Investigation into the circumstances surrounding the death of a man at HMPYOI Glen Parva in June 2009

Report by the Prisons and Probation Ombudsman for England and Wales

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This report considers the circumstances surrounding the death of a man in HMYOI Glen Parva on 2 June 2009. The man was found hanging in his cell at approximately 4.30am. He was 20 years old.

I offer my sincere condolences to the man's mother, brother, sister-in-law, and all those who knew him. I regret the delay issuing my report and any additional distress this may have caused the man's family.

The investigation on which this report is based was conducted by an investigator on my behalf. I would like to thank the Governor and Deputy Governor, as well as a Governor, who acted as the liaison for my office. I am also grateful to the members of staff at Glen Parva who co-operated fully with the investigation. In addition, I thank the doctor, who conducted a review of the man's clinical care. He was appointed by Leicestershire Partnership Trust.

The man first entered the prison system in April 2008. He served the majority of his sentence at HMP Portland and was released on licence in January 2009. My report covers the man's time at Portland in some detail and, although I make no recommendations to the Governor, I draw the report to his attention. Unfortunately, he was returned to custody only two weeks after his release. In March, the man was transferred from Portland to HMP Feltham, and then to Glen Parva. At the time of his death, he had been in the prison for just over two months.

Throughout his time in custody, the man struggled with low mood, depression, and a propensity to self-harm. He was subject to additional monitoring because of concerns around self-harm and suicide on several occasions. At the time of his death, though, he was not considered to be at imminent risk.

I have made a recommendation about the quality of written entries for people considered to be at increased risk of suicide. My other main recommendations also concern the monitoring and recording process for those at risk.

This is the fifth apparently self-inflicted death in Glen Parva since I took responsibility for investigating all deaths in prison custody in 2004. My most recent investigation, following a death in July 2007, also highlighted issues around the quality of written records for suicide and self-harm monitoring.

Jane Webb
Acting Prisons and Probation Ombudsman **June 2010**

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SUMMARY

The man was sentenced to 18 months' imprisonment on 17 July 2008. It was his first conviction and prison sentence. He transferred from HMP Feltham to HMP Portland on 24 July. At Portland, an Assessment, Care in Custody and Teamwork (ACCT) document (the ACCT process is used by the National Offender Management Service to monitor and support prisoners at risk of self-harm or suicide) was immediately opened because of concerns about self-harm. On the following day, 25 July, Levi harmed himself using a piece of plastic which he broke off his bed, and was moved to a cell with a closed circuit television (CCTV) camera.

The man was assessed by a mental health nurse on 28 July as posing a high risk of self-harm and suicide. He remained in the camera cell. Over the next few days, the man was seen again on several occasions by the nurse and by his offender supervisor. His mood remained low and there were continued concerns about self-harm.

On 8 August, the man moved from the camera cell to a gated cell (a cell with a gated rather than a solid door, to facilitate easier observation), on a different unit, but he harmed himself again using a radio aerial and was subsequently returned to the camera cell. The next day, 9 August, he was again moved to a gated cell and two days later to a skills development unit. Reviews of Levi's ACCT document indicate that his mood improved over the following month. He integrated well into the unit and engaged in activities such as the unit talent show. On 16 September, the man's ACCT document was closed as the members of staff involved felt that his level of risk had reduced. A post-closure review (a meeting to look at a prisoner's progress after the closure of the ACCT) was held on 23 September. Staff at the review reported that Levi felt settled and had not thought of harming himself recently.

Eight days later, on 1 October, the man was seen by the mental health nurse and appeared unhappy. On 4 October, a second ACCT document was opened after he told an officer that he felt like harming himself. He said he felt very miserable and did not care if he lived or died. The man was moved to an anti-ligature cell on a different unit, and returned to the skills development unit the following day. He reported feeling happier. However, over the next few days and weeks, the man's mood seemed to fluctuate a great deal. Some reports indicate that he was in high spirits, whilst others state that he was very low in mood. On 10 October, the man was found sitting on the floor of his cell, clutching his knees to his chest. A week later, on 17 and 19 October, he was reported to be joking with unit staff and chatting about guitar instruction, but on 23 October he rang his cell alarm to say he felt like 'doing something'.

Despite these variations in mood, the man seemed to improve and, on 12 November his ACCT document was closed. Three days later, however, he seriously burned his arm using a cigarette lighter, and had to be restrained to prevent him from harming himself further. He was moved to a different unit and placed under constant observation. Another ACCT document was opened and, on 16 November, the man told the assessing officer that his depression was like a switch and overtook him without warning.

Again, the man seemed to improve, and his ACCT document was closed on 3 December. During the post-closure review eight days later, the man said he would approach members of staff if he felt low in mood. On the same day, in an interview with a mental health nurse, the man said he felt positive about his future.

The man was released from Portland on 6 January 2009, with licence conditions including residence at a probation approved premises. On 21 January, 15 days after his release, he was returned to custody after breaching his licence conditions. He spent a week at HMP Dorchester before being transferred back to Portland. On 16 February, the Parole Board recommended that the man should remain in custody until his sentence end date of 7 October.

The man was assaulted by three other prisoners on 21 February and his injuries were treated at an outside hospital. He returned to the prison and was located on a standard residential unit. Two days later, he harmed himself by burning his arm over the previous burns. An ACCT document was opened. The man said he had "never felt worse" and wanted to die. His mood fluctuated and staff on the unit expressed concerns about whether they could effectively care for someone with such complex needs. Over the next three weeks, the man was twice moved temporarily to another unit for increased observation.

On 19 March, the possibility of transferring to Feltham was suggested to the man, who was initially reluctant. However, members of staff spoke to him about the benefits of a dedicated healthcare unit and the ways in which his needs could be managed more effectively. He became more positive about moving and, on 24 March, was transferred to Feltham. However, after assessment he did not meet the criteria for the healthcare unit and was transferred to Glen Parva on 31 March.

The ACCT document opened on 23 February remained open and subject to regular reviews throughout this period. A review was held on 1 April in the prison's induction unit. The man was described as a mature and talkative young man. He was seen by a mental health nurse the following day who reported that he had settled well but continued to struggle with his mood.

On 7 April, one week after arriving at Glen Parva, the man moved to a normal residential unit. He had shared a cell with a prisoner on the induction unit, and continued to share with the same man after the move. Members of staff recalled that the man was very quiet and withdrawn when he arrived, but improved over the following week. An entry in his ACCT document on 11 April noted that he was laughing and joking with a large group of his peers whilst out of his cell during the association period.

The man appeared to settle over the subsequent fortnight. No concerns were raised about self-harm. On 28 April, he met a mental health nurse and was accepted on to the mental health in-reach team's (MHIT) caseload. This meant he would be seen regularly for support and advice. On the same day, a decision was made, in conjunction with the mental health nurse, to close his ACCT document. The post-closure review meeting was held on 5 May, and no concerns were raised.

Two days later, the mental health nurse wrote in the man's clinical record that he was again very unhappy. On 15 May, she wrote that, although he was feeling more relaxed, he continued to isolate himself in his cell and did not leave for association activities. Three days later, on 18 May, the nurse wrote that she had discussed with him the benefit of interacting with others, but he remained unwilling to consider the option.

The man saw a mental health nurse on 27 May and asked for a single cell, saying he would benefit from his own space and some time to himself. The unit's senior officer discussed this with the mental health nurse, and they decided to give the man a single cell. He moved on the same day.

At approximately 4.30am on 2 June, the patrolling officer support grade (OSG) saw what he thought was the man standing in front of the window in his cell. After being unable to get a verbal response, the OSG turned on the cell light and saw that the man was hanging from a ligature that had been fashioned from a bed sheet and attached to the window bars. The OSG requested immediate assistance. Other officers and a nurse attended within minutes. Resuscitation was attempted but was unsuccessful. The man was pronounced dead by paramedics on the scene at 5.11am.

I pay particular attention to issues relating to the ACCT process, single cell accommodation, and transfers within the prison system. I also look into a number of allegations that were made after the man's death, as well as issues raised by his family. I make eight recommendations and endorse a further two made by the clinical reviewer.

THE INVESTIGATION PROCESS

1. The investigator opened the investigation on 2 June 2009 and arranged to visit the prison three days later. During this visit, the investigator met with the PPO's liaison officer and Glen Parva's Head of Residential Care, Governor. The Governor provided the documentation relating to the man's time in custody. The investigator also met the family liaison officer appointed by Glen Parva, as well the Independent Monitoring Board (IMB). Finally, the investigator met the governor at the time and the deputy governor.

2. The IMB expressed concern that the man was in four prisons (Portland, Dorchester, Feltham and Glen Parva) within a relatively brief period of time. He felt that this would be unsettling for any prisoner, but was likely to be particularly traumatic for the man given his mental health problems. He was also concerned that after being subject to self-harm and suicide monitoring for a relatively long period before his transfer, it was ended shortly after his arrival. Furthermore, the IMB told my investigator that on the morning of the man's death the IMB was not contacted until 7.45am, some three hours after he was found hanging in his cell.

3. One of my family liaison officers (FLOs), contacted the man's brother who was his nominated next of kin. During telephone conversation, the brother raised a number of concerns. He said the man suffered from bipolar disorder, a condition characterised by extreme highs and lows of mood, and wondered if the man had been considered at increased risk of self-harm and suicide as a result. The man's brother asked about additional monitoring for prisoners at risk. He also asked why the man was in a single cell, given his mental health issues. Finally, he asked what the man had used to fashion a ligature.

4. The FLO also contacted the man's mother. She welcomed a visit to discuss her concerns surrounding the man's time in custody and the circumstances of his death. The investigator and FLO met with the man's mother on 28 July at a central London hotel. Although she had instructed solicitors, their representative was not present at the meeting.

