

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adrian Glover a prisoner at HMP Whitemoor on 12 February 2017

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Adrian Glover was found hanged in his cell at HMP Whitemoor on 12 February 2017. He was 51 years old. I offer my condolences to his family and friends.

Staff appropriately managed Mr Glover under suicide and self-harm prevention procedures after his arrival at Whitemoor, but these procedures were subsequently ended. Staff continued to make efforts to support him but I consider that staff should have identified that he was once again at risk of suicide or self-harm shortly before he died and put in place formal protective measures. I am also concerned that his mental healthcare was inadequate and that there were some deficiencies in the emergency response.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

October 2017

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Summary

Events

1. In July 2011, Mr Adrian Glover was sentenced to 12 years in prison for attempted murder. Mr Glover was monitored under suicide and self-harm prevention procedures, known as ACCT, a number of times. On 1 August 2016, Mr Glover was released on licence but, on 2 November, he was recalled to HMP Birmingham.
2. On 18 December 2016, Mr Glover was one of ten prisoners moved to HMP Whitemoor after a major riot in Birmingham. An officer started ACCT procedures in January as he was concerned that Mr Glover stayed in his cell, refused meals and did not take his medication. Mr Glover moved to C wing, a quieter wing, and ACCT monitoring stopped shortly afterwards. The mental health team saw him and a GP prescribed an antidepressant.
3. On 9 February, Mr Glover was assessed for an offending behaviour programme. He did not want to take part and told the member of staff who assessed him that he had been struggling in the past few days. The member of staff told an officer who spoke to Mr Glover. He denied feeling low and said he was simply unwell. The next day, the officer spoke to Mr Glover again after he did not collect his meals. Mr Glover said he felt under the weather, but would be fine. On 11 February, another officer noted that Mr Glover had refused his morning medication, refused his meals, stayed in his cell all day and that another prisoner was concerned about him. The officer spoke to the wing manager who spoke to Mr Glover that afternoon. He was in bed and said he felt under the weather and wanted to remain locked up. They decided ACCT monitoring was unnecessary.
4. The two night staff decided to check on Mr Glover a few extra times. Mr Glover was seen at 8.05pm and 9.45pm. At the next check, just after midnight, an officer saw Mr Glover at the back of the cell, with a ligature around his neck. He did not have a radio so ran to the office to obtain the radio. He called a medical emergency code blue at 12.03am. An ambulance was called three minutes later. The officer went back to Mr Glover's cell, and when a dog handler arrived at 12.05am they unlocked the door, went in and cut the ligature. Other staff arrived and gave Mr Glover chest compressions until a nurse, manager and supervising officer arrived a few minutes later. A first response car arrived at Whitemoor at 12.11am and a paramedic attended Mr Glover's cell at 12.20am. At 12.28am, the paramedic pronounced that Mr Glover had died.

Findings

5. Mr Glover had some risk factors for suicide and self-harm: he had been recalled to prison and faced nearly six more years in custody, he had recently been transferred to a prison far from home and he had previously been managed under ACCT procedures. Mr Glover was appropriately managed under ACCT procedures at Whitemoor, but these were closed once he appeared more settled. However, in light of Mr Glover's behaviour on 11 February and the concerns raised about him two days earlier, we consider that staff should have restarted ACCT procedures despite Mr Glover denying thoughts of suicide and self-harm.

6. There was a delay in staff calling an emergency code blue because night staff shared a radio and the officer who found Mr Glover, did not have a radio with him.
7. There were some deficiencies in the emergency response (a delay of three minutes in calling an ambulance and an officer waited two minutes for other staff to arrive before going into the cell). While it is unlikely that these changed the outcome for Mr Glover, such delays could be critical in other circumstances.
8. The clinical reviewer considered that Mr Glover's mental healthcare was not equivalent to that which he would have received in the community.

