PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a young man at HMYOI Glen Parva in April 2013

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 young man who was found hanging in his cell at HMYOI Glen Parva in April 2013. He was 20 years old. I offer my condolences to his family and friends.

A clinical reviewer reviewed the man's clinical care in prison. The prison cooperated fully with this investigation.

The man received an eight week custodial sentence on 3 April 2013 and was taken to Glen Parva where he had been before. He had a history of mental health problems and drug misuse. On the night of 14 April, he tried to hang himself and appeared very disturbed. The YOI staff began to monitor him under suicide and self-harm prevention procedures and moved him to a 'safer cell' designed to have limited ligature points. A few days later, after a case review, he was moved back to a standard cell, but was observed by staff more frequently as a precaution. At 7.55pm that day, an officer conducting a roll check found him hanging in his cell. Despite attempts by staff and paramedics to resuscitate him, he was pronounced dead at hospital.

It is apparent that the man was a very troubled young man who prison staff found difficult to manage. However, I am satisfied that a range of staff made considerable efforts to ensure he was actively supported. He also had full access to mental health services and was properly monitored after he tried to kill himself. Nonetheless, it does appear that there is some learning to be gained from his tragic case. In particular, it is of concern that he was moved from a safer cell when there had not been a sustained improvement in his mood and just after a doctor had assessed him as being mentally unwell and requiring a transfer to a psychiatric hospital. In addition, the investigation identified some areas for improvement in emergency procedures.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2014**

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SUMMARY

1. The young man was born in London in 1992. He had begun using cannabis from the age of 13 and had a number of drug-related problems. His mother moved to Coventry in 2011. At first he slept rough in London but then followed his mother to Coventry. He had no accommodation there and stayed with a number of friends or in hostels. He spent several periods in custody.

2. The young man was taken to HMP Glen Parva on 3 April 2013, after being sentenced to eight weeks in prison for offences relating to harassing his mother. He had been there before. His history of mental health issues and drug misuse was noted when he arrived, and he was assessed by the mental health in-reach team He told them he did not want to engage and was not taken on to their caseload.

3. On 14 April, the young man called officers to his cell. He had tried to hang himself but the ligature had broken. The officers said he was confused and disorientated, they began suicide and self-harm prevention procedures (known as ACCT). Because of his complex needs and risks he was reviewed several times over the next three days using enhanced care management procedures and moved to a cell designed to have limited ligature points (known as a safer cell).

4. On 17 April, a psychiatrist assessed the young man and found his mood changeable. He diagnosed bi-polar affective disorder and hypomania and considered he needed to transfer urgently to a psychiatric unit. A prison GP completed the documents for the transfer the next day and noted that he had subtle markers of mania. He was not reassured that the young man would not take his own life.

5. Just after the GP had seen him, the young man attended an ACCT review where it was noted he seemed much brighter in mood. It is not apparent what weight, if any, they attached to the GP's comments or the fact that it had been decided that he should be admitted to a psychiatric unit. The review panel decided he could move from the safer cell, but at the same time they increased the level of his observations. A few hours later, during a routine roll check at 7.55pm, an officer found him hanging in his cell. Despite attempts by staff and officers, he was pronounced dead in hospital.

6. Despite considerable efforts by staff to support the young man, we are not satisfied that the ACCT review on 18 April had sufficient information to decide that his risk had reduced sufficiently to move him from the safer cell. Emergency procedures did not operate effectively. We make three recommendations about these matters.

THE INVESTIGATION PROCESS

7. The investigator issued notices about the investigation to staff and prisoners at HMYOI Glen Parva inviting anyone with information to contact her. No one came forward.

8. The investigator visited Glen Parva on 25 April and met the Deputy Governor and the then Head of Safer Custody and Violence Reduction (now acting Head of Residence and Safety). She spoke to representatives of the Independent Monitoring Board and the POA (prison officers' union). She saw the young man's cell and spoke informally to the last member of staff to speak to him. She collected copies of his prison record and other relevant paperwork.

9. The local PCT commissioned a clinical reviewer to review the young man's clinical care at Glen Parva. The investigator interviewed 13 members of staff and gave verbal and written feedback to the Governor after the interviews. She also spoke to the police investigator and the Coroner's officer.

10. One of our family liaison officers informed the young man's mother about the investigation. A copy of this report has been made available to her.

HMYOI GLEN PARVA

11. Glen Parva holds a maximum of about 800 convicted and unconvicted young adult male prisoners aged between 18 and 21. There are ten residential units each holding up to 80 young prisoners. The residential units for sentenced prisoners each have three landings accessible from stairs leading from the main association area. The landings are not visible from the unit office but there is closed circuit television (CCTV) coverage on some units.

12. Primary mental health services at the prison are delivered by Leicestershire Partnership Trust and in-reach (acute) mental health services are provided by Northamptonshire PCT. Following a review by the Centre for Mental Health, two units now have 24-hour nursing cover for some cells. Care for these prisoners is based on a community model with prisoners integrated into the wider unit community.

Her Majesty's Inspectorate of Prisons

13. Her Majesty's Inspectorate of Prisons last inspected Glen Parva for an unannounced short follow-up inspection in July/August 2012. At the previous inspection in 2009, inspectors found that there were failures in the operation of the personal officer scheme and deficiencies in the operation of ACCT procedures. Few ACCT reviews were multidisciplinary and there was little evidence that personal officers played any significant role in supporting prisoners at risk. (Each prisoner should be allocated a personal officer to support them and be their first point of contact.) The inspection of 2012 found that ACCT reviews were now appropriately multi-disciplinary, particularly in terms of representation from the mental health team. The work of personal officers was found to be better than in a lot of prisons. Managers checked personal officer entries in prisoners' files but the quality and effectiveness of these were variable. Personal officers knew the prisoners they were responsible for, but entries in electronic records did not always reflect this. Half-day mental health awareness training was provided for up to 15 staff each month.

Independent Monitoring Board

14. Every prison in England and Wales has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. The 2012, Glen Parva IMB report noted that the delay from assessment to successfully securing a hospital bed for mentally ill prisoners was up to 14 days from diagnosis. This created difficulties for prison staff responsible for their management. The IMB said that there was a largely positive relationship between staff and prisoners but that some prisoners told them that they did not feel supported by their personal officers.

Previous deaths at Glen Parva

15. There were two self-inflicted deaths at Glen Parva in November 2011. Neither of the two investigations raised issues which are similar to the circumstances of the young man's death.

ACCT (Assessment Care in Custody and Teamwork)

16. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a 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.