5. The man's mother raised a number of issues during the meeting and asked that her questions be answered as part of the investigation. She mentioned that she had discovered since his death that he had suffered from bipolar disorder. She questioned how this was managed in prison and what medication he had taken. She also asked why the man was not in the healthcare unit, given his illness. On a similar note, his mother said she was aware that he had been in a single cell and questioned this decision based on his vulnerability and bipolar disorder.

6. Regarding the man's time in custody, his mother said she had been told by the man's brother that there had been two attempts on the man's life whilst he was in prison custody. She said that a prisoner was stabbed because he had been mistaken for the man, and that on another occasion there had been an incident during a game of pool. She felt that these attacks might have been racially motivated as the man was of mixed race and had been bullied as a

result of this is the past. She asked if it was possible to confirm whether these attacks took place, and if so, what steps were taken to protect the man.

7. In terms of the night of the man's death, his mother had a number of concerns. She said it was her understanding that he had been subject to checks by staff every two hours, and questioned why they were no more frequent given his bipolar disorder. She felt strongly that the man should have been subject to special monitoring in view of his ongoing depression. The man's mother was also concerned that members of prison staff had not made lengthy attempts to resuscitate him. She understood that their attempts had ceased before the paramedics arrived. She asked whether this was the case, and if so, why this happened before outside medical personnel arrived at the prison.

8. The man's mother said her experience of family liaison from Glen Parva had not been good. She felt that whilst the prison family liaison officer had initially been caring and pleasant towards her, his attitude had changed and he had inappropriately taken sides with the man's brother. She also mentioned a distressing voicemail message left on her mobile telephone by the prison family liaison officer which appeared to be intended for someone else. She said the nature of the message, referring to a prisoner who was alive and well at the prison, was particularly distressing in light of her recent loss.

9. The solicitor acting for the man's mother received a copy of the draft report and made written representations in response. Where appropriate, amendments were made and have been incorporated into this final version of the report. Other issues were addressed by letter, outside the report.

10. The investigator returned to Glen Parva to interview prisoners and members of staff in October 2009. Interviews took place in October and November, with 15 members of staff and four prisoners seen. In December, the investigator interviewed the man's offender manager at her central London office.

11. Leicestershire Partnership Trust appointed a doctor to conduct a review of the man's clinical care whilst in custody. The purpose of a clinical review is to examine the medical care that a prisoner received whilst in custody, which should be of an equivalent standard to what might have been expected in the community. The clinical reviewer consulted the man's medical record and also interviewed a member of the clinical team at Glen Parva in conjunction with my investigator. His findings are summarised in this report and the full clinical review is included as an annex.

HMYOI Glen Parva

General

12. Glen Parva is a young offender institution located near Leicester. It has a maximum operational capacity of 808, and holds remanded, unsentenced and convicted prisoners aged between 18 and 21 years. Since it opened in 1974, the establishment has always held young offenders.

13. Prisoners spend their first six nights in a dedicated induction unit, before moving to one of the nine other residential units. In addition, there is a separate segregation unit and a healthcare centre. At the time of my investigation, the healthcare centre was closed to in-patients due to major and protracted building work.

14. Healthcare at Glen Parva is provided by Leicestershire and Rutland Primary Care Trust (PCT). A primary mental health team is managed by the prison's healthcare department, and Leicestershire Partnership Mental Health Trust provides a mental health in-reach team under the management of Northamptonshire NHS Foundation Trust.

Performance

15. The Ministry of Justice produces quarterly performance figures for all prisons in England and Wales. Every establishment is given a rating between 1 and 4 based on 34 agreed performance indicators. For the first quarter of 2009-2010 (April, May and June 2009), Glen Parva received a rating of 3, indicating good performance (the maximum score of 4 indicates exceptional performance). During quarters 2, 3 and 4 (the most recently available figures at the time of writing), the prison maintained its rating of 3.

16. HM Chief Inspector of Prisons inspected Glen Parva in November 2009, though her report had not yet been published at the time of writing. The most recent published report about Glen Parva concerned an unannounced inspection in 2007, following the previous full inspection in 2004. The prison had shown marked improvement, and of the 57 recommendations made in 2004, 37 had been fully implemented and ten implemented in part. The report found that Glen Parva was now "performing reasonably well across all the main areas that constitute a healthy prison". The establishment was described as essentially safe, although the Chief Inspector thought that more needed to be done to address bullying, and that the suicide prevention arrangements needed to focus on quality rather than simply process. Both of these issues are pertinent to this case and are discussed in the body of the report.

17. The most recent report issued by the Independent Monitoring Board (IMB) at Glen Parva relates to the two year period from December 2006 to November 2008. IMBs are made up of independent, unpaid members of the public, and monitor the standards of prisons. The Board stated that Glen Parva had continued to improve, though it also expressed concerns about the living

standards, saying that “Units 1, 2 and 5 are inadequate and well below the normal standard of accommodation; the heating in these units is unreliable, with some heaters not working at all, windows need replacing, and the showers are unpredictable”.

Previous deaths at the prison

18. My office has been responsible for investigating deaths in custody since April 2004. Prior to the man’s death, I investigated four other apparently self-inflicted deaths. Two of the deaths occurred in 2005, one in 2006 and the last in July 2007. Although three of the four deaths were by hanging, they involved few similar circumstances to the man’s death. The most recent death, in 2007, followed a cell fire. The investigator in that case highlighted deficiencies in the quality of documents relating to suicide and self-monitoring. I address covered the same issue in this report.

HMYOI PORTLAND

19. Portland is on England's south coast and holds young men aged 18 to 21. It has a maximum operational capacity of 624. It has a number of units serving different purposes. Of those mentioned in this report, Drake and Nelson are normal residential units, Grenville is the induction unit, Beaufort is a skills development unit, and Collingwood usually houses those who have earned extra privileges.

HMYOI FELTHAM

20. Feltham is located in the Greater London area, and has a maximum operational capacity of 762. In addition to young adults aged 18 to 21, Feltham also holds young men aged 15 to 18, though the different age groups are housed separately. The units mentioned in this report are Kingfisher and Lapwing, which are the induction and medical inpatients unit respectively.

ASSESSMENT, CARE IN CUSTODY AND TEAMWORK (ACCT)

21. The National Offender Management Service uses the ACCT process as a way of monitoring and providing support to prisoners identified as being at risk of self-harm or suicide. This is used in all prisons and young offender institutions across England and Wales. All members of staff should receive basic ACCT training and be able to open a document, as well as making appropriate entries in the ongoing record. Case reviews should comprise no fewer than two members of staff and also involve the prisoner subject to the ACCT document. These reviews should also, ideally, be multi-disciplinary. When staff members conducting a review determine that risk has been significantly reduced or is no longer evident, and it is felt that further intensive support and monitoring is not required, the document can be closed. A post-closure review should take place seven days later to confirm that risk remains reduced. Ideally, this review should also be multi-disciplinary.

KEY FINDINGS

22. The man was initially remanded to HMP High Down on 7 April 2008, and remained there until his conviction on 12 June, whereupon he was transferred to HMP Feltham. On 17 July, he was sentenced at Southwark Crown Court to 18 months' imprisonment and, on 24 July, transferred to HMP Portland.

Transfer to HMP Portland

23. When prisoners arrive at a prison, they undergo a number of basic assessments in the reception area. One of these is a cell sharing risk assessment (CSRA), the purpose of which is to identify any risks or concerns associated with the prisoner sharing a cell. The CRSA completed for the man at Portland mentioned that he had harmed himself one week previously, and that an Assessment, Care in Custody and Teamwork (ACCT) document would be opened.

24. Following the decision to instigate the ACCT process, a number of documents are completed. The first is known as a Concern and Keep Safe form. In the man's case, it was completed by an officer, who indicated that he had a very low mood and had self-harmed one week earlier by burning his arm with a cigarette. An Immediate Action Plan was then completed. It stated that the man would have access to a telephone linked to the Samaritans, and be observed by wing staff three times during the day and twice during the evening. It did not specify whether there would be any additional checks overnight. (The front cover of the document, however, specifies three conversations and observations during the hours of 8.00am and 8.30pm, and two observations overnight. The ACCT ongoing record also shows that the man was checked overnight.) The form also stated that, whilst there were no concerns about cell sharing, the man was at that time located in a single cell and was happy with the arrangement.

25. The following day, 25 July, an ACCT assessment interview was conducted by an officer. Such interviews are conducted by trained ACCT assessors and are intended to gain a more detailed overview of a prisoner subject to the ACCT process. The record of the interview states that the man suffered from bouts of depression and that they were not specifically related to his imprisonment. He said that he felt suicidal after being accused of misconduct at work (an event which precipitated the offence for which he was imprisoned), and burned his arm and face with a cigarette as a result of feeling that his situation was hopeless. The man also spoke about a suicide attempt two months earlier, which involved him taking ten strong migraine tablets after finding himself consistently unhappy. During the interview, the man said he did not feel suicidal at that time, but suffered disturbed sleep and worrying thoughts. Despite this, an Action Following Assessment form completed only three hours later suggested that the man now felt suicidal and had experienced a dramatic increase in depressive symptoms since the earlier interview. He spoke about hearing the voice of his mother saying she wanted him dead, and also said he wanted to end his life using a razor blade.

26. As a result of the concerns raised, he was placed in an anti-ligature cell (a cell designed to substantially reduce the number of available ligature points) and an urgent referral was made for mental health assessment.

27. Two hours later, a self-harm/attempted suicide form was completed by a Senior Officer. This stated that, whilst in an anti-ligature cell on normal location, the man had cut his arms using a piece of plastic which he broke off his bed. Though the injuries were not severe, concerns that the man might do serious harm to himself were raised. As a result, he was moved to a cell covered by CCTV in the Care and Control Unit (CCU). (The use of such a cell does not necessarily mean that he was observed constantly, but it would provide the facility for remote monitoring.)