Recommendations

Assessing and sharing information about the risk of suicide and self-harm

- The Governor should ensure that all staff manage prisoners at risk of suicide and self-harm in line with national guidance, including that staff:
 - Understand their responsibilities and the need to share all relevant information about a prisoner's risk.
 - Understand a prisoner's risk factors and do not rely solely on a prisoner's presentation in deciding whether to start ACCT procedures.

Emergency response

- The Governor should ensure that radios are issued to all night staff so that they can promptly raise the alarm in an emergency situation.
- The Governor should ensure that, subject to a personal risk assessment, staff enter a cell at night when there is a potential risk to life and that the control room calls an ambulance immediately a medical emergency code is called, without waiting for confirmation or further information.

Clinical care

- The Governor and Head of Healthcare should ensure appropriate mental healthcare for prisoners at all times.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Whitemoor informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. NHS England commissioned a clinical reviewer to review Mr Glover's clinical care at the prison.
11. The investigator visited Whitemoor on 17 February 2017. She obtained copies of relevant extracts from Mr Glover's' prison and medical records.
12. The investigator interviewed 11 members of staff and one prisoner at Whitemoor in March. The clinical reviewer joined the investigator for interviews with two clinical staff.
13. We informed HM Coroner for Cambridgeshire and Peterborough District of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Glover's daughter to explain the investigation. She asked about the circumstances in which her father had been arrested while on licence and how he had ended up at Whitemoor. She wanted to know the details of Mr Glover's mental health assessments and whether the prison knew he had self-harmed at the approved premises before his arrest. Mr Glover's daughter asked whether her father would have been told that the move to Whitemoor was temporary. She thought he would have worried that being in Whitemoor would have meant he would stay in prison for longer. She also asked what he had used as a ligature. We have addressed the issues Mr Glover's daughter raised either in this report or through separate correspondence.
15. Mr Glover's family received a copy of the initial report. They had no further comments or questions about the report but wished to raise some matters at the inquest.
16. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Whitemoor

17. HMP Whitemoor is a high security prison, which holds around 450 men serving long sentences. Healthcare is provided by Northamptonshire Healthcare NHS Foundation Trust.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Whitemoor was in March 2017. Inspectors reported that in the context of a high security prison with some extremely challenging prisoners, Whitemoor was safe overall and levels of violence were low. Inspectors said that Whitemoor had a comprehensive local suicide and self-harm prevention strategy and ACCT documents were reasonable overall. However, they reported that some caremaps were limited, case management was inconsistent and some reviews were late. Inspectors said that some prisoners monitored under ACCT procedures did not feel staff cared for them adequately when they were in crisis and many felt staff observed them rather than interacted with them. They considered relationships between staff and prisoners were a relative strength. They said that there were not enough nurses to provide therapeutic responses and while recruitment was underway, the lack of capacity was exacerbated at times by mental health nurses assisting with general healthcare duties. Inspectors reported that the team leader provided consistent support to the safer custody team and ACCT reviews, and prisoners were usually seen within five days, which was reasonable, those in crisis could be seen within a few hours on week days and those receiving psychiatric medications were carefully monitored..

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to May 2016, the IMB reported that Whitemoor was well led but not enough managerial time was devoted to delivering better prisoner outcomes. They commented that staffing profiles left no room for manoeuvre. Prisoners were not always able to benefit from a consistent or foreseeable regime.

Previous deaths at HMP Whitemoor

20. Mr Glover was the sixth prisoner to die at Whitemoor since August 2014. Three of these deaths were from natural causes and two were self-inflicted. We have raised concerns in previous reports about delays in calling an ambulance in emergencies and in paramedics attending cells.

Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support and monitor prisoners assessed as at risk of suicide or self-harm. The purpose of the ACCT process 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. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

22. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

Background

23. On 2 August 2010, Mr Adrian Glover was charged with attempted murder and remanded into custody. On 22 July 2011, he was sentenced to 12 years in prison. He was monitored a number of times under ACCT procedures, most recently in May 2016. On 1 August 2016, Mr Glover was released on licence to an approved premises in Birmingham. He was recalled to HMP Birmingham on 5 November 2016 after breaching the terms of his licence. He was expected to serve his remaining sentence in prison (until 1 August 2022). Mr Glover arrived with a suicide and self-harm warning form, but told the first night centre staff was unlikely to harm himself. They did not start suicide and self-harm prevention procedures, known as ACCT.