17. Prisoners thought to have active suicidal intent or who have attempted serious self harm are managed by an enhanced case review team. This includes a member of the mental health team or doctor and a higher level of operational management than a typical ACCT case review team. At Glen Parva, all prisoners held in safer cells are managed by an enhanced case review team.

Safer cells

18. The definition of a safer cell is contained in Prison Service Instruction 17/2012 which says:

> "The design of safer cells has several features which can assist staff in the task of managing those at risk from suicide or self harm by ligaturing, such as specially designed furniture and fixtures which are manufactured and installed to make the attachment of ligatures very difficult, and prevent access to window bars via specialist approved window design. Safer cells are designed not only to minimise ligature points, but also to create a more normalising environment. They have been found to be more durable, easier to maintain and easier to search.
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> "Safer cell designs are not intended to remove the need for appropriate operational processes. They do not deal with the problems underlying a prisoner's self-harming or suicidal behaviours, and so safer cells can only complement (i.e. not replace) a regime providing individualised and multi-disciplinary care for at-risk prisoners."

KEY EVENTS

19. The young man was born in London in 1992. He began using cannabis when he was 13. His mother moved to Coventry in 2011. He slept rough in London for a time, before following his mother to Coventry. He had no accommodation in Coventry and stayed with different friends or in hostels.

20. The young man was first remanded to Glen Parva on 26 November 2011. His behaviour at his induction board was described as very strange. Healthcare staff noticed he appeared to be responding to unseen stimuli and he was referred to the mental health team for assessment as a high priority. Two nurses from the mental health in-reach team assessed him on 28 November. They decided that his strange behaviour was related to his personality and was not mental illness. An interview with a member of staff from Nacro (a charity dealing with the resettlement of offenders) was stopped after he had asked her personal questions and refused to co-operate. He was monitored under anti-social behaviour procedures because staff believed he had been planning to assault another prisoner. On 19 December, a SO became concerned about what he described as his "unusual and peculiar" behaviour and asked the mental health in-reach team to assess him again.

21. On 21 December, before the assessment took place, the young man received an 18 month supervision order for burglary, theft, failure to surrender, damage to property and breach of a community order. The damage to property related to him breaking a window at his mother's home. The same day, his mother was granted a two year restraining order against him to protect her from "further conduct which amounts to harassment or will cause fear of violence". The order prevented him from having any contact with his mother or visiting her home. He was released from court.

22. The young man was remanded to Glen Parva again on 27 January 2012. He was described as rude and abusive on arrival. He was again managed under anti-social behaviour procedures after threatening to kill a trans-gender prisoner. On 31 January 2012, wing officers asked the mental health team to assess him because of his strange behaviour. A member of the mental health team saw him the same day. He did not think he was psychotic but advised that he should be observed and reviewed again. He was put on the caseload of the primary mental health team. On 6 February, two nurses from the primary mental health team assessed him after wing staff were again concerned about his behaviour and referred him to the mental health in-reach team. A nurse assessed him on 8 February. He became abusive and said he would not see anyone from the mental health team. The nurse said that he was adamant that he was not mentally ill so she suggested that he see the psychiatrist to get a definitive diagnosis. He refused. She did not consider that he was suffering from a mental illness.

23. On 14 February 2012, an ACCT was opened after the young man threatened to kill himself if he was not given a smoker's pack. (Tobacco, cigarette papers and a lighter usually given to prisoners when they first arrive and for which payments are deducted from their prison pay.) He refused to take part in his

ACCT assessment. His behaviour continued to be of concern and his ACCT remained open. Mental health nurses advised officers that his behaviour was behavioural not medical. He was released on bail on 20 February 2012 but returned three days later on 23 February. He told an officer that as long as he was given a smoker's pack he was not at risk of harming himself. He was released on 9 March after being acquitted of the charges.

24. On 12 March 2012, the young man was again remanded at Glen Parva. On reception a nurse noted his previous involvement with the mental health teams. She said that he gave guarded answers and laughed inappropriately during his assessment. She put him on the waiting list to see the mental health team. He refused mental health assessments on 17 and 20 March. On 2 April, an ACCT was opened because he made an application for a smoker's pack and wrote that he felt suicidal without one. The next day he told staff that he did not feel suicidal but had just been trying to get tobacco. The ACCT was closed. On 17 April 2012, he was monitored under anti-social behaviour arrangements after assaulting another prisoner. His record shows numerous entries reporting that he asked other prisoners for tobacco. On 30 April 2012, he was sentenced to detention in a YOI but was released the same day because of the time he had already served on remand.

25. On 8 May 2012, the young man was remanded to HMYOI Feltham. He refused to be assessed by the mental health team when officers were concerned about his behaviour. He repeatedly stated that he was not mentally ill. On 24 May, he was admitted to the Albatross Unit at Feltham (a ten bed mental health inpatient unit). His behaviour was described as strange, aggressive, confrontational and unpredictable. A psychiatrist assessed him on 25 May and found him to be acutely psychotic. On 29 May, he decided to prescribe olanzapine (an anti psychotic) and to carry out a capacity assessment.

26. On 30 May, the psychiatrist reviewed the young man again with another psychiatrist. He recorded that he appeared thought disordered, laughed inappropriately and was responding to internal stimuli. He made intrusive and threatening remarks to the other psychiatrist and talked about hitting officers. The interview was terminated because of his increasingly threatening behaviour. The psychiatrist concluded that he was threatening and volatile with evidence of persecutory, grandiose and somatic delusions. He showed no insight into his behaviour and was only intermittently compliant with his antipsychotic medication. He recommended urgent transfer to a secure mental health facility. His behaviour continued to be abusive and disruptive. On 18 June, he made sexually inappropriate comments to two female members of staff and tried to grab one of them.

27. On 26 June, he was released after the charges against him were withdrawn. Later that day, he was admitted to hospital under section two of the Mental Health Act 1993 (compulsory admission for assessment for a period of up to 28 days). The psychiatrist's discharge report described him as acutely psychotic, insightless, aggressive and neglectful of his self-care. In July 2012, he was discharged from hospital with a diagnosis of drug-induced psychosis.

At some point after this, he went to Coventry, apparently to see his mother, although the restraining order of December 2011 required him not to contact her.

28. In August 2012, the young man was arrested for breaching the restraining order against his mother. While in police custody he presented as thought disordered and with auditory hallucinations. Following a mental health assessment, he was admitted to the Caludon Centre (a mental health unit with a secure ward) in Coventry on 4 August under section 2 of the Mental Health Act. On admission, he was found to be thought disordered with flight of ideas and experiencing auditory hallucinations in the second and third person. He told staff he suffered from "cannabis psychosis" but could not explain what that meant. He said that before his admission he had been misusing cannabis.