28. As mentioned above, open ACCT documents are subject to regular review. On 26 July, the day after the man moved to the CCU, his document was reviewed with the level of risk identified as 'raised'. The review document, completed by the SO, stated: "the man still bitterly depressed though somewhat better than yesterday. Still wishes to kill himself and would do so if the means were available." A decision was taken that the man would remain in the camera cell, subject to hourly observations, until he was assessed by the mental heath team.

29. A mental health assessment was conducted by a registered mental health nurse, on 28 July, four days after the man's reception into Portland and three days after he harmed himself. He recorded the following in the man's ongoing record:

> "Poor eye contact, low voice tone, slowed rate and rhythm. Poor posture. Palate has been affected. Sleep poor, vivid dreams. Strong family history of depression. Assessed to be high risk of both self-harm and suicide. To remain in CCU with hourly observations."

30. The registered mental health nurse also wrote that caution would be needed when prescribing any medication given the family history of misuse and the man's low mood.

31. On the same day, a further review of the ACCT document was carried out, stating that the man had declined food, exercise and showers, and continued to ask for a razor blade. Later the same day, a note in the ongoing record stated that the man continued to bang his head against the wall of his cell.

32. Over the next few days, the man remained in the CCU cell and, although the ACCT reviews recorded some improvement in his general demeanour, concerns remained about the possibility of attempted suicide. The nurse saw the man on 29 and 30 July, and on 1, 2 and 4 August. Although he noted some improvement in the man's mood, he wrote in the clinical record that he remained at high risk of self-harm and suicide.

33. The man's offender supervisor at Portland first saw him on 30 July in the CCU cell. She wrote in the Offender Management Unit (OMU) contact sheet that

she had seen him for an hour and that, for the first 35 minutes, he did not speak and barely acknowledged her presence. The offender supervisor reported that after that time, the man did start to talk to her, though it was "tough going".

34. On 4 August a nurse saw the man and wrote in the clinical record that he felt worse and was suicidal all the time. On the same day, during the sixth review of his ACCT document, the prospect of moving him to the Coping Skills Unit was raised. Whilst the man understood that it was not appropriate for him to remain on the CCU indefinitely, he was apprehensive about moving. This was made clear by a Security Information Report (SIR) four days later, on 8 August, in which the offender supervisor wrote:

> "Whilst interviewing the man on 06/08/08 in the CCU, he mentioned that he might be transferred to Collingwood [the Coping Skills Unit] on 08/08/08. If this did happen he said he would find something with which to harm himself and also that he would attack someone else. This was not said in a threatening manner nor did he say it was a plan or intentional. It was more that he would have 'thoughts' that he couldn't control in a busy environment and that he would act on them. He said he wanted to stay in the CCU as he was left alone and could control his thoughts in isolation."

35. The offender supervisor recorded similar concerns after seeing the man on 8 August. She wrote in the OMU log that:

> "He is due to move to Collingwood [on] Friday 8/8. I believe, and he says, if he does he will harm himself and assault someone. He says this is not intentional but when he is in a crowded place he gets thoughts which he cannot control."

36. Despite these concerns, the man was moved to Collingwood unit on 8 August and located in a gated cell to facilitate observation by staff. Later the same evening, it was discovered that he had made numerous scratches to his left forearm using a radio aerial. As a result, he was moved back to the CCU. The following day, he was seen by the registered mental health nurse who completed a mental health assessment and stated that Levi's mood seemed to have improved. The nurse recommended that the man should return to the Collingwood unit with observations every half-hour. His cell was to contain nothing that he could use to harm himself. This was also discussed in an ACCT review, during which the man was unable to explain why he had cut his arm the previous day. The man then went back to the Collingwood unit in what constituted his third move in a 24 hour period.

37. Shortly after the man's move to the Collingwood unit, an officer wrote the following entry in his ongoing record:

> "Had a chat with the man to see if he wanted to come out and associate but he declined. I asked how he was and explained that it sometimes helps to talk to people. He said it wasn't being in prison that made him feel depressed as he was like it on the out. I asked what sort of things

help with his mood and he said playing music. He has asked for a guitar to be authorised by a governor. I did explain that I wasn't sure if this would be possible whilst he was on high levels of observation. We discussed moving to Beaufort on Monday and I explained the music facilities to him, and he seemed to brighten up a little. I have changed one of the TV channels to TMF [a music video station] as he said music helps him to chill out."

38. It appears, therefore, that the man's move to the Collingwood unit was intended as an interim arrangement, with the ultimate aim being a return to a normal residential unit. It also seems that the Beaufort unit had facilities that might prove conducive to an improvement in the man's state of mind. Indeed, the ACCT review that took place on 11 August discussed his enjoyment of music and the possible move to the Beaufort unit. The man moved to this unit on the same day.

39. The nurse saw the man on 18 August and reported a definite improvement. He wrote in the clinical record:

> "Voice tone rate and rhythm nearly back to audible levels. Diet improved. Personal hygiene a massive improvement, full self-care noted and appears to be much less depressed. Undertook his first music session today and has … a few friends on the wing that … he feels he can connect to."

40. An ACCT review (the tenth) conducted the same day – a week after the man's move – reported that he felt settled on the wing and enjoyed spending time in the music room. The man said he always thought of harming himself but, at that time, did not feel the need to act on them. Although his risk was now identified as 'low', members of staff at the review meeting decided to keep the ACCT document open.

41. Over the following week, the entries in the man's ongoing record appeared much more positive than those made previously. The man was reported to be spending much of his time in the unit's music room and had been playing in a band as well as rehearsing for a talent show. He was apparently engaging with members of staff more frequently, enjoying watching the Olympic Games on television, and chatting with officers about cooking and recipes. This was reflected in his ACCT review, which reported that he was eating properly, was settled on the unit, and was finding solace through music. Despite this, he was still very concerned about his relationship with his mother, and could not guarantee that he would refrain from self-harm in the future.

42. Further ACCT reviews were conducted on 1 and 9 September, and both were largely positive in nature. On 2 September, he gained employment as a library officer, and on 11 September took part in the unit talent show. The documentation appears to indicate that the man was making progress in terms of his general demeanour and state of mind.

43. On 16 September, the 14th review of the ACCT document was carried out, and a decision was taken to close the document. The review form stated: the man has shown no signs of self-harm and communicates well with staff. Loves the music room, and attends all activities allocated." (It appears that nobody from the healthcare or mental health teams were present during this review.)

44. On 22 September, the man saw the nurse for a mental health review. He wrote that the man had made "massive improvements in his socialisation and articulation but finds himself returning to negative ways". His mood still appeared low but he did not report any thoughts of harming himself. The nurse wrote that he had consulted the doctor and had decided to prescribe anti-depressants for the man for a trial period of six weeks. This was to attempt to stabilise his mood and decrease the number of low points that he was experiencing. A daily dose of 20mg Fluoxetine was prescribed.

45. When an ACCT document is closed, a post-closure review should be scheduled for a future date. The purpose of the review is to examine the decision to end the ACCT support in light of the prisoner's behaviour in the interim period, and decide whether it should remain closed or be re-opened. In this case, a post-closure review took place on 23 September, which reported that Levi felt settled, enjoyed music, and liked to be kept busy. He had experienced no recent thoughts of self-harm. The ACCT document therefore remained closed.

46. The nurse saw the man for a mental health review on 1 October. He noted that the man was flat in mood and "on his self-confessed downward spiral". He discussed the man's medication with him, and noted that he was tolerating his anti-depressants well with no side effects. The man requested a stronger dose, although this was not given at the time. The nurse saw the man again the following day because he appeared miserable and had a poor outlook on life. He noted in the clinical record that the MHIT would remain involved with the man and would continue to monitor him on a regular basis.

47. On the morning of 4 October, a further ACCT document was opened. An officer wrote on the Concern and Keep Safe form that the man had told him he felt like "slitting his wrists or neck". He could not identify a particular cause for his feelings and could not concentrate on his usual coping mechanisms such as music. The man had surrendered his razor to the officer upon request. In an assessment interview two hours later, the man told an officer that he had felt like cutting himself the previous evening, and did not care whether he lived or died. He mentioned that he had suffered from depression since the age of 15, and that on a scale of 1-10 (1 being the lowest) he was a two. The man said he constantly thought about unresolved family problems, and recurring nightmares relating to gang membership when he was younger.

48. Following the assessment interview, the man met a Senior Officer (SO), an officer, and somebody from the healthcare team, in order to look at what further action would be taken. It was mentioned that the man had recently started a new course of anti-depressants but would not feel the benefit for a

few weeks. A decision was taken for the man to remain in his cell rather than move to an anti-ligature cell, given that his thoughts were about cutting himself rather than hanging. Somebody from healthcare advised that the man should be observed every 15 minutes, and reviewed in 24 hours. She also suggested different ways of keeping him occupied in his cell, such as allowing him to have a guitar.

49. Despite the decisions taken at this meeting, the man was moved to an anti-ligature cell on the Collingwood unit. A review the same evening stated that the man remained unhappy. A further review took place the following morning, when he reported feeling happier and said he had slept relatively well. He was keen to move back to the normal residential location where there were activities to help alleviate his depression. It was agreed that the man would move back to Beaufort unit and be subject to hourly observations throughout the day, and half-hourly observations at night.

50. On the same evening, after the man went back to Beaufort unit, a note was made in his ongoing record stating: "Went into his cell to speak to him, says he is having one of his depressed moods. An officer and myself spoke to him at length. Gave him a stereo system and he chose some CDs from the wing collection. Seemed to cheer up a bit and at least had a smile on his face when we left."