HMP Whitemoor

24. On 16 December 2016, there was a major riot in Birmingham and over 200 prisoners were transferred across the prison estate. Mr Glover was one of ten prisoners taken to HMP Whitemoor on 18 December. Mr Glover told the reception nurse that he felt anxious because he had not taken his antidepressants for a few days due to the riot. Mr Glover said he had no thoughts of suicide or self-harm but she referred him to the mental health team because of his history of depression. New prisoners are routinely moved to the induction unit (on C wing), but as there were too many new arrivals to accommodate, Mr Glover was moved to A wing, a standard residential wing. A prison GP prescribed Mr Glover amitriptyline, the antidepressant he had taken at Birmingham.
25. On 19 December, staff gave Mr Glover phone credit to let his family know where he was, and some clothing and toiletries as he had arrived with no property. The Head of the Mental Health Team said he assessed the needs of the newly arrived prisoners, but did not think Mr Glover needed to be prioritised above some of the other prisoners. He decided to see him in January.
26. On 3 January, Mr Glover told his offender supervisor that his property had not arrived from Birmingham and he did not have his glasses. She advised him to make an application about his property and to ask to see the optician.
27. On 5 January, the Head of the Mental Health Team saw Mr Glover, who said his sleep had been unsettled since he moved to Whitemoor. He said that he did not leave his cell much as he did not like some of the young men on the wing but he was reasonably happy. Mr Glover told him that he had taken a medication overdose when he was first recalled but did not have current thoughts of suicide. He noted that Mr Glover was prescribed an antidepressant but thought the dose was so low that it was likely to be for pain control. He said Mr Glover was unhappy being in a prison far from home.
28. A member from the activities hub, which allocated work and education places in Whitemoor, said that Mr Glover could not have an education assessment because he did not have his glasses. Without being assessed, Mr Glover could not be offered a work or education placement.

29. On 7 January, Mr Glover was notified that Whitemoor's mail department had withheld from him a postal order for £12, a card and two first class stamps because the sender was not identifiable. The offender supervisor visited Mr Glover to tell him that his daughter had not collected his property from the approved premises in Birmingham. Mr Glover refused to speak to her, so she passed the information to a Supervising Officer (SO) who told him.
30. On 10 January, an officer started ACCT procedures because Mr Glover continued to stay in his cell, refused his medication and missed a healthcare appointment. When the officer spoke to Mr Glover, he was tearful and kept saying he wanted to stay in his cell. He did not tell the officer why he was upset. Another officer, who was the ACCT assessor, assessed Mr Glover based on his records because he refused to meet her.
31. Later that day, Mr Glover refused to attend his first case review. The SO, who chaired the review, noted that staff had been concerned about Mr Glover and set his ACCT observations at three per hour. His caremap noted two actions: for his personal officer to contact HMP Birmingham about Mr Glover's property and for Mr Glover to contact his family to collect his property from the approved premises.
32. On 11 January, the staff in the activities hub met and discussed Mr Glover, but did not allocate him a job or education placement as he had not been assessed.
33. That day, Mr Glover's property arrived from HMP Birmingham and an optician prescribed new glasses. A custodial manager chaired his second ACCT case review and noted Mr Glover was withdrawn, not eating properly and not taking his medication. He told Mr Glover he was considering moving him to a gated cell (used for prisoners subject to constant ACCT monitoring). Although Mr Glover denied that he was being bullied, he was not convinced and wondered if Mr Glover found A wing too intimidating. He asked the mental health team to speak to Mr Glover. A nurse subsequently spoke to Mr Mitchell-Casey about this. The manager asked C wing staff whether they could accommodate Mr Glover on the spur for prisoners over the age of 50. These actions were added to Mr Glover's caremap and Mr Glover's observations were increased to four an hour. The Head of the Mental Health Team saw Mr Glover for a few minutes and arranged to see him the next morning.
34. On 12 January, the Head of the Mental Health Team saw Mr Glover as planned. He said Mr Glover was quietly spoken, slow to answer questions and only made occasional eye contact. Mr Glover said that although he was unhappy at Whitemoor, he was not suicidal and his daughter and partner were strong protective factors.
35. At 10.30am, a custodial manager chaired the third ACCT case review with a SO and the Head of the Mental Health Team. Mr Glover refused to attend. The Head said he did not think Mr Glover was at immediate risk of suicide or self-harm but felt that until he moved from A wing, he should continue to be monitored four times an hour. A short time later, Mr Glover was moved to a single cell on C wing as there was no space available on the over 50s spur.
36. At 3.45pm on 12 January, a SO held an ACCT case review. Mr Glover was initially tearful and felt frustrated. Mr Glover said he was desperate to write to his

