case Managers based on this guidance.</p> <p>F) There is a Governor's Order in place that requires ACCT Case Manager's to book reviews for when they are on duty to ensure consistency.</p> <p>Adherence to this GO is monitored through the weekly management checks.</p> <p>The daily operational briefing sheet details all prisoners on ACCTs, their allocated Case Manager and the date of their next review. The Governing Governor confirms that the appropriate Case Manager is on duty when a review is due.</p> <p>Where Case Manager's do not comply with this requirement they are challenged individually through the Safer Prisons Unit and their line manager.</p>	<p>Complete</p> <p>Complete</p> <p>Complete</p> <p>Complete</p>	
3	<p>The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Glen Parva has a Medical Emergency Response</p>	<p>Accepted</p>			

	<p>Code protocol which:</p> <p>a) Provides guidance to staff on efficiently communicating the nature of a medical emergency;</p> <p>b) Ensures staff called to the scene bring the relevant equipment; and</p> <p>c) Ensures there are no delays in calling, directing or discharging ambulances</p>		<p>A) Local policy reviewed and updated</p> <p>NTS to be published making clear the Medical Emergency Response Code protocol</p> <p>B) Healthcare Managers to ensure appropriate equipment is available</p> <p>Healthcare Managers to ensure all staff know what equipment they must bring to the scene</p> <p>C) NTS to be published making clear the Medical Emergency Response protocol.</p>	<p>Complete</p> <p>Complete</p> <p>30.05.14</p> <p>30.05.14</p> <p>Complete</p>	
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