51. On 7 October, a nurse discussed the man's case with a doctor and said he had displayed possible symptoms of serotonin syndrome (an adverse reaction that can occur in response to some types of anti-depressants). Fluoxetine was no longer thought to be an appropriate treatment, and so the man was prescribed Diazepam instead.

52. Although reports in the man's ongoing record suggested an improvement over the next two days, he rang his cell bell on 8 October to say that he was very unhappy. He declined the offer of speaking to the Samaritans by telephone, and also said he did not want to see a Listener (a trusted prisoner trained by the Samaritans). The man explained to an officer that he had recurring nightmares about his friend being shot dead, something he had witnessed when he was younger.

53. On 10 October, a note was made in the man's ongoing record that he remained depressed. He had been given a guitar so that he was able to play music in his cell, and his door had been left open so that he could see unit staff whenever he wanted to. Two days later, the man appeared so low in mood that unit staff felt it was necessary to move him to an anti-ligature cell on the Collingwood unit. He returned to Beaufort unit the following morning and a note in his ongoing record stated, "I have phoned healthcare and requested as a matter of high importance that the man is seen by someone as his mood is so very low and of great concern." It appears that unit staff remained worried about his state of mind but felt they were limited in the actions they could take to alleviate his depression.

54. The man saw a doctor on 13 October, and he was prescribed a 70mg daily dose of Lofepramine, an anti-depressant which works in a different way to the previous medication. The following day a nurse wrote in the clinical record that the man still needed to see him and the doctor to discuss a second anti-depressant.

55. Reports indicate that the man's mood was prone to rapid and severe fluctuation. For instance, during the ACCT review on 14 October he was described as "in a very good mood". However the following day a nurse conducted an assessment and found him to have "flat mood, poor eye contact and rapport, with hopelessness and poor coping strategies". On 16 October, an officer noted that he was unable to see the man when conducting the roll check. He went into the cell and found him sitting on the bathroom floor, clutching his knees.

56. Also on 16 October, the nurse saw the man for a mental health review. He wrote in the clinical record that the man had been asking for a guitar as a form of stimulation but was not allowed it as staff members feared he would use it to attempt suicide. The nurse wrote that he thought the guitar would be therapeutic and advised unit staff against such negative thinking. However, he found the following day that he had not been allowed the guitar.

57. The man's change in demeanour continued over the next few days. On 17 and 19 October, he was reported to be joking with unit staff and talking about guitar instruction, and during his ACCT review on 21 October was described as feeling good. From 20 October he was allowed to use a guitar in his cell, he was about to start teaching guitar to other prisoners, had begun library orderly training, and was soon to start writing music for the unit pantomime. However, on 23 October, the man rang his cell alarm to report that he was depressed and felt like 'doing something' (meaning harming himself).

58. The man's mood appeared to improve over the next two weeks, with reports in his ongoing record largely positive. A seemingly brief ACCT review on 5 November stated only that he felt worse at the weekends but did not know why, and no change was made to his observation levels. A week later, an ACCT review chaired by an SO and attended by the nurse, reported that the man was much happier, was engaged in "purposeful activity" (work, education or other organised activity), and was responding to his medication. They decided to close the ACCT document.

59. Three days later, on 15 November, the man pressed his cell alarm and the officers who attended discovered severe burns on his left arm. As some officers monitored him whilst others returned to the unit office to alert healthcare staff and the orderly officer, the man produced a cigarette lighter and attempted to harm himself again. The lighter was removed and he was restrained. He cooperated and was taken to the healthcare centre to have his injuries treated.

60. An ACCT document was opened and the man was moved to the Collingwood unit where he was subject to constant observation. In his assessment

interview on 16 November, the man said his depression was “like a switch”. He had felt okay the previous morning but very low by lunchtime. He described the act of self-harm as a form of sensation in order to provoke feeling and release his low mood. When asked to place himself on the scale of 1-10 (one being worst, ten being best), the man responded with a firm one. Prior to his depression increasing, he had been eating, sleeping and associating well. The man was keen to return to Beaufort unit; he said he found the regime enjoyable and the unit staff supportive.

61. During the first ACCT case review on 17 November, the man appeared to be in higher spirits and quite chatty. The review was attended by a Governor, Principle Officer (PO), an officer and somebody from healthcare. The man and the staff discussed his act of self-harm, particularly why he did not inform unit staff until after he had burned himself. It was reported that he needed to be encouraged into activities to occupy his time, and that unit staff were aware of this and would work with him. The ACCT observations were changed from constant to hourly. On the same day, the man moved back to Beaufort unit, with an officer describing him as quite jovial at that time.

62. Three ACCT reviews were held between 18 November and 3 December, all of which were generally positive in nature. Also on 18 November, a clinical decision was taken to re-refer the man to the MHIT. Until that point, he had been seen very regularly by the nurse, but was not part of the MHIT caseload. The man’s medication was also increased to 140mg in the morning and 70mg at night.

63. On 24 November, the offender supervisor and the man held a telephone conference with his offender manager (a probation officer based in the community). They discussed his accommodation arrangements and licence conditions for his release. He said he preferred not to return to his mother’s home due to the difficult nature of their relationship. He mentioned moving to Leicester to be closer to his brother, but this was a thought rather than a specific plan. Three days later, the offender supervisor again met the man and discussed his release arrangements. She reported in the OMU log that the man was happy to live in a probation approved premises.

64. The decision to close the man’s ACCT document was made on 3 December, and a post-closure review conducted on 11 December. The man said he would approach members of staff if he started to feel very unhappy. On the same day, a mental health nurse in Portland’s MHIT, completed a detailed mental health assessment. During the interview, the man told the nurse that he felt positive about his future. In terms of the risk of self-harm, she wrote:

> “The man has a history of self-harm and/or attempted suicide. He self-reports that these are not planned but are impulsive. He is in a high risk age group for successful suicide and therefore, although the risk is currently low, this will increase if his mental state begins to deteriorate.”

65. A nurse wrote that, if the man were to remain in custody, she would continue to see him for ongoing assessment. She acknowledged, however, that he would soon be released.

66. On 15 December, the offender supervisor met the man to discuss his release arrangements. The man said he wanted to stay in Dorset after release to make a new start. The offender supervisor was concerned that, because the man did not know anyone in the area, he might isolate himself. However, by 18 December the man had made the decision to stay in Weymouth. In practical terms, this was useful because the offender manager was struggling to find appropriate accommodation for him in the London area.

67. The man was released from custody on 6 January 2009, his automatic release date. (Prisoners are usually released at the halfway point of their sentence, and serve the second half of the sentence in the community under the supervision of an offender manager and whilst subject to licence conditions.) The man's sentence expiry date was 7 October 2009. He had a prescription for 70mg Lofepramine at the time of his release. In addition to the standard licence conditions and two further conditions which related to him refraining from contacting the victim of his offence, the man was also required to reside at a probation approved premises. (Approved premises are hostels run by the probation area of the National Offender Management Service. They provide additional monitoring and support for people upon their release from prison.)

68. It is usual practice for prisoners to be released into an approved premises in their home area. Regular appointments with an offender manager, usually a probation officer based in the same area though not in the approved premises follow. In the man's case, and somewhat unusually, his licence required him to reside at Weston approved premises in Weymouth, Dorset, whilst his supervising probation officer was based in central London, some 140 miles away.

69. On 20 November 2009, my investigator met with the offender manager to discuss these unorthodox arrangements. She explained that, prior to the man's release; he had said that he did not want to return to live with his mother. The offender manager was unable to secure appropriate accommodation for him before his release date, and so offender supervisor located the approved premises in Weymouth as a temporary arrangement.

70. This was, undoubtedly, not an ideal arrangement though it was thought more beneficial to the man's progress in the community to the alternative of being released without a place to live. Being located so far away, it was not feasible for the offender manager to keep face to face appointments with the man, although she did speak to him by telephone and received daily progress reports from approved premises staff.

71. The man had in fact expressed a wish to stay in the Dorset area, rather than return to London some three weeks prior to his release from Portland. At this time, the offender manager attempted to transfer his case, though Dorset

Probation Area refused to accept him for supervision. This led to the arrangement in question, whereby the man was located in Dorset on a temporary basis but supervised by a probation officer based in London. The offender manager explained that she continued to look for suitable accommodation for him in London but, on 15 January, he told her that he wanted to relocate to Leicester to be nearer to his brother. The offender manager began to liaise with Leicestershire and Rutland Probation Trust with a view to transferring him to an approved premises in the area, and for his supervision to be managed by a local office. Before this could happen, the man was returned to custody for breaching the terms of his licence.

72. Regarding the breach of licence, the man failed to remain in his room at the approved premises when instructed, after a fight broke out between two other residents on the night of 18 January. He then left the premises at 12.30am on 19 January – outside the curfew time – and returned, intoxicated, at 4.45am. The man was subsequently arrested by the police on suspicion of assault during the time that he was absent from the approved premises.

73. On the advice of the senior probation officer based in the approved premises, paperwork was sent to the Release and Recall Section of NOMS requesting revocation of the man's licence. The licence was revoked by the Secretary of State for Justice on 20 January. The following day, 15 days after his release from Portland, he was returned to custody. He was imprisoned at HMP Dorchester for one week before transferring to Portland on 28 January. On the same day, he was prescribed 70mg Lofepramine.

74. When transferred to Portland, the man originally went back to the Beaufort unit, where he had spent much of his time prior to release. On 2 February, the offender supervisor wrote the following in his OMU record:

> "Spoke to a SO on Beaufort wing. I was a little concerned that the man went straight back to Beaufort when he came back, I felt he should have gone through the normal channels and gone to a normal wing. I feel going back to Beaufort will not change anything or teach him anything. The SO felt the same and is going to arrange move."