29. The young man was treated with 50mgs of quetiapine (an anti-psychotic) at night. He was described as rude, demanding, intimidating and verbally hostile to staff. He had minimal interaction with staff and was seen laughing to himself. On 14 August, he was re-graded to a voluntary patient while staff helped him find accommodation. He did not comply with his treatment plan, behaved in a sexually inappropriate way to female staff and was suspected of supplying and using drugs on the ward. As a result, he was discharged on 29 August 2012 with a diagnosis of drug induced psychosis and a prescription for quetiapine100mg daily. His treatment plan was described as a follow up with the liaison link nurse on 4 September and input from the crisis resolution/home treatment team. It does not appear that he kept this appointment and it is not clear whether there was any follow-up from the crisis resolution/home treatment team.

30. On 9 October 2012, the young man had a community order imposed on him at Magistrates Court. As part of the condition he was required to keep his supervising officer aware of his whereabouts.

31. On 3 April 2013, the young man was sentenced to eight weeks imprisonment for destroying or damaging property, attempted burglary, failure to surrender to custody and having a bladed article in a public place. The sentence meant he was due for unconditional release on 30 April 2013. He was taken to Glen Parva the same day. His person escort record completed by the police (PER – a form highlighting risk factors that travels with every prisoner when they move between prisons, police stations and courts) showed that he had markings on his police national computer record (PNC record) for violence to others and drugs/alcohol. "States he is bi-polar" was written in the section for mental health.

32. A nurse completed a first reception health screen. The young man told him that he had received treatment from a psychiatrist outside prison and had been seen by a doctor in Coventry for bi-polar disorder. He told the nurse that he no longer required medication and did not want to take any. He said he had last taken quetiapine for bi-polar disorder in September 2012 because he did not like the side-effects and felt his symptoms were under control. He

admitted to binge drinking at weekends and was referred to the prison's integrated drug treatment service (IDTS). The nurse said he presented as settled and responded appropriately and coherently. He referred him for a mental health assessment.

33. The young man telephoned a friend that evening and spoke for about three minutes. He described his sentence as "only a little four weeks". He gave the address of the prison and asked his friend to write and send some money.

34. The next day on 4 April, a nurse saw the young man for his referral to the integrated drug treatment service (IDTS) for binge drinking. He told her he smoked cannabis daily outside prison. She said he was calm and appeared settled but was sometimes vague in his responses and appeared to think carefully before answering. He did not appear to be in withdrawal from drugs or alcohol. She asked him directly if he had any thoughts of self-harm and he replied that he did not. She completed a substance misuse care plan and referred him for continued support from the IDTS team. (He did not attend his IDTS clinic appointments over the next few days so staff visited him on the wing to assess him. He did not show any signs of withdrawal.)

35. The same afternoon, a nurse from the primary mental health team assessed the young man in response to his mental health referral. He denied he had been involved with mental health services during previous times in custody. He said he had been admitted to the Caludon Centre in Coventry in August 2012 after being arrested by the police. He said he had been prescribed quetiapine when he was there but had stopped taking it when he was discharged. He said he did not want to be involved with mental health services in Glen Parva. The nurse referred him the mental health in-reach team because he had previously been on their caseload. He said "the more nurses I see the more my head is fucked up".

36. On 5 April, the young man was warned for being abusive and threatening to a teacher during his education induction. On 7 April, his offender supervisor interviewed him to complete an initial categorisation and allocation form. The offender supervisor indicated on the form that he had a history of medical care, psychiatric care, risk of self-harm and control problems. In the box giving details he wrote:

> "Mental health bi-polar, heart problems, previously on ACCT April 2012, risk to females, sectioned under mental health act Bevan Unit London transfer from HMP Feltham."

37. On 8 April, the young man did not attend an appointment with the prison GP. On 9 April, a nurse from the mental health in-reach team saw him for his assessment. The nurse described him as very pleasant and happy to talk to her. He was calm and relaxed with good concentration and eye contact. She said he did not say anything weird or bizarre. He could not really explain why he had been admitted to hospital in 2012 but said he had been getting angry. He denied any paranoid ideas. He said he was struggling a little because he had no tobacco but otherwise had no concerns and had been eating and

sleeping well. He said he did not want input from the mental health team in Glen Parva.

38. The nurse said she was unsure what the mental health in-reach team could offer him. He was only in prison for a short sentence and did not want to engage with mental health services. She decided to contact the Caludon Centre for a copy of their discharge report and received it by email the same day. The report did not indicate whether the young man was receiving any input from community mental health services so she telephoned the Caludon Centre and they confirmed that he was not. If he had been, then he would automatically have been placed on the prison mental health in-reach team caseload regardless of whether he wanted their input.

39. The nurse discussed the young man with another nurse who remembered him from previous sentences. She said she could not see any reason, either because of risk or mental illness, for taking him on to their caseload. She thought his risk would be greater in the community when he had access to cannabis. If he was taken on their caseload, his first review would not be until two weeks later by which time he was due for release. There was no option to refer him to community mental health services because he did not want to engage and was non-compliant with his medication.

40. That day, 9 April, the young man was issued another warning for collecting tobacco from another prisoner on a different landing. The same day, his offender supervisor interviewed him again to complete a public protection notification because of the restraining order against him. On 11 April, he was issued with a third warning under the incentives and earned privileges scheme for misusing his cell bell. He had a review the next day when it was decided to issue him with a final warning rather than place him on the basic regime as a result of his warnings. The Unit 12 manager remembered him from previous sentences. He described him as more aggressive on this sentence. He said he did not talk much to staff and often responded in an abusive way. He usually only approached staff when he wanted tobacco and did not mix particularly with the other prisoners.

41. At about 10.15pm on 14 April, an Officer A answered the young man's cell bell. He was naked and agitated and asked the officer why he kept coming back to life. The officer said he was taken aback by the question and talked to him for a few minutes, when he told him that he had tried to hang himself. The officer contacted the Night Orderly Officer (NOO), who came to the wing with a nurse and a healthcare support worker and two assistant orderly officers. The NOO said he opened the cell door and asked him to put some clothes on before the nurses came in. The officer noticed faeces on the cell floor. There was a torn sheet tied to the cell window bars and one of the officers took it down.

42. The NOO said the young man put a sheet around his shoulders and then used the toilet. He left the cell while he did so and the officer observed him through the toilet observation flap.