girlfriend but had no stamps. The SO gave Mr Glover two extra stamped letters. Mr Glover said he had not received all of his property from Birmingham and he did not have any phone numbers. The SO printed out Mr Glover's approved PIN phone numbers and Mr Glover said he thought he could be able to resolve this issue himself. The SO asked Mr Glover if he thought about hurting himself. Mr Glover replied that he felt okay and wanted his observations reduced. As Mr Glover was engaging well and many of his issues were being addressed, his ACCT observations were reduced to two an hour.

37. An officer said he introduced himself to Mr Glover as his personal officer. Mr Glover told him he could not get all his property from Birmingham. He sometimes unlocked Mr Glover (with other unemployed prisoners) so they could help clean the landings and be out of their cell more during the day. Mr Glover never spoke to him about wanting a job or to attend an education course and he did not know there were problems with him being offered a place.
38. The personal officer was the cleaning officer on Mr Glover's spur, so saw him often. He said he did not make entries in Mr Glover's case notes about their conversations because of time pressure. He described Mr Glover as quiet but thought he was friends with two other prisoners. (One had been transferred elsewhere at the time of our investigation.) An officer said Mr Glover spoke to him regularly about his issues such as getting his property from Birmingham and from the approved premises.
39. A prisoner lived on C wing near Mr Glover's cell. He said Mr Glover usually came out of his cell during association periods and stood outside his door looking over the railings. He said he and another prisoner were the only people Mr Glover really talked to. He did not think there was much bullying on the wing.
40. On 15 January, a SO chaired an ACCT review with Mr Glover and an officer. Mr Glover was eating meals again, taking his medication and said he was coming to terms with having to serve the remainder of his sentence. Mr Glover said he felt more settled on C wing, that it was a calmer place and he had made some friends. The review decided to stop ACCT monitoring.
41. On 17 January, Mr Glover had a GP appointment. He said he had been low in mood and had disturbed sleep for the last two weeks. The prison GP discussed the possibility of talking therapy for his depression. Mr Glover said he preferred medication and the GP prescribed citalopram (an antidepressant). The GP said he would review him in a month and Mr Glover would receive mental health support. He said he usually advised patients that the positive effects of antidepressants were not immediate, and would take two to four weeks.
42. On 19 January, Mr Glover received two new pairs of glasses from healthcare. The activities hub did not know that Mr Glover had been given glasses. He did not have his education assessment, and was not allocated a job.
43. The post-closure review of Mr Glover's ACCT was held on 20 January. A SO completed the review and wrote that Mr Glover was in touch with his solicitor about being recalled to prison. She said Mr Glover was starting to get used to the fact that he might serve the rest of his sentence in prison. Mr Glover had applied for work but had not been offered anything yet. Mr Glover said he felt

supported by staff and would talk to them if he needed further support. She said she asked Mr Glover about thoughts of suicide and self-harm throughout their conversation and would have started ACCT monitoring again if she had been concerned.