75. When the offender supervisor next saw the man on 11 February, he was on the Drake unit after leaving the Beaufort unit. Throughout much of February, the man appears to have lived at Portland without incident and certainly he was not subject to the ACCT process. On 16 February, the Parole Board notified him that he would not be re-released before the end of his sentence. The document stated:

> "The panel was concerned that the man had breached licence conditions very shortly after release and that there were allegations of a new violent offence being committed. Although having only one conviction on his record the apparent commission of a further offence so soon after release, together with the use of alcohol and the apparent wilful breach of hostel conditions led the panel to the conclusion that risk was not manageable in

the community currently. Accordingly no recommendation was made as to release."

76. This decision meant that the man would remain in custody until his sentence end date of 7 October.

77. On 21 February, the man was assaulted by other prisoners on Drake unit. A officer reported in a Security Intelligence Report (SIR) that the man had "sustained numerous facial injuries with one eye already closing". The injury was discovered when another officer unlocked his cell in order that he could collect his medication. An officer noted that, although Levi claimed to have tripped on the stairs during association, it was his belief that Levi had been assaulted, possibly in his cell. As a result of an investigation into the incident, sanctions were taken against three other prisoners.

78. Notes in the man's clinical record describe him having "sustained an injury to his left eye, this was very bruised and swollen, he also had a bloodied nose and several marks around the left area of his face". The man was treated for his injuries at Dorchester Hospital. His condition was described simply as a "facial injury" and he was prescribed pain relief medication. When he returned to Portland, the man was moved to the Grenville unit and then, on 23 February, to the Nelson unit. On the same day, the man used a lighter to burn his left arm over the previous burns. An ACCT document was opened. An officer noted on the Concern and Keep Safe form that the man had told him it was the worst he had ever felt and he wanted to die. After treatment in the healthcare centre, he was relocated to the Collingwood unit. However, it appears that clear instructions about the man's needs were not immediately given to unit staff, as an officer stated in the ongoing record:

> "Received no instruction as to what to do with the man so rang healthcare. He was to be housed in 1-12 with an anti-rip blanket and an anti-rip gown. He also has socks and slippers. This is all he is to have until he is reviewed tomorrow."

79. Also on 23 February, the man saw a doctor, who noted his physical injuries from the assault and the self-inflicted burning of his arm. She increased his dose of Lofepramine to 140mg in the morning and 70mg in the evening. The man had previously been prescribed this dose, but it had been reduced prior to his release from custody.

80. The man attended hospital on 24 February for the treatment of injuries relating to the assault on three days earlier. His right wrist felt tender and an X-ray was performed. The wrist was not broken and a diagnosis of soft tissue injury was given. The man was also referred to an ophthalmologist for injuries sustained to his eyes. An appointment was made for 10 March.

81. Also on 24 February, an assessment interview was completed which detailed the man's long history of depression and the previous incidents of self-harm. It did not specifically mention the possibility of the assault as a trigger for the latest incident, though it did acknowledge that the man felt as if he was in a

"dark cloud of depression". The man mentioned that he had previously spent time teaching guitar on the Beaufort unit. He said he would like to move back to the state he was in just before release, when he was playing and teaching music on this unit.

82. Shortly afterwards, the Action Following Assessment form was completed, and stated that the man's urge to self-harm had fallen significantly from the previous day. It was also recorded that he had expressed a strong desire to return to the Beaufort unit, for which a referral had been made. The Immediate Action Plan recorded that the man was to be observed constantly, and was not to be left with a lighter in his cell. He was assessed as a high risk on the cell sharing risk assessment (CSRA) due to the nature of his self-harm.

83. It is clear that members of staff on the Nelson unit remained very concerned about the man, and about their ability to manage his needs appropriately. On 25 February, an officer wrote the following in the man's ongoing record:

> "Had a long chat with the man. I have serious concerns about his well-being. The man is in a very low depressive trough at the moment. He has no motivation at all and says that on top of that he has really had his self-confidence knocked by the assault on Drake [unit]. He didn't want a shower or for me to walk him to the library. He says he can only see the situation remaining the same when he is released. He does however have family (brother) support when he is released, but at the moment sees only negative things. Nelson is a very busy working [unit] and I am worried that we will not give him our full attention or we just do not have the resources to deal with a complex medical diagnosis. There appear to be issues with him going back to Beaufort. However I feel the man's situation far outweighs those issues and we have a duty to offer him the best care we can physically provide."

84. There is no indication that any direct action was taken as a result of an officer's entry in the ongoing record, and it is unclear whether he raised his concerns directly with other members of staff.

85. As with the man's previous time in custody, he experienced fluctuations in his mood. At his ACCT review on 27 February, the man reported feeling somewhat better. A positive move was that he handed a razor blade from his cell to unit staff. However, on the following day the man went to the healthcare centre and confided in staff that he could not trust himself to refrain from harming himself. At this time, a decision was taken to relocate him to the Collingwood unit.

86. On 27 February, the man was told during his ACCT review that Beaufort unit was unwilling to accept him back. My investigator spoke to, the senior officer for Beaufort unit, about the criteria for accepting prisoners. The SO explained that when prisoners who have previously spent time on the Beaufort unit are recalled to custody, they are often returned to the unit by default. This is what happened to the man when he returned to prison. However, if members of

unit staff feel that there is little further progress that can be made with a particular prisoner and the place can be better utilised by someone else, then that prisoner will be returned to a normal residential unit. This was the case with the man. Although his experience on the Beaufort unit had been largely positive, the unit staff members felt that he would not benefit from being on the unit any more than he would on a standard unit. For this reason, the man was moved to the Drake unit and was not accepted back to Beaufort.

87. During case reviews held on the Collingwood unit, the man's state of mind continued to fluctuate, though he was mostly depressed and remained subject to constant ACCT observations. It appears that officers on the unit attempted to engage him in some activity, for example, on 1 and 2 March he was allowed to walk around the grounds with an officer. The man continued to ask about returning to the Beaufort unit and continuing his music lessons, but was told that this would not be possible.

88. On 3 March, the man returned to the Nelson unit but remained miserable. The same day he was reported to be very low and a cause for concern to staff. On 4 March he was withdrawn and not very talkative, and two days later described as "very flat". On 9 March, an officer made another detailed entry in the man's ongoing record, stating:

> "Having spent much more time with the man now, I feel that he is in quite a good place mentally at the moment. He has built up quite a good trust of some members of staff on Nelson and is quite open and honest about his emotions now. He speaks often about where he feels he is at on a scale of 1-10. The man is still very fragile and I am aware that at any time he may rapidly deteriorate, however now I know him better I can spot some of the signs when he goes downhill. He is eating, although not a great deal. He reads and attends library now. We are getting the man out and about as much as possible and he is very polite and well-mannered. After some discussion with offender supervisor and a governor it has been decided the man cannot go back to Beaufort. He seems happy here but I am not convinced it is the best and safest place for him."

89. As with the previous entry, it appears that the officer was keen to ensure that the man was appropriately cared for, but was unsure that a normal residential location was the right place for this to be provided. Provision was, however, made for the man to have a guitar in his cell for certain periods.

90. On 10 March, the man attended a hospital appointment with the ophthalmologist. This was a follow-up appointment after he was assaulted 17 days earlier. No further treatment was required, and the man was discharged.

91. The next day, the officer made another entry in the ongoing record, stating that the man enjoyed music and was happy to have been given the guitar. Five days later, at the 12th review of his ACCT document, the man reported feeling very low in mood. Although he said he did not feel like harming himself and did not want to go to the Collingwood unit, (which provided a better facility for constant observation) a decision was taken to move him

there and place him on constant observation. The following day – 17 March – after a further review, the man moved back to the Nelson unit and subject to half-hourly observations.

92. During an ACCT review held on 19 March, the man was told that he could not return to Beaufort unit but that he might be able to transfer to Feltham. However, the man said he did not want to go to Feltham and would rather stay on the Nelson unit at Portland. The following day, a note regarding this issue was made in his ongoing record by an SO, who stated:

> "Spoke to the man ref his transfer concerns. He was under the impression that a transfer to Feltham would put him on the poor coping skills unit where he would not get the help he knows he needs. I explained to him that even if he was put on that wing initially he would have a very good chance of getting a place on the unit he needs, a far better chance than if he stayed here. This he appeared to accept wholly."

93. It is clear that, with no inpatient medical facilities, wing staff were concerned that Portland was not the most appropriate place for the man, and that Feltham would be able to offer a more suitable regime. Indeed, on 23 March, the man was told by the officer that he would be moving to Feltham the following day. The officer wrote that he had a positive chat with the man about the benefits of being in a dedicated healthcare unit and the proactive help that he would get regarding his depression and paranoia. An SO also noted that the man was positive about the move and realised that the help he needed would now be available to him.

Transfer to HMP Feltham

94. The man transferred to Feltham on 24 March, where the usual reception process, including a CSRA, was completed. He was initially placed on the Kingfisher unit. An ACCT review took place on the day of the man's arrival, during which the man said he was low in mood and had been told he was transferring to Feltham in order to be located on Lapwing (the inpatient healthcare unit). An SO recorded that this was not what was portrayed by Portland in advance of the transfer to Feltham, and he would have to be assessed for suitability. The man explained that his mood was never positive and that he would like full support from the healthcare team.

95. Several conversations between the man and various officers are recorded on 25 March. During each conversation he appeared anxious about whether or not he would be transferred to the Lapwing unit. When told that he would need to be assessed by the Community Mental Health Team (CMHT) and was not guaranteed a place, the man expressed his belief that staff at Portland had lied to him. He felt they had used the prospect of Lapwing to transfer him out. The man also said he had formulated a plan to kill himself by obtaining a razor blade from another prisoner and cutting his wrists.