43. The nurse and healthcare assistant examined the young man and found he had a red mark around his neck which he said was painful. The healthcare assistant said he was evasive, dismissive and aggressive when asked about what had happened, but told her that a ligature had snapped. The NOO decided that he should be moved immediately to the safer cell on Unit 15 (the induction unit). The healthcare assistant tried to talk to him again there but he became hostile and she had to leave the cell. She said he asked the NOO how far heaven was. The nurse referred him to the mental health crisis team.

44. The officer opened an ACCT and completed the concern and keep safe form, the first part of the procedures, and the NOO completed an immediate action plan. The NOO decided that he should be observed every half hour overnight. He considered constant supervision but the nurse and healthcare assistant thought half-hourly observations were sufficient. He explained to an operational support grade (OSG) on Unit 15 what had happened and asked another OSG on induction to go to Unit 15 to help observe him. He was given a clean tracksuit and fresh bedding. The NOO left his shoes and socks outside the cell door in case he tried to use the laces as a ligature.

45. The young man rang his cell bell at 1.50am in the early morning of 15 April, and asked for a television. The OSG explained that there were none available. He then demanded to move to another cell. The OSG explained this was not possible either and he became aggressive and threatened to smash his head against the cell wall unless he was given a television. The OSG spoke to him at length again at 2.20am. She said he kept asking about going to heaven and his mood switched from placid to extremely aggressive. The NOO tried to talk to him when he was on his rounds of the units at 3.00am. He said he had not put his clothes on and told him that he needed to be naked to get into heaven. He tried to persuade him to get dressed. He said he did not realise at the time that he had mental health problems and tried to get some banter going with him. He began swearing at him and called him the son of Satan. The NOO continued to check with the OSG throughout the night that everything was okay.

46. The Unit 15 manager spoke to the young man at 8.00am that morning. He described him as initially calm and polite but then closed, defensive and paranoid. He went with him to collect his breakfast and when they got back to his cell he told him that there would be a review later that morning. He asked for his socks and shoes and some tobacco. After checking with a custodial manager, he gave him his socks but said he needed to have a full briefing before he let him have his shoes and a lighter in his cell.

47. Later the same morning a chaplain visited the young man. He told the chaplain that he was stressed and needed a smoke and a television. The chaplain asked an officer to explain to him that he would get a television once the works department had found a new lead because the television in that cell had been smashed by a previous occupant.

48. An officer completed an ACCT assessment interview at 9.10am on 15 April. The officer described the young man as articulate and very open in his

answers. He spoke calmly but often got up and walked around the room. He said that he was tired of life and had been talking to God. He said he now understood the meaning of life and death. He said he had hanged himself from the cell light and acted out for the officer how he had done this. The light in the room they were in had a round plastic cover and he said it was a light like that. The officer concluded that he had used the light in the cell toilet because this was the same shape. He said that at the time he felt good because God had talked to him and showed him the light and the path to take. He said this was his first attempt at suicide. He had been naked and this had helped him to feel free. When asked about his mental state he said that he had talked to God and gained an understanding of himself and the world around him. He said he was not sure if he wanted to be dead because life was no longer fun. He did not understand why he had woken up but said it must be because God had wanted him to. At that time he said he had no plans to kill himself. He said he coped by talking to God and that finding happiness through love was something that might prevent him taking his life. He said he had felt like this since inhaling drugs with friends a while before.

49. After the assessment interview, the officer told the Unit 15 manager he was worried about the young man's mental state because he appeared calm, articulate and lacked emotion. In his experience, people who have made a serious attempt to kill themselves are frightened and in shock. The officer did not believe his assertion that he had no plans to kill himself. He told the manager that he thought the mental health team should assess him and the manager said he had already arranged for them to attend the first case review later that afternoon.

50. Prisoners at Glen Parva who are in safer cells and on ACCT are automatically subject to enhanced case reviews. This means that they are chaired by an operational manager, usually the duty governor. The Unit 15 manager explained that the senior officer from the young man's residential unit would also normally come to the review. The regular Unit 12 senior officer was off duty and although the senior officer covering Unit 12 came to the review, he decided to attend as well because he had spoken to the young man and the officer.

51. The young man's review took place at 2.30pm. The duty governor chaired the review, which was also attended by the Unit 15 manager, the Unit 12 manager, a nurse from the primary mental health team and the young man. The Unit 15 manager said that he acted bizarrely during the review. He initially said he thought he was dead and in heaven. He also spoke about his plans after he was released and his girlfriend. He said he would not harm himself and wanted to go back to Unit 12. However, he also continued to speak of death and would not give any assurances that he would not try to take his own life. He went back to the safer cell while the members of the review decided how to proceed. The duty governor and the nurse thought that he was mentally unwell and the review concluded that he presented a high risk of self-harm, should remain in the safer cell and be referred to the mental health in-reach team.

52. The young man was brought back into the room and this was explained to him. The Unit 15 manager asked the duty manager if he would attend the review the next day. The duty manager said he would attend if he could but otherwise it would be whoever was the duty governor. The manager decided to invite the prison Imam. Observations remained at two each hour. The caremap was completed with two goals. The young man was to be assessed by the mental health team and to be visited by the Imam to talk about his religious issues.

53. The mental health nurse wrote in the young man's medical record that he appeared distracted during the ACCT review. He said he was in heaven but he came from Earth. He said he had thoughts in his head and had seen a light, which meant there was an angel, and that he was fighting with the Devil. He spoke at length about religion. She said he appeared sometimes oriented and sometimes confused. She said it was a very bizarre conversation. She wrote "Refer to in-reach, review in the morning".

54. A nurse from the mental health in-reach team visited the young man at 10.20am on 16 April. He told her he was fine and wanted to be left alone. He said his admission to the Caludon Centre had not been due to drug-induced psychosis but was bi-polar disorder as a result of how his mother had treated him. The nurse offered to recommence his quetiapine but he said he did not want to take it. He said he did not feel the same as when he had been admitted to psychiatric hospital. He did not appear to be responding to unseen stimuli but said that he was not sure if he was in heaven or not. He said he did not now want to kill himself and had tried to because he did not have any tobacco and was bored. After about ten minutes he walked out of the interview but later he caught up with the nurse and asked her for a smoker's pack. She said he was hostile when she told him that she could not give him one. She said his presentation was unusual because, despite talking about being in heaven, he did not appear to be suffering from delusions. When she joked with him that prison was the last place to be confused with heaven he laughed appropriately.