44. Mr Glover called his girlfriend a number of times. The investigator listened to the most recent calls he made on 4, 6, 7 and 8 February. On 4 and 6 February, they talked about the cards and letters she had sent and Mr Glover said the words on the cards meant a lot to him. The general tone of the calls was upbeat. On 7 and 8 February, they talked about court procedures as Mr Glover's girlfriend was due in court. Mr Glover said he felt his probation officer was trying to "stitch him up" by saying he had been violent and uncooperative in the past. Mr Glover felt he had served that sentence and that he should be judged by his behaviour during this period in prison. Mr Glover called his solicitor on 8 February. (These calls were not monitored.) He did not speak to anyone by telephone after 8 February. (He tried to call his partner on 9 February but had no phone credit.)
45. On 9 February, an interventions facilitator with the psychology department met Mr Glover to discuss the Thinking Skills Programme (TSP) – an accredited programme at Whitemoor. Mr Glover said he preferred to keep to himself because he felt paranoid and was more comfortable when he did not do anything or interact with others. Mr Glover told her he was "struggling" and that although he had felt better recently, he had gone "a bit downhill" in the past few days. She did not directly ask him about feelings of suicide or self-harm. Mr Glover said he did not want to be assessed for TSP at that time.
46. The interventions facilitator made an entry in Mr Glover's prison records and spoke to an officer about their meeting. The officer spoke to a supervising officer, who asked if the facilitator had started ACCT procedures. The officer said she had not but thought staff should check on Mr Glover. The officer said he did not think about making an entry in the wing observation book.
47. As prisoners were arriving for lunch on 9 February, the officer saw Mr Glover and asked him if he was alright. Mr Glover said yes and the officer said that he had heard he was not feeling well and had been down. Mr Glover said he thought there was a bug going around, but that he was fine.
48. At teatime, Mr Glover did not collect his food. The officer was still on duty and went to see Mr Glover in his cell. He asked if he was alright. Mr Glover said that he thought he was coming down with something like flu, and attributed his low mood to feeling physically unwell.
49. A prisoner described Mr Glover as a quiet person and said they had only spoken in the two weeks before Mr Glover's death. He thought Mr Glover was nervous of other people. Mr Glover had asked him if he could go into the showers with him because he was worried about being in the showers when other prisoners were around or at busy times. He thought Mr Glover was "a bit paranoid" about other prisoners and did not like mixing.
50. On 10 February, the officer spoke to Mr Glover in his cell a few times because he did not collect his meals. Mr Glover continued to say that he felt under the weather, but would be fine.

51. On Saturday 11 February, an officer noted that Mr Glover had refused his morning medication, asked to remain locked up and, when he checked on him, Mr Glover seemed frustrated and upset. He checked on Mr Glover a number of times that morning, sometimes asking if he was alright. Mr Glover said he was fine but wanted to be left alone. He said he knew something was not quite right as Mr Glover's tone of voice was different to usual and, unusually, did not say much.
52. The SO who was in charge of C wing that day asked Mr Glover to come to the office after lunch so she could talk to him. (It was not her usual place of work and she was not familiar with managing a residential wing.) Mr Glover refused to leave his cell and said he felt under the weather. She telephoned a custodial manager, who suggested that she call the healthcare team to ask if missing his medication would have a detrimental effect. She contacted a nurse in the healthcare team, who said it would not matter. She asked staff to monitor Mr Glover in the afternoon.
53. An officer noted that Mr Glover had refused his medication, his lunch and evening meal, and had been locked up all day. He said he spoke to Mr Glover several times as he was concerned about his welfare and asked if he wanted to talk (or speak to the supervising officer). Mr Glover declined and told him not to worry.
54. The SO spoke to Mr Glover at his cell door, and asked if he was okay. Mr Glover was in bed. He said he felt under the weather, that he was coming down with a bug and wanted to be left locked up. She asked Mr Glover if he had any issues on the wing or if he was being bullied but he reiterated that he felt under the weather and wanted to sleep. She said Mr Glover declined to speak to the Samaritans or a Listener, and denied thoughts of suicide or self-harm.
55. An officer said he was on his way to visit Mr Glover when he saw the SO outside his cell. As they crossed on the stairs, he told her he was going to see Mr Glover. She said that there was no need as she had spoken to him and he said he would be fine.
56. A prisoner spoke to an officer at tea time and asked why Mr Glover had been locked up all day. He said he was worried about him. The officer said Mr Glover was not feeling well and that he was a bit low but staff were keeping an eye on him. The prisoner did not think Mr Glover would end his life but said they had never talked about it. The officer noted this conversation and referred to the SO having talked to Mr Glover and that he said he had no thoughts of self-harm and just felt run down.
57. The officer and the SO discussed whether to start ACCT procedures. He said they both agreed that ACCT procedures were unnecessary because Mr Glover had said he was fine, had no intentions of suicide or self-harm and wanted to be alone. While he said he was not aware that the interventions facilitator had raised concerns two days earlier, the SO said she had seen the entry in Mr Glover's prison records and was aware that Mr Glover had previously been monitored under ACCT procedures.