96. On the same day, the man was seen by somebody from the CMHT. He told her that he had been diagnosed with bipolar disorder. He was able to

describe how he came to feel depressed but could not identify particular triggers. The man said he had no motivation to do anything and felt hopeless. He said he had thought about different ways to kill himself but had no specific plan.

97. In the evening of the same day, an officer made a note in the ongoing record, documenting a conversation he had with the man. The officer wrote that the CMHT had said that the man did not fit their criteria, though it is not clear whether or not he passed this information on to the man. An officer said that, as the man had now formulated a plan to take his own life, unit staff were extremely concerned for his well-being. The entry also mentioned that the man was due to be transferred to HMP Rochester two days later, but that the officer had decided not to tell the man as it might worsen his situation.

98. The following day, 26 March, the man continued to tell staff of his plan to obtain a razor blade from another prisoner. An SIR was raised in relation to this. It was agreed that other prisoners would be searched when the man was out on association and he would be subject to a full search following any activity that brought him into contact with other prisoners. Unsurprisingly, the man declined association shortly afterwards, saying he did not care to socialise.

99. An ACCT review took place the same afternoon. The review form in its entirety reads: "The man has been informed that he will not be going to Lapwing and he will be going to Glen Parva at the earliest opportunity. The man accepted what he was told and will be seen again tomorrow." This would almost certainly have been unwelcome news for the man, who had arrived at Feltham only two days earlier having been told more than once that Feltham would be better able to meet his mental health needs.

100. Despite the decision to move him from Feltham almost as soon as he had arrived, he appeared to adapt quite well. During reviews on 27 and 30 March (neither of which appear to have been attended by any discipline staff) the man appeared positive about the move, which would find him in close proximity to his brother, who lived in Leicester. A note in the man's wing history sheet on 30 March records that he asked to go to a vulnerable prisoner unit at Glen Parva for his own safety and because he felt they would have more time for his needs. (No such unit exists at the prison, although there is no evidence that the man was told this at the time.)

101. At 4.30pm on 30 March, an outreach worker based in Feltham's Safer Custody office, noted the following in the man's ongoing record:

> "The man has now been told that he will not be going to Glen Parva in the foreseeable future. He didn't say anything, he just hung his head and asked for a light. I asked if he wanted his evening meal – this he declined." At 5.35pm, a further entry was made, again by the outreach worker, this time stating: "The man has now been told he will be going to the prison in the morning – he is happy with the decision."

Transfer to HMYOI Glen Parva

102. The man was indeed transferred to Glen Parva on the morning of 31 March, eight days after, he was transferred from Portland to Feltham. The man was assessed as posing a medium risk on the CSRA, which also stated that he had bipolar disorder and liked to be alone when he felt low in mood. A note in his ongoing record on the same day also stated that the man had bipolar disorder, though there is no record of an official diagnosis.

103. On the same day, the man saw a psychiatrist, for a detailed assessment. He wrote in the clinical record that the man felt very low and had thoughts of killing himself. In addition, he said the man always felt hopeless and had no plans for the future. The psychiatrist wrote that the plan was for the man to continue taking Lofepramine, which he had been prescribed before arriving at the prison. He was also to have regular reviews by nurses working in the prison.

104. On 1 April, an ACCT review was conducted. The document had been opened in February at Portland, and this was its 20th review. Having arrived at the prison the previous day, the man was residing on the induction unit. An SO reported that the man presented as a very mature and talkative young man. The following day, a mental health nurse, saw him for mental health support. She wrote in his clinical record that he had settled well but still struggled with his mood. The nurse saw the man again on 6 April and wrote that he was getting on well with his cellmate and would like to continue sharing a cell with him.

105. The following day, 7 April, the man again saw the psychiatrist, and reported good days and bad days. He said he still felt suicidal at times, but in general was feeling better than before. However, the man felt he was not getting enough benefit from the Lofepramine. The psychologist decided to change the man's medication to 30mg of Mirtazapine (a different anti-depressant), from 14 April.

106. Also on 7 April, the man moved from the induction unit to Unit 1, a standard residential unit. He had shared his cell with another prisoner whilst on the induction unit. As the two prisoners appeared to get on well, a decision was made to move them to a residential unit together. A note in the man's ongoing record made by a Unit 1 senior officer stated that he would remain a medium risk until a further review in May, and that the man was happy to continue sharing a cell.

107. On the day of his arrival on Unit 1, an officer wrote in the man's ongoing record: "The man seems fairly settled, introduced myself as his personal officer. Seemed in good spirits and was happy to be padded up with another prisoner. No issues to report." An ACCT review was conducted on 8 April, which identified the man's risk as low. An SO, chairing the review, stated that the man was happier in the Midlands as he was nearer to his brother, and that he wished to relocate in the area upon release.

108. During her interview with my investigator, a Unit 1 officer, described the man's presentation when he arrived on the unit differently, saying he was "very quiet, very withdrawn … he didn't interact with any of the prisoners, he didn't come out of his cell even for showering or changing his clothes". The officer said the man's demeanour was a cause for concern and that, as with any other such prisoner, officers tried to build a relationship with him. Two other Unit 1 officers, recalled the man respectively as someone who was quiet and slept a lot, and a shy but not vulnerable prisoner. One of the senior officers in charge of Unit 1, described the man as very quiet when he arrived on the unit, but said he made progress as time went on.

109. Between 8 and 15 April, no particular concerns were identified in the ongoing record. The man appeared to be getting on well with his cellmate, was associating with other prisoners, and was not causing any problems or concerns for staff. A Unit 1 officer talked during interview about the way in which the man responded to attempts that were made to build rapport. Indeed, she wrote in the ongoing record on 11 April that Levi was "out on morning association, very vocal, laughing and joking with a large group of peers, interacting well with unit staff and appears settled".

110. An ACCT review took place on 15 April, chaired by an SO and attended by two officers. During the review, the man reported feeling settled on the unit. It was noted that, although geographically closer to his brother, he was yet to send out a visiting order. He was advised to speak to his personal officer regarding suitable employment. The man's risk was assessed as low, but a decision was made for the ACCT procedures to remain in place.

111. On the following day, a note in the man's ongoing record indicates that he was visited by a member of the mental health team. The member of staff indicated that, although the man denied thoughts of self-harm, he continued to feel low in mood throughout the day. A review was to be arranged with the psychiatrist.

112. An officer wrote in the man's ongoing record on 21 April, stating: "Spoke to the man today at length. Seemed settled, stated his mood was fair and seemed happy when I told him he would be starting at workshop 3 tomorrow morning. No issues to report." Although this was a relatively brief entry in the ongoing record, it seems fairly positive in nature.

113. On the same day, the man again saw the psychiatrist. He reported that his mood had improved but he did sometimes feel low during the day. However, he also felt anxious and fearful. No changes were made to his medication at this time.

114. The following day, a review of the man's ACCT document was held. The man said that on a scale of 1-10, he felt that his mood was a five. He said that being occupied helped him and that he had started work. In terms of medication, the man reported no issues and said he considered it to be working well. He also said he had sent out a visiting order to his brother. As

at the last review, the risk was identified as low but the ACCT document remained open.

115. Over the next week, the man remained relatively settled. Entries in his ongoing record, whilst brief, were positive. The man also received good reports about his behaviour and attitude in the workshop, as well as the way in which he was mixing with other prisoners. On 28 April, the man was seen by another mental health nurse from the MHIT. She wrote in the man's clinical record that he displayed clear symptoms of depression and would be taken on to the MHIT's caseload. The nurse also wrote in the ACCT ongoing record that he was not thinking about harming himself and did not want the ACCT monitoring to continue. She reported that, in her clinical opinion, it would be appropriate to close the ACCT document. The man agreed that he would talk to unit staff about any problems and would ask to see a mental health nurse if necessary. This meeting appears to have been a prelude to the ACCT review held later the same day, chaired by the Unit 1 SO and attended by a nurse. Given the previous meeting, and the fact that the man appeared to have been settled on the unit for some time, a decision was taken to close the ACCT document.

116. During interview, the Unit 1 SO recalled this ACCT review and said that the man had asked a few times for the ACCT document to be closed. He said the man was working away from the unit, was participating in association, had a group of friends, and behaved in much the same way as any other prisoner on the unit.

117. Five days later, on 3 May, an officer made a further brief entry into the man's wing history sheet, stating: "The man seems to have had an unsettled week this week, he did not attend his workplace on two occasions. The man himself stated he feels ok and will return to work on Tuesday. No further issues." Given that this was after the closure of his ACCT document, meaning that formal reporting of observations in the document had ceased, but prior to the post-closure review, it might have been beneficial for the personal officer to have provided a more comprehensive entry, with the issues given some context and discussion.

118. The post-closure review of the man's ACCT document took place on 5 May. The Unit 1 SO stated that he was happy for the document to remain closed, and that "the man isn't feeling well (ill) at the moment but expressed no cause for concern". In interview, the unit 1 SO explained that he had written 'ill' in brackets to clarify that this related to a physical illness rather than any concerns about the man's mental health. During the review, the man asked whether it would be possible for his medication to be altered, as he felt it was making him feel drowsy too early in the evenings. A note was made in the entry to liaise with healthcare staff in relation to this. A further post-closure review was not deemed necessary, although no mention appears to have been made of the unsettled week referred to by an officer in her entry in the man's wing history sheet. It is unclear whether this information was available or discussed during the post-closure review.