55. The nurse decided to accept the young man onto the in-reach team caseload. She made an appointment for him to see the visiting psychiatrist the following day. Because he was only in prison for another two weeks she decided contact the Caludon Centre in case he needed support in the community.

56. The young man had another enhanced ACCT review on Unit 15 at 10.45am on 16 April. The SO who was covering the Unit 12 manager's role that day, the mental health nurse, the Imam, suicide prevention co-ordinator and the duty governor that day all attended. He said that his attempt to hang himself on 14 April was his first suicide attempt. He claimed that all of his problems were due to a lack of tobacco and that staff would be killing him if he did not get more tobacco. It was decided that he should remain in the safer cell on the same number of observations and that staff should monitor him closely when he was out of his cell. Another review was scheduled for the next day.

57. The mental health nurse summarised the ACCT review on the young man's medical record. She said that she had told the meeting before he attended that he was not floridly psychotic (having full blown hallucinations or delusions) but that he might be having some unusual thoughts as a result of using illicit substances in the community. She also told them that he had been offered medication but had declined. She said that his comments that staff would be killing him if he did not have smoker's pack meant that he might harm himself in a further attempt to get tobacco. In a later entry she wrote, "Whilst not appearing to wish to die, the risk of significant self-harm or accidental death due to engaging in acts of self harm in order to gain tobacco mean that risks are significant at this time". When interviewed she explained that, although she did not think he was psychotic, his thoughts were clearly not rational.

58. The nurse wrote a care plan for the young man. She said she would liaise with mental health services in Coventry and inform them of his mental state when he was released. She also planned to monitor his mental state in prison and attempt to ascertain any developing psychotic illness.

59. During afternoon association the same day, an officer reported that the young man had told her he loved her and would like to meet her after he was released. She told him that his comments were inappropriate and submitted a security information report (SIR) reporting the conversation. He played table football with other prisoners and was noted to ask them for tobacco. That afternoon, he was moved to the safer cell on Unit 10. One of the Unit 10 managers spoke to him. He said that he had tried to hang himself on 14 April to get tobacco. He talked about time and death being only numbers. The manager said he was not sure how much of what he said was for effect and how much was due to poor mental health.

60. At 4.40am on 17 April, the young man smashed his television and demanded tobacco. He was abusive to an OSG (the night patrol officer) and threatened to assault the night orderly officer unless she gave him tobacco. She said he was laughing and sneering and making threats. The other prisoners shouted at him to be quiet and he calmed down slightly. The OSG checked him again at 5.25am and he told him he wanted to cut him up. At 9.30am, he was moved from the safer cell on Unit 10 while the smashed television was removed and the cell made safe. He was taken back there afterwards. He was charged with breaking Prison Rules for smashing his television and threatening staff. He was due to appear at an adjudication (a prison disciplinary hearing) in relation to this on 18 April.

61. At 10.25am, the mental health nurse and the visiting psychiatrist went to the young man's cell to assess him. The nurse said his thought processes appeared disjointed. She said he was not very willing to talk to the psychiatrist and kept asking for tobacco. He told the psychiatrist that he had bi-polar affective disorder. After the assessment the psychiatrist told the nurse he thought he might be having a hypomanic episode (a symptom of bi-polar disorder.) He thought that he should be transferred to hospital.

62. The psychiatrist wrote on the young man's medical record that his mood was changeable with elation and irritability. He had pressure of speech and no insight. He refused medication and was preoccupied with getting some tobacco. He diagnosed him with bi-polar affective disorder and hypomania. He recommended offering him olanzapine and completed an urgent application for transfer to a secure mental hospital under section 47 of the Mental Health act 1983 (the section allowing immediate transfer of a serving prisoner to hospital).

63. The mental health nurse contacted the Mental Health Unit in the Ministry of Justice to ask if they would accept the young man in a psychiatric intensive care unit (PICU – a lower security category than a medium secure unit with a much shorter waiting time for a bed). She was given permission to pursue a place and then contacted the Caludon Centre. She was initially told that the consultant psychiatrist did not think he was mentally ill and they would not take him because he was of no fixed abode. Later a different manager called her back and agreed that, because he committed his offence in the Coventry area, he was their responsibility. The manager asked her to speak to the consultant's secretary the next morning to arrange a transfer.

64. The young man attended a further ACCT case review on Unit 10 at 3.20pm that afternoon. The Unit 12 manager chaired the review. The mental health nurse, the Imam, an officer and the duty governor also attended. The manager said that he appeared aggressive and argumentative during the review. His main issue was that he had run out of tobacco. The manager agreed that he could be given a further pack of tobacco. The review decided that his tobacco would be given to him in daily amounts to help him make it last the week. The manager updated his caremap. He was to engage with the mental health in-reach team and comply with his medication. His poor management of tobacco was to be addressed by splitting his pack and issuing amounts daily. He was given drawing materials to help him stay occupied in his cell. He was also to continue to engage with the chaplaincy. The Imam said he would have individual prayer meetings and daily support visits with him, as it was not appropriate with his presentation at the time for him to join in with main prayers.

65. The review also decided that the young man should remain in the safer cell pending a further review on 18 April. The level of observations remained the same. His cell sharing risk assessment was reviewed and his risk category changed to high risk because of new medical concerns. A 'medical advisory comment' noted that he was not coping in prison and was bi-polar.

66. The young man was issued with an envelope of tobacco for the night as agreed at his case review. Staff reported that he seemed in a good mood and was happy to receive the tobacco. He was later seen reading a book and, apart from walking around his cell at 2.20am, he had a quiet night.

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67. The young man was due to appear at adjudication for the charges of smashing his television and threatening staff. The mental health manager advised the duty governor that he did not have capacity and was subject to a hospital order for transfer to a mental health facility at the earliest opportunity. The duty governor therefore did not proceed with the adjudications and wrote the charges off.

68. An officer gave the young man another ration of tobacco at 11.50am. He told her he felt all right and agreed that the tobacco rationing was a good idea. A prison GP went to see him at 1.35pm because the Section 47 papers to transfer him to hospital required a second signature from a GP or another psychiatrist. The GP explained to him that he had come to have a chat with him because people were worried about him. He told him that he did not have cigarettes and had only been given chips to eat. The GP told the investigator that the more he spoke to him the more it became apparent that he was not mentally well. Initially he was quite calm and collected and was not unkempt or ungroomed and the GP thought that he could probably have falsely reassured people that he was okay.