58. An officer gave a handover to the night staff, an officer and an operational support grade (OSG) when they arrived at around 8.00pm. He told them about Mr Glover, and they agreed that the OSG and the officer would check on Mr Glover a few times more than usual. The officer read the entries in the observation book and thought that the supervising officer had considered ACCT monitoring unnecessary. The officer had a radio, but the OSG did not. The OSG said they shared the radio and whoever checked the prisoners usually carried it.
59. The officer checked Mr Glover at 8.05pm as part of the roll count. At around 9.45pm, the OSG checked Mr Glover while checking other prisoners on his spur. Mr Glover was sitting on his bed, watching television. The OSG asked Mr Glover if he was alright. He said Mr Glover looked at him but did not reply.

Emergency response

60. The investigator watched CCTV footage of C wing from 11.00pm. The officer went to Mr Glover's cell at 12.00am to check on him. He saw Mr Glover at the back of the cell and it looked as though he was sitting on the pipes (that ran along the back wall). His head was tilted slightly. He shone his torch and then put the night light on. He saw that Mr Glover had a ligature (made from ripped bed sheet) around his neck. This was attached to the window bars (which were hidden behind a curtain). Mr Glover did not respond to him. He did not have the radio with him, so ran down the landing at 12.01am and obtained it from an office. He radioed a medical emergency code blue, to signal that a prisoner is not breathing, at 12.03am. He told the OSG, who was in the staff room making a drink. (The times shown on the control room log are inaccurate as the control room clock was two minutes slow.)
61. The custodial manager in charge of the prison that night heard the code blue. He and a SO went to the healthcare department to take the nurse to C wing. (Nurses do not have keys at night time.)
62. The officer went back to Mr Glover's cell at 12.03am. He did not go in. CCTV footage showed him leaning over the three's landing. (He appears to be talking to someone on the landing below.) A dog handler then arrived with his dog. The OSG was about to follow the officer to Mr Glover's cell when the SO from the control room phoned the office to ask for more information to give the ambulance service. The OSG told him what he knew and went to Mr Glover's cell. He arrived and the emergency cell key was used to unlock the door at 12.05am. The officer went into the cell and used his fish knife to cut the ligature.
63. Another officer who worked on D wing arrived, went into Mr Glover's cell with the dog handler at 12.05am and helped lay Mr Glover onto the floor. The OSG went into the cell and offered to do chest compressions because he had recently been trained in emergency response techniques. He said he thought Mr Glover's skin looked a normal colour and he did not feel cold.
64. The control room called an ambulance at 12.06am. The custodial manager, SO and nurse reached Mr Glover's cell at 12.07am. The nurse brought an emergency bag with him. He inserted an airway and gave Mr Glover oxygen. A defibrillator was applied but no shockable heart rhythm was found. He described Mr Glover as grey, cold and clammy.