119. On 7 May, two days after the post-closure review, a nurse saw the man and wrote the following in his clinical record:

> "Remains low in mood. Appears very pale and drawn. Low appetite, concentration poor, gross loss of motivation, anhedonia [the failure to derive pleasure from activities that would normally be associated with this reaction]. Sense of hopelessness, and high levels of anxiety. Denies any intent to self-harm. Again asking for an increase in Mirtazapine. He has now been on 30mg for a period of three and a half weeks. Prior to this was on 15mg. In view of this, now increased to 15mg in the morning and 30mg at tea time."

120. During interview, a nurse said the man had been taking Mirtazapine for just over three weeks, and he reported feeling no benefit. She therefore made the decision to increase his medication, and decided on a split dosage because he wanted to be able to manage his anxiety in the mornings.

121. On the same day, the nurse also made an entry in the man's wing history sheet stating:

> "The man currently has a depressive illness which makes it difficult for him to work. He should be allowed to not attend for at least another two weeks. This will then be reviewed. He is receiving treatment for this."

122. There is no indication of the overall impact that non-attendance at work might have, and discipline staff do not appear to have looked for other constructive activity which might have been suitable for him.

123. There was little information documented by prison officers about the man between 7 and 27 May. The ACCT document had been closed, and so interactions were not being recorded as frequently as had previously been the case. There were no concerns recorded on his wing history sheet. The nurse saw the man on 15 May and reported that, although feeling more relaxed, he continued to isolate himself in his cell and did not leave for association. She saw him again on 18 May and they discussed the benefit of interacting with others, though he remained "unwilling to consider this at this time".

124. On 27 May, a cell sharing risk review was carried out by the Unit 1 SO and a mental health nurse. The review stated that the man had asked for a single cell as he was "getting more and more agitated with his bipolar issues", and felt he would benefit from space and time to himself. The SO recalled that the review came about after the nurse had approached him, having spoken to the man about the issue. The review noted the possibility of injury to the man's cellmate, arising from his mental health problems. The SO assessed him as high risk for the purposes of cell sharing, and "single cell" was noted on the form as a specific need. The SO recalled that, by the end of that day, the man had moved from his shared cell into a single cell on the same landing. He would still have been able to associate with his peers. The SO was clear

that the man was moved at his own request but also to alleviate his mental health symptoms and ensure the continued safety of his cellmate.

125. A Staff Nurse at Glen Parva, recalled that on the morning of Saturday 30 May, the man did not attend the healthcare unit to collect his medication. The Nurse rang Unit 1 to check the reasons for this, and was told that the man had refused to collect it. He went to healthcare on the same afternoon, when the Staff Nurse emphasised the importance of attending twice a day as planned.

126. However, on the following day, the man did not attend either of his healthcare appointments to collect his medication. On 1 June, he did not attend the healthcare unit in the morning. There is no entry in the man's clinical record to show whether or not he received medication in the afternoon. However, an officer recalled that, he unlocked the man's cell at around 4.30pm to allow him to visit the healthcare centre for his medication. The officer saw the man sitting at the table in his cell, and asked him if he wanted to go for his medication. The man replied no, and the officer asked if he was sure, to which he responded yes. The officer said he was able to remember this particular exchange because it was the last time he saw the man before his death. Although only a brief conversation, the officer did not feel there was any particular cause for concern at this time. He told my investigator that it was not uncommon for prisoners to refuse their medication, which would not necessarily indicate that a person might be at risk.

Events during the night of 1 and 2 June

127. The overnight discipline staffing of Glen Parva comprises a senior officer, two 'roaming' prison officers, and an officer based on each unit. The unit-based members of staff are generally Officer Support Grades (OSGs), with the exception of Units 2, 9 and 11, which are staffed by prison officers. Keys are held by the senior officer and the two roaming officers only, with other officers being confined to the unit where they are based. All members of staff, however, possess a cell key in a sealed pouch. When prisoners are locked in their cells overnight, the sealed cell keys can be used in an emergency if a cell needs to be opened.

128. On the night of 1 to 2 June, an OSG, was based on Unit 1. He explained in interview that his normal procedure is to check the unit landings every half hour and activate an electronic sensor which logs the time when the check is completed. Computerised reports from this system show that the sensors were activated around every half an hour that night. The OSG went on to say that, for prisoners not subject to ACCT monitoring, he would not necessarily look into every cell during every check, but would look into cells at random. He said that, as Unit 1 cells do not have privacy flaps but have an unobstructed glass panel, it is easy to look into cells when necessary.

129. The OSG said that around 4.30am, during his routine check of the landings, he happened to look into the man's cell and saw what he thought was the man standing in front of the window. He tried to engage him in conversation and, when this failed, switched on the cell light using a switch located on the

outside. It was at this point that the nature of the situation became clear to the OSG. He saw that the man was hanging from a ligature, fashioned from a bed sheet that had been tied to the window bars of his cell.

130. The OSG used his radio to alert other members of staff. He recalled advising that the situation was a 'code blue', indicating that someone was not breathing, though other officers thought the initial radio message contained only the information that assistance was required. One of the roaming officers who was on Unit 2 at the time, said he looked at his watch when he received the radio message and saw that it was 4.32am. The senior officer, who was based in the administration centre, said that although the message indicated only that assistance was required, he could tell that this was an urgent situation from the tone of the OSG's voice. He said that the OSG sounded "not distressed but perhaps quite hyped up with regards this was really urgent … he said it with a lot of urgency … and he didn't say it once, he repeated it".

131. A number of officers made their way to Unit 1 immediately after hearing the radio message. Two officers' one of which based on Unit 2 were two such people. Both report arriving at Unit 1 only seconds after the initial message was received. One of the officers said he ascertained the nature of the situation from the OSG, and clarified the initial radio call with a 'code blue' message.

132. Meanwhile, an SO had used his radio to alert a nurse that he would collect her from the healthcare department in order to attend Unit 1. (Healthcare staff members do not carry keys when working overnight, and so she would require an escort.) Given that he was based in the administration centre, directly above the healthcare unit, the SO arrived quickly and the nurse was waiting to be collected. They ran to Unit 1, and the SO estimated that they arrived less than one minute after he collected the nurse.

133. The second roaming patrol officer, was based in the south corridor when he received the call over the radio. He recalled that only seconds after the initial message, the 'code blue' clarification was made. Although he acknowledged that it was difficult to estimate, he said he arrived on Unit 1 between 60 and 90 seconds after the first radio message.

134. There was two officers arrived at Unit 1 first, followed by another office, an SO and a nurse. The SO opened the man's cell door. An officer explained that there was no delay in opening the cell, and he would have used his own sealed cell key had the SO not arrived when he did.

135. The SO and an officer entered the cell and took the man's weight. The SO cut the ligature with his anti-ligature knife (a standard piece of equipment carried by all discipline staff). The officers placed the man on his back on the floor of the cell. Based on his appearance an officer and nurse both believed that the man had been dead for some time. The nurse said she immediately thought that cardio pulmonary resuscitation (CPR) was not viable, but it was nevertheless attempted. The nurse performed chest compressions as well as mouth to nose breaths. She was unable to attempt mouth to mouth because

the man's tongue was obstructing his airway. She also asked an officer to collect a defibrillator (a piece of medical equipment to assess heart rhythm and to deliver an electric shock if necessary) from the healthcare centre, as she had not taken one with her to Unit 1.

136. An officer returned with a trolley containing medical equipment, including a defibrillator, within a few minutes. The nurse attached the defibrillator's pads to the man's chest. The machine indicated that there was no shockable electrical rhythm and advised that manual CPR should be continued.

137. Although the SO recalled that the nurse ceased resuscitation attempts before the arrival of the ambulance paramedics, she was adamant in interview that she continued until the paramedics arrived. The nurse said she stopped only to attach the defibrillator pads and then continued CPR. It is worth noting that the SO was not present at the cell for the entire time, as he left to escort the two paramedics into the prison. My investigator confirmed with the East Midlands Ambulance Trust that the 999 call was received at 4.34am, and that the ambulance arrived at the prison at 4.38am.

138. The SO said the paramedics were able to enter the prison quickly, and they ran with him to Unit 1. Nevertheless, given the geography of the prison this was likely to have taken at least a couple of minutes. Upon arrival at the cell, they attached an electrocardiogram (ECG) machine to the man to check for any signs of life. None were found. The paramedic from the East Midlands Ambulance Trust told my investigator that their electronic dispatch system recorded the man's death at 5.11am. The nurse recalled that she was the last person to leave the cell. She placed a sheet over the man, not for any medical reasons but to afford him some respect and dignity.

139. The SO acted as a co-ordinator following the man's death and the night manager took responsibility for implementing Glen Parva's contingency plan. The OSG left the unit and an officer took over its running. An officer was appointed to keep a log of people attending the unit. The Governor and the duty governor arrived at the prison, and a hot debrief was held at around 7.30am. (The purpose of the hot debrief was to reflect upon the situation, talk about the response and check on the well-being of staff.) Most of the people involved attended the debrief, minutes of which were taken. An officer was still in charge of Unit 1 at that time and was not able to attend, though he spoke to the care team separately. The OSG made a statement before he left the prison

140. At 10.00am, a governor and an officer, as well as the prison's family liaison officer, visited the man's brother at his home in Leicester. He was listed as the man's next of kin. The man's mother was visiting her son, and so they were able to break the news of his death to both his mother and brother at the same time. On the same day, a service for prisoners was held in the chapel at Glen Parva.

141. The following day, 3 June, members of staff started to become aware of prisoners speculating that the man had been bullied and that this might have triggered his death. SIRs were produced by an officer and by an education tutor, and statements taken from a number of prisoners. A principal officer and the head of Safer Custody conducted a simple enquiry and produced a report on 8 June. (A simple enquiry is a relatively brief and informal investigation into a specific issue, intended to reach conclusions quickly.) The enquiry involved a PO and a senior officer also from Safer Custody, interviewing three prisoners who were accused of bullying the man. All three prisoners had worked as orderlies on the Unit 1 servery prior to the man's death. The enquiry recommended that the prisoners were returned to normal location, but not employed on the unit servery. There was no conclusive finding as to whether the man had been bullied, though the prisoners in question admitted that some altercations had taken place.