69. As they spoke further, the young man told the GP that the stars had told him to tie the ligature on 14 April so that he could join them in heaven. The GP said that he had no insight or awareness about his comments and complained about the quickness of his thoughts and irritability. He said he did not want medication. The GP said he made intense eye contact and had periods of distraction. He was unable to reassure the GP that he would not make another attempt on his life. He said he wanted a television in his cell as this helped calm him down. The GP wrote on the ACCT that he appeared settled but there were “subtle markers of mania”. He signed the Section 47 application. He told the investigator that the young man clearly had a psychosis that needed treating and had no insight, which therefore meant that he was a danger to himself.

70. The unit manager chaired another enhanced ACCT review with the young man at 2.30pm on 18 April. The mental health nurse and the duty governor also attended. He was reported to be calm and relaxed and he talked pleasantly. The nurse said he was completely different to the day before. He thanked her for bringing him the in-cell activities and said he really appreciated it. She said he was warmer and agreed with the goals on his caremap. He was pleased that the disciplinary charge against him had been dropped. The review decided that he should go back to Unit 12 in a standard cell because he was no longer thought to be in crisis. He appeared pleased about this and promised to talk to staff if he felt low. He was promised a television at the weekend if he behaved well. The nurse told the investigator that she was satisfied he was not at risk of harming himself. Observations were increased the three per hour during patrol state, morning, afternoon and evening duty. A further review was scheduled for 19 April.

71. The unit manager took the young man back to Unit 12 and got him a sandwich for his lunch. He left his belongings in the unit office and joined the other prisoners on association. A nurse wrote on his medical record that the Section 47 application had been faxed to the Ministry of Justice mental health casework team. She noted that they were waiting for the psychiatrist to discuss him with the consultant psychiatrist at the Caludon Centre, because they had agreed a consultant to consultant referral.

72. An OSG remembered the young man coming back to Unit 12 that afternoon. She said he joined in with association and then went to have his hair cut. She saw other prisoners laughing at the style he asked for. She did not think he was laughing with them even though other prisoners later told her that he was. He then came to the officer to get his envelope of tobacco. She said she asked him how he was and what he was doing but he only replied, "getting this". She said that he appeared glazed over.

73. Later, after dinner, the OSG saw the young man waiting for some new bedding before being taken to his new cell. She told him that she knew he had had a couple of rough days and did not want him to feel like he was on his own. She told him that if he needed anything or just wanted to talk he should press his cell bell and ask her as she was on duty until 9.00pm. She said he looked blankly at her, nodded and said he would. She said she was told by two of the officers on duty that he had eaten a good dinner and had appeared to be okay when they locked him in his cell.

74. The day staff went off duty at about 7.15pm leaving the OSG alone on the unit. As well as doing the checks required for the young man's ACCT she went round the unit checking that everyone had a canteen sheet to make their weekly shop order and their weekly letter. At about 7.45pm she got to his cell and saw him sitting on the top bunk. He said he was okay. She told him she would put his weekly letter sheet through the door and he shrugged. When she told him that she had not received his canteen order he laughed and told her he did not need it. She remembered that he was due to be released on 30 April and would not need a canteen order for that week. She said she would see him the next day. She said he said, "Yeah see you Miss, bye".

75. Officer B came on duty at 7.45pm. He received a verbal handover from the OSG who passed him the unit radio. At night staff on the units are not issued a cell key with their prison keys but are expected to carry a cell key in a sealed pouch for use in an emergency. She had put the sealed pouch with the emergency key and a cut down tool (anti-ligature knife) in the office safe. The officer did not collect these before beginning his first roll check at about 7.55pm and had his own cut down tool on his belt.

76. When the officer got to the young man's cell (3-15) on the third level he looked in but could not see him through the door observation panel. He then looked through the observation panel to the toilet area and saw him apparently suspended. He could not see whether his feet were off the floor. He radioed an emergency response code blue (indicating a prisoner in breathing difficulty). He shouted to the OSG for assistance, but she did not

hear him and only became aware there was a problem when Officer C arrived on the unit in response to the emergency radio call. As Officer B did not have the sealed pouch with the cell key with him he could not go into the cell without assistance.

77. Officer C said he was on Unit 11 when he heard a call over the radio for emergency assistance on Unit 12. He went straight there; the distance between the doors between the two units is about ten feet and saw the OSG in the office. He said he heard shouting from the landings and went up to cell 3-15 and saw Officer B standing outside the cell with an anti-ligature knife in his hand. He unlocked the cell and Officer B went in first. The young man was suspended from the light by a sheet tied round his neck. Both officers supported his weight and Officer B cut the sheet. He had made a noose from torn strips of bed sheet knotted together and fastened through two holes burned into the circular plastic cover of his light. The duty governor arrived and radioed the control room for an emergency ambulance. At the same time another officer joined the first two officers and helped take the young man's legs and together they laid him on the floor. The emergency response nurses then arrived.

78. The designated emergency response nurse that night was in the nursing office when he heard the call for emergency assistance on Unit 12. He went immediately to the scene while his colleagues collected the emergency equipment bags. The nurse arrived at the cell as the young man was being laid on the floor. He noticed a ligature hanging from the overhead light in the toilet area. The nurse said he appeared not to be breathing, he could feel no pulse and his pupils were fixed and dilated and he started chest compressions. This was about 8.05pm.

79. Three more nurses arrived next. The nurses maintained the young man's airway and gave him oxygen. They attached a defibrillator (a defibrillator advises whether to give a shock to restart the heart in cases of cardiac arrest) to him and they took it in turn to do cardiopulmonary resuscitation (CPR – chest compressions and rescue breaths) at a rate of 30 compressions to two breaths. The defibrillator did not advise a shock and CPR continued. At about 8.14pm, he regurgitated stomach contents and a hand held suction machine was brought to try to maintain his airway. A nurse asked for the portable suction machine from the healthcare centre to be brought. The original airway inserted became clogged and was replaced with another. A senior nurse arrived with the suction machine at 8.15pm and then returned with more oxygen and airways. The defibrillator assessed him ten times before the paramedics arrived and advised no shock on each occasion.

80. Paramedics arrived at the gate at 8.30pm and were at the cell by 8.32pm. They gave the young man adrenaline and fluids at 8.39pm while the nurses carried on with CPR. He was given more adrenaline at 8.48pm. At 8.50pm a faint output was detected in his heart. At 8.53pm, he was given more adrenaline and at 8.54pm he was transferred to a stretcher. More adrenaline was given but the faint output was lost at 9.01pm. At 9.08pm, he was taken to

the ambulance with staff continuing cardiopulmonary resuscitation as they went.