65. A first response car arrived at Whitemoor at 12.11am. An OSG escorted the first response car to C wing, and the paramedic reached Mr Glover's cell at 12.20am. The paramedic said that she thought Mr Glover's neck was fractured and that there was blood pooling (a sign of death). At 12.28am, the paramedic pronounced that Mr Glover had died.

Contact with Mr Glover's family

66. At 1.40am, a trained family liaison officer (FLO) was asked to come to the prison. When she arrived at 3.30am, she found that Whitemoor had several addresses for Mr Glover's daughter, so she asked the police to confirm the correct address. The duty governor asked the police to break the news to the family as he was concerned that Mr Glover's next of kin might find out from a prisoner that Mr Glover had died. The police visited two addresses, but Mr Glover's daughter no longer lived at either address. The police found her new address and broke the news of Mr Glover's death at 10.22am.
67. Another trained family liaison officer was reallocated the role of family liaison officer as the other FLO was about to go on leave. She tried to visit Mr Glover's daughter with a custodial manager at 3.00pm, but there was no response. They returned 45 minutes later and met Mr Glover's daughter and partner. They offered their condolences. In line with national instructions, Whitemoor contributed to the cost of Mr Glover's funeral.

Support for prisoners and staff

68. PSI 08/2010 on post incident care requires a senior manager to debrief the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. While this did not happen, the duty governor said he spoke to all the staff involved before they went home at the end of their shift and the staff care team offered support.
69. The prison posted notices informing other prisoners of Mr Glover's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Glover's death.

Post-mortem report

70. A post-mortem examination found that Mr Glover died by hanging. Toxicology tests found citalopram in his blood and a low level of amitriptyline in his urine. No other illicit drugs, including new psychoactive substances (NPS), were detected in Mr Glover's system.

Findings

Assessing and sharing information about the risk of suicide and self-harm

71. PSI 64/2011 on safer custody lists a number of risk factors for suicide or self-harm, including being recalled to prison on licence and being transferred between prisons. Mr Glover was recalled into custody, faced nearly six more years in prison, had been monitored under ACCT procedures a number of times before and had recently been transferred to a prison far from home.
72. An officer appropriately started ACCT procedures in January 2017 after he became concerned about Mr Glover's low mood, refusal to eat, take medication or interact with people. Staff supported him well by for example, moving him to a quieter wing and helping him to contact his family. ACCT procedures were operated reasonably effectively: staff reviewed Mr Glover's risk despite him not wanting to attend, they set observations at a reasonable level, and reviewed them appropriately. We consider that the decision to stop ACCT monitoring on 15 January was reasonable as Mr Glover appeared to have settled on C wing, which he described as calmer and he said he had made some friends.
73. Despite this, Mr Glover told the interventions facilitator he was "struggling" in the days before he died. She said she was not concerned that he might harm himself, although she had not asked him whether he had thoughts of suicide or self-harm. She passed on her concerns to an officer and made an entry in Mr Glover's case notes, but she did not make an entry in the wing observation book. Mr Glover told the officer there was a bug going around and attributed his low mood to this. Staff judgement is fundamental in assessing the risk of suicide. The system relies on staff using their experience and skills, as well as local and national assessment tools to determine risk. While we do not think it was unreasonable for the facilitator or the officer to decide not to start ACCT monitoring at this time, it is unfortunate that neither made an entry in the wing observation book.
74. A few days later, on 11 February, an officer went out of his way to offer Mr Glover support. He appropriately passed his concerns to the wing manager and wrote three entries in the wing observation book. He was not aware of the concerns raised by the interventions facilitator two days earlier and said if he had been it would have affected his decision not to start ACCT procedures.
75. We acknowledge that the SO was not the usual C wing manager and she told us there were other incidents taking place when she was deciding how to manage Mr Glover. However, we are concerned that she did not err on the side of caution and start ACCT monitoring on 11 February, particularly as she did not know Mr Glover. He was unwell, refused his meals and medication and had not left his cell all day. Another prisoner had raised concerns about Mr Glover and he was recorded as struggling two days earlier in his case notes. Mr Glover's behaviour and background risk factors should have been sufficient to start ACCT monitoring despite Mr Glover denying thoughts of suicide and self-harm.
76. The OSG and the officer felt that if the day staff were satisfied ACCT procedures were not needed, it was unnecessary to revisit the decision. We acknowledge that the night staff made a few additional checks of Mr Glover and that, if ACCT