142. In addition to the issue of bullying, it was suggested in written statements made by prisoners that, on the weekend before his death, the man had a very obvious and recent ligature mark around his neck which members of staff failed to notice or act upon. Furthermore, an anonymous letter sent from the parent of a serving prisoner at Glen Parva to the Chief Inspector of Prisons, claimed that unit staff had ridiculed the man due to his poor level of personal hygiene. This letter also claimed that on the night of 1 to 2 June, prisoners in nearby cells had discovered that something was wrong and had attempted in vain to alert a member of staff to the situation. The prison's liaison officer passed the letter to my office for investigation.

143. A memorial service for the man was held in Glen Parva's chapel on 25 June, to coincide with his funeral. A critical incident debrief, intended to offer support to members of staff who were involved in the response on 2 June, was held on 16 September.

ISSUES

Assessment, Care in Custody and Teamwork

144. The National Offender Management Service uses the ACCT process as a tool for, amongst other things, monitoring and providing support to prisoners identified as being at risk of self-harm or suicide. All members of staff should receive basic ACCT training and be able to open a document, as well as making appropriate entries in the ongoing record. Some members of staff receive more comprehensive training to conduct assessment interviews (something that should take place within 24 hours of an ACCT document being opened). A trained member of staff should undertake this initial assessment interview. Subsequent case reviews should comprise no fewer than two members of staff and also involve the prisoner subject to the ACCT document. These reviews should also, ideally, be multi-disciplinary. When staff members conducting a review determine that risk has been significantly reduced or is no longer evident, and it is felt that further intensive support and monitoring is not required, the document can be closed. A post-closure review should take place seven days later to confirm that risk remains reduced. Ideally, this review should also be multi-disciplinary.

145. The man was subject to four separate ACCT documents during his custodial sentence. The most recent was opened on 23 February 2009 at Portland, where the initial procedures were carried out as described above. Reviews were held very regularly, sometimes on consecutive days. On some occasions, though not all, they were attended by members of staff from different areas of the prison, including healthcare. During the period immediately prior to the man's transfer to Feltham, the reviews documented the reasoning behind the transfer, as well as the man's thoughts and feelings about it. A review was held on 24 March before his departure from Portland.

146. When he was transferred to Feltham, the man remained subject to the ACCT procedures. Reviews were held on 24 (the day of his arrival), 26, 27 and 30 March, although they do not appear to have been well attended. These reviews also seemed less positive and supportive than those which took place at Portland. In particular, the review on 26 March seemed to be merely an exercise in information sharing, with the review document stating the following:

> "The man has been informed that he will not be going to Lapwing, and he will be going to Glen Parva at the earliest opportunity. The man accepted what he was told and will be seen again tomorrow."

147. The man did not have an ACCT review on the day of his departure from Feltham (31 March), although one had been held on the previous day. Similarly, a review was not held at Glen Parva on the day of his arrival, but was held instead on 1 April. Despite reviews having previously been held at very frequent intervals, the man was immediately subject to a weekly review schedule. My investigator spoke to a PO, the head of Safer Custody, by telephone to enquire about his interpretation of the ACCT process and the

normal schedule of reviews. The PO explained that decisions about the frequency of ACCT reviews were made on a case by case basis, and there was no 'standard' reviewing schedule. He went on to say that, although some prisoners would be reviewed weekly, others were reviewed more frequently - in some cases daily - in accordance with their risk and need.

148. The man had moved from Portland to Feltham and then to Glen Parva over the course of nine days. It is, therefore, likely that he felt unsettled and was potentially vulnerable. A second review was not held until 8 April, by which time the man had been subject to yet another move, from the induction unit at Glen Parva to a standard residential unit. Whilst the change in review schedule was not necessarily detrimental to the man's care at the prison, there is nothing to suggest that any consideration was given to facilitating more frequent reviews, even though this had been the case at the last two establishments.

The Safer Custody manager should remind staff that ACCT reviews should take place according to the prisoner's circumstances rather than at standard intervals.

149. Although the frequency of ACCT reviews declined after the man's arrival at Glen Parva, the documents themselves were relatively clear about his presentation and demeanour, whether he was coping on the unit, and any problems he was experiencing. There was, however, little continuity in terms of the members of staff who chaired and attended the reviews. They were not always multi-disciplinary, and the man's personal officer never attended.

150. Outside of the formal review process, ACCT documents include an ongoing record. The purpose is to record meaningful interaction with the prisoner. In many cases, a minimum frequency for daily observations and conversations (which will differ depending on risk and need) will be stipulated on the ACCT document, and the ongoing record should be used to note the details. However, the ongoing record can and should be used to note all significant interaction, even when this exceeds the minimum level of information required.

151. The 2007 HMCIP inspection of Glen Parva noted the following with regard to ACCT:

> "Although there were regular management checks of ACCT documents, there was little evidence that these made any difference to quality. Documents were variable; some were satisfactory but a significant number were not, and there was an over-reliance on process rather than quality. Reviews and recorded observations generally took place within required timescales. However, staff recordings were often brief observations rather than details of interactions with prisoners. Records of conversations were often superficial and cursory. Some entries, particularly at night, were too predictable. Management checks tended to pick up on the quantity rather than the quality of written entries, and were often little more than a signature. Specialist staff who may have had a role in caring for the

prisoner rarely made written entries, and it was not always possible to get a detailed picture of the prisoner's overall wellbeing from the ACCT document."

152. My investigator had similar concerns, particularly in relation to the ongoing record element of the ACCT document. Entries tended to be brief, often containing only rudimentary information about the man's day to day activity. The entries made by the man's personal officer were no more detailed than any of the others, and made only at fortnightly intervals. During interview, an officer mentioned that she had a good rapport with the man, and that she interacted with most prisoners whenever she was on duty. She also said that the fortnightly personal officer entries represented a summary of interactions over the previous two weeks. In my view the entries in the man's file are very basic, particularly if intended to cover such an interval.

153. Although an officer said she interacted well with him, this was not readily apparent when reading her personal officer entries. The officer explained that there was no time specifically allocated for personal officer duties, and so this work was accommodated around the demands of other tasks. She went on to say that her normal daily routine would bring her into contact with prisoners, but that finding time to document their interactions could be difficult. Glen Parva's personal officer policy states that prisoners should be seen at least once every two weeks, with the contact documented in the wing history record. The policy does not specify the level of detail needed. Officer West therefore adhered to the requirements of the policy by writing an entry every two weeks. Nevertheless, more substantial and meaningful notes from the personal officer would be preferable.

154. Given that the man's most recent ACCT document was opened at Portland and travelled with him to Feltham and the prison, it is possible to compare the ways in which observations were recorded at the three establishments. The man spent only a week at Feltham and much of the documentation focused on the confusion about whether he would be admitted to the healthcare unit or transferred to another establishment. At Portland, a number of comprehensive and quality entries appeared in the ongoing record, particularly those made by the man's personal officer. Certainly, the entries made at Portland are useful in giving an overview of how the man felt on a day to day basis, whereas this was not always the case at Glen Parva.

155. In addition to the concerns expressed by HMCIP regarding meaningful entries in ACCT documents, my own most recent investigation into a death at Glen Parva (published in draft in May 2009, and in its final form in August 2009) highlighted deficiencies in the quality of entries. I wrote:

> "Once opened, the prisoner's ACCT document was scant in places and there were few documented meaningful assessments of his state of mind. Meaningful entries are an important requirement in the ACCT observation process and ongoing record. Such entries help assess the level of risk and indicate when risk is heightened or reduced."

156. It is disappointing to draw attention to the same areas of concern here. Whilst I appreciate that officers have a multitude of responsibilities and find it difficult to allocate time to write comprehensive entries, the whole purpose of the ongoing record is to document meaningful interactions and to provide an overview of the prisoner. When surveying the document, I would expect to gain an immediate insight into the prisoner subject to the ACCT process, not only in terms of mere observations but also regarding conversations, concerns and state of mind. This was not always the case with the documents completed at Glen Parva.

The Governor should remind all staff to complete the ACCT document properly, with high quality, meaningful entries.

157. Although the ongoing record was not always comprehensive, the records of the ACCT reviews seem to provide adequate information regarding the content of the meeting and any ongoing concerns. There was, however, little continuity in terms of the members of staff who chaired and attended the reviews. Nevertheless, the documents indicate that the man settled well on Unit 1, which is consistent with the recollections of unit staff. An officer, in particular, was able to recall that although the man was very quiet and withdrawn when he arrived on Unit 1, significant progress was made in terms of his integration into the regime and the way in which he interacted with others.

158. The ACCT review on 28 April, which led to the document being closed, was chaired by an SO. The head of Glen Parva's mental health in-reach team (MHIT), also attended, as did the man. No other discipline staff members were present, though the SO recalled that he spoke to various officers prior to the review. On the review document, he wrote:

> "No prevalent issues or current issues of note, settled well for some considerable time now on Unit 1, was himself asking to close the document, Amanda also happy to have ACCT closed as am I and unit staff."

159. The nurse had become directly involved in the man's clinical care on the same day. Although she would not yet have had a comprehensive working knowledge of him, she had assessed him as a mental health professional. The SO was based on Unit 1 and would, therefore, have had day to day contact with the man. He had also canvassed other unit staff members and had noted their views in the review document. The man was happy for the document to be closed, and in fact had asked whether this would be possible.