81. Two officers travelled in the ambulance with the young man to hospital. No restraints were applied. The ambulance left Glen Parva at 9.15pm and arrived at the hospital at 9.23pm. At 9.35pm both officers were told that he had died. They informed the prison immediately.

82. A hot debrief took place at 9.50pm. The Governor attended with a member of the prison's staff care team. Observations on all prisoners on open ACCT forms were increased overnight to hourly. The next day, these prisoners had case reviews in case they had been affected by the young man's death. The Governor spoke to the prisoners near to his cell the next day. Prayers were said for him at the next Muslim service and a memorial service was held for the prisoners on 23 April. At interview all staff said told the investigator that they were satisfied that they had been offered appropriate support after his death.

Family liaison

83. The Governor, a SO and the Muslim Chaplain left Glen Parva at 11.30pm to visit the young man's nominated next of kin, who was a friend he had stayed with in Coventry. They broke the news of his death. At 11.30am the next morning, they went to visit the young man's mother and broke the news of his death to her. The prison offered appropriate financial assistance towards the funeral costs. The SO maintained contact with the young man's mother and his nominated next of kin. He and the Governor both attended the funeral.

Further action taken by the prison

84. In the days after the young man's death, the light fittings in every cell were checked. Those that were not intact (including those with holes burned through the cover) were repaired or replaced. Staff were reminded of the requirements of the daily cell fabric checks, including to check lights.

85. On 23 April, the Governor issued a new order about carrying cell keys in sealed pouches and anti-ligature knives during patrol state. The order clarified that patrol officers must have a cell key in a sealed pouch and an anti-ligature knife attached to their person during patrol state. It stated that at the end of early start and lunchtime patrol states, once the other staff have returned, the cell key and the knife must be returned to the unit safe. When handing over to night staff, the evening duty patrol officer is now required to pass these to the night patrol officer before he or she begins their roll count.

Post-mortem

86. The post-mortem report gave the cause of death as hanging. The pathologist said that in cases of hanging, pressure around the neck causes restriction of blood flow to and from the brain and this restriction of blood causes death. The young man was likely to have lost consciousness in a matter of seconds

followed by death within a matter of minutes. A toxicology report showed that he had not been under the influence of drugs or alcohol at the time of his death.

ISSUES

Mental health assessment

87. The young man was referred to the mental health team for review at his first reception health screen interview on 3 April 2013. He was seen by a member of the primary mental health team the next day. Despite telling the nurse he did not want to take any medication or have any involvement with the mental health team, he was referred to the mental health in-reach team because they had seen him on a previous sentence. A nurse saw him within the five day target for assessment. She contacted the Caludon Centre and received a copy of the discharge summary the same day. She discussed him with another nurse, who she knew had seen him before, and decided not to take him on to their caseload at that point. We are satisfied that he was appropriately assessed in a timely manner and the decision not to take him on the caseload of the mental health in-reach team was informed and reasonable in the circumstances.

88. The young man was then referred urgently to the mental health team after he attempted to hang himself during the night of 14/15 April. He was assessed on 15 April, referred to the mental health in-reach team and taken onto their caseload on 16 April. An appointment was made with the psychiatrist, who saw him on 17 April. The same day a nurse obtained permission from the Ministry of Justice mental health unit to pursue a place in a psychiatric intensive care unit and agreement for a consultant to consultant transfer to the Caludon Centre. The Section 47 papers to arrange the transfer were completed by a doctor on 18 April. We consider that his assessment during this period, the decision to section him and the allocation of a bed at the Caludon Centre was completed with commendable speed.

89. The nurse explained to the investigator that she was aware that the young man was due for release at the end of April and that he did not have community mental health support. The decision to section him was prompted not only by concern that he was mentally ill but also so that he would not be released into the community without support. We consider this was a well-motivated and appropriate decision.

ACCT reviews

90. An ACCT was opened appropriately after the young man tried to hang himself and the assessment took place within the required amount of time. There was a good handover between the assessor and the SO. The SO made a point of talking to him that morning, which was appropriate. Prisoners at risk of suicide and self-harm who are placed in safer cells at Glen Parva automatically have enhanced case reviews. The senior officer of the residential unit the prisoner is from is invited to all reviews, which are attended by the duty governor. Unfortunately at the time there was only one permanent senior officer on Unit 12 instead of two. The permanent senior officer was off duty on the first two days the ACCT was open. Therefore there were three different senior officers at the four reviews and four different duty governors,

which is not ideal. The reviews were appropriately multi-disciplinary and the nurse attended the second, third and fourth reviews. The suicide prevention officer and the Imam attended the second and third review. While it would have been preferable for there to be as more consistent presence from the young man's unit, we are satisfied that, in the circumstances, the reviews were held appropriately. The PSI 64/2011 requires the presence of the duty governor at enhanced reviews and it is almost inevitable that this will lead to different managers attending.

The decision to move the young man from the safer cell to Unit 12 on 18 April

91. Despite several reported concerns about his mental health in prison since November 2011, the only time the young man was previously diagnosed with a major mental illness (drug-induced psychosis) during a period in hospital in July 2012. He was clearly difficult to diagnose and the opportunity for meaningful assessment and observation over time was reduced by his denial of any problem, unwillingness to engage with mental health services and the fact that he served several very short periods in custody. As the clinical reviewer comments, even at the point of sectioning in April, there was uncertainty between the psychiatrist, a doctor and a nurse about his diagnosis. In the doctor's opinion, the young man was psychotic but could have falsely reassured people that he was okay.

92. The young man's presentation on 18 April was clearly different to his presentation on 15, 16 and 17 April. The CCTV coverage of his return to houseblock 12 and the evidence of staff does not suggest a person in distress. Nevertheless, he had made a serious attempt to hang himself only four days previously and he was considered sufficiently lacking in insight to warrant transfer to hospital under section. People who have previously attempted suicide are at high risk of subsequently completing suicide. His lack of insight increased his risk. He was reviewed by the doctor shortly before the case review and he considered he had a psychosis and no insight. He wrote on the ACCT document that there were subtle markers of mania. We consider that, especially as he was subject to enhanced case reviews, the doctor should have been invited to the review or asked for his opinion. The clinical reviewer expresses surprise that he was moved back to a normal cell in these circumstances, especially as his observations were increased which suggested an acknowledgement of increased risk.