procedures had been started, monitoring might not have been set at a level sufficiently high to have prevented his actions. Nevertheless, with hindsight, we consider formal ACCT procedures should have been restarted and make the following recommendation:

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

- **Understand their responsibilities and the need to share all relevant information about a prisoner's risk.**
- **Understand a prisoner's risk factors and do not rely solely on a prisoner's presentation in deciding whether to start ACCT procedures.**

Emergency response

77. The officer delayed radioing a code blue emergency call by nearly three minutes because he did not have a radio and needed to obtain the shared radio from the office. Whitemoor issued a memo on 15 November 2014 which required night staff to wear their radio when on duty. It specified that leaving a radio on a desk was unacceptable and bad practice. The officer and OSG said it was their usual practice to leave the radio in the office and whoever checked on prisoners would take the radio with them. It is unfortunate that the officer did not take the radio with him when he checked on prisoners at midnight. This would have been avoided if night staff did not have to share a radio. We make the following recommendation:

The Governor should ensure that radios are issued to all night staff so that they can promptly raise the alarm in an emergency situation.

78. Whitemoor's night instructions say that a decision to open a sealed pouch and enter a cell in night state without assistance can be made in a serious emergency where life is threatened. A Staff Information Notice (159/2015) on 30 July 2015 about staff entering a cell alone in an emergency acknowledged that it was a difficult judgement and said staff must make an immediate and dynamic risk assessment. The officer returned to Mr Glover's cell after he called a code blue at 12.03am. He did not use the key in his sealed pouch to unlock the door, but waited for another member of staff. Mr Glover's cell was unlocked two minutes later when another officer arrived, and an ambulance called a minute later (three minutes after a code blue was radioed). While the OSG said that Mr Glover was not cold and his skin looked normal, the nurse and the paramedic who responded described signs of death. While it is unlikely the delay affected the outcome for Mr Glover, we have previously raised concerns about emergency response at Whitemoor and, in other circumstances, such delays can be critical. We therefore make the following recommendation:

The Governor should ensure that, subject to a personal risk assessment, staff enter a cell at night when there is a potential risk to life and that the control room calls an ambulance immediately a medical emergency code is called, without waiting for confirmation or further information.

Clinical care

79. The clinical reviewer considered that Mr Glover's mental healthcare at Whitemoor was not equivalent to that which he could have expected to receive in the community.
80. At the time of Mr Glover's transfer, the Head of the Mental Health Team was the only registered mental health nurse on duty to assess and manage the ten unexpected new arrivals from Birmingham, in addition to his existing caseload. (Whitemoor told us that they do not usually have more than ten new prisoners a month.)
81. Whitemoor's mental health team aimed to see prisoners within five working days of referral. Despite this, the Head of the Mental Health Team was unable to see Mr Glover in that timeframe because he considered that many of the other prisoners had more pressing needs. When he assessed Mr Glover on 5 January, he did not complete the full mental health assessment (as he should have done) but said he did not have concerns about Mr Glover at that time.
82. When a prison GP reviewed Mr Glover on 17 January, he said that he was not concerned that Mr Glover was at risk of suicide or self-harm. He prescribed a more effective antidepressant, planned for Mr Glover to receive mental health support and planned to review Mr Glover in a month. However, Mr Glover did not receive any further mental health support during the four weeks before his death. The Head of the Mental Health Team agreed that he should have been seen (ideally every two weeks) and added to the waiting list for a talking therapy. We make the following recommendation:

The Governor and Head of Healthcare should ensure appropriate mental healthcare for prisoners at all times.

**Prisons &
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