93. We understand that the young man was a difficult person to assess but we consider that the high risk factors present should have outweighed his presentation on the day. Location in a safer cell does not guarantee a person's safety. A safer cell is simply one with fewer ligature points; it is not free of them. The light covering in the toilet of the safer cell at Glen Parva is not very different to the light covering in the toilet of their normal cells, although we do not consider either of them to be obvious ligature points. However, he has displayed very challenging behaviour for three days since he had attempted to kill himself, followed by only a day of settled behaviour. Immediately before his review he had been seen by a doctor who agreed that he needed to be sectioned under Section 47 of the Mental Health Act. In

these circumstances, it is difficult to see why he was not kept in a safer cell until it was clear that his behaviour had stabilised. Moving him to a standard cell might also have led to him no longer having enhanced case reviews. We make the following recommendation:

The Governor should ensure that ACCT reviews take into account all information about a prisoner's risk and that prisoners who are placed in safer cells for their own protection are relocated only after showing a sustained improvement in their behaviour or mood.

94. We note that after the young man's death every cell light was checked and those with holes burned into them were repaired or replaced. Staff were also reminded that light coverings should be checked as part of the daily cell fabric checks.

The emergency response

95. At the time the young man was discovered, neither of the members of staff on Unit 12 were carrying a cell key. There was only one radio on the unit, which meant that Officer B was unable to contact the OSG in the unit office and she was unable to hear the emergency call. Officer C still had his set of keys and was able to attend relatively promptly from Unit 11 and open the cell. However, the post mortem report sets out the very small window of opportunity during which it is possible to save the life of a person who has hanged themselves. In such circumstances every second is vital. We are pleased to see that the Governor took swift action and re-issued and expanded a previous order to remind staff of handover procedures. The acting Head of Residence and Safety confirmed in an email to the investigator that the operation of these procedures have since been tested by prison management and have been found to be robust. We are satisfied that this is an appropriate response and make no further recommendation.

96. The prison provided several staff statements to the investigator. The OSG who was on duty in the gate on the night of the incident said that he heard Officer B call a code blue and shortly afterwards a further call asked for an emergency ambulance, at which point he telephoned for one. The communication room log records the code blue was called at 8.03pm. The East Midlands Ambulance Service records show that the emergency ambulance was called at 8.05pm. PSI 03/2013 Medical Emergency Response Codes provides guidance to staff on communicating the nature of a medical emergency and ensuring there are no delays in calling ambulances. Paragraph 5.4 says:

> "A representative NHS Ambulance guide for use in the community states that an ambulance should be called when there are signs of chest pain, difficulty in breathing, unconsciousness, severe loss of blood, severe burns or scalds, choking, fitting or concussion, severe allergic reactions or a suspected stroke. *This must also be the case for prisoners and therefore, in these situations when the emergency is called over the radio network an ambulance must be called immediately.*"

Annex A to the PSI sets out the mandatory contingency responses to emergency codes and requires that when a code blue or code red is called 'Communication control room automatically calls an ambulance and awaits update from the scene'.

97. Glen Parva's local instructions to staff are contained in their suicide and self-harm prevention policy. Section 2.2 instructs staff to call a code blue emergency if the nature of the incident involves breathing difficulties or unconsciousness for example in the case of heart attack, hanging or choking. Section 2.1 instructs the duty governor to attend emergency incidents, "Assess the situation and on the advice of on scene healthcare staff, request the communications room to call an ambulance." In this case the duty governor arrived at the young man's cell almost simultaneously with Officer C. There was therefore very little delay in calling an ambulance. Nevertheless, PSI 03/2013 gives clear instruction that ambulances should be called automatically when emergencies are called over the radio using the code system and that it should not be necessary for a duty governor to assess the situation and consult healthcare staff before calling an ambulance. Glen Parva's local policy does not reflect this and does not appear to have been updated in line with the new instruction which came into effect on 28 February 2013. This required governors to have medical emergency response code protocol based on the instruction and for all staff to be made aware of the instruction and understand their responsibilities during an emergency. We therefore make the following recommendation:

The Governor should ensure in line with PSI 03/2013, that Glen Parva has a Medical Emergency Response Code protocol which all staff are aware of and which ensures that ambulances are called automatically as soon as an emergency code is called.

98. Emergency response nurses were with the young man very quickly and the resuscitation attempt was immediate and according to Resuscitation Council guidelines. Appropriate emergency equipment was brought and was in working order. The ambulance was called at 8.05pm but did not arrive at the gate until 8.30pm according to the communications room log (the ambulance records say 8.29pm). The scene log records the paramedics arriving at his cell at 8.32pm. There was a long delay between the ambulance being called and it arriving at the gate. (We understand that this was an unusual occurrence and Glen Parva has raised the issue with the Ambulance Service.) Once paramedics had arrived they were with him only two minutes later. The staff involved in the resuscitation attempt worked commendably hard throughout.

RECOMMENDATIONS

1. The Governor should ensure that prisoners who are placed in safer cells for their own protection are relocated only after showing a sustained improvement in their behaviour or mood.

2. The Governor should ensure that ACCT reviews take into account all information about a prisoner's risk and that prisoners who are placed in safer cells for their own protection are relocated only after showing a sustained improvement in their behaviour or mood.

3. The Governor should ensure in line with PSI 03/2013, that Glen Parva has a Medical Emergency Response Code protocol which all staff are aware of and which ensures that ambulances are called automatically as soon as an emergency code is called.

ACTION PLAN: **The Young Man at HMYOI Glen Parva in April 2013**

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that prisoners who are placed in safer cells for their own protection are relocated only after showing a sustained improvement in their behaviour or mood.	Accepted	Guidance is to be published providing advice to those that conduct reviews for prisoners in Safer Cells. This will provide direction on the process that should be followed in determining if and when a prisoner should be moved out of safer cells.	01.01.14	
2	The Governor should ensure that ACCT reviews take into account all information about a prisoner's risk and that prisoners who are placed in safer cells for their own protection are relocated only after showing a sustained improvement in their behaviour or mood.	Accepted	ACCT Case Manager training to be reviewed to ensure Case Managers are required to take into account all information about a prisoner's risk. Meeting with healthcare staff to take place to ensure they are aware that all relevant risk information must be shared during the ACCT process. Guidance is to be published providing advice to those that conduct reviews for prisoners in Safer Cells. This will provide direction on the process that should be followed in determining if and when a prisoner should be moved out of safer cells.	01.02.14	

3	The Governor should ensure in line with PSI 03/2013, that Glen Parva has a Medical Emergency Response Code protocol which all staff are aware of and which ensures that ambulances are called automatically as soon as an emergency code is called.	Accepted	The local Suicide and Self-harm strategy will be reviewed to ensure that it is compliant with the requirements of PSI 03/2013.	01.01.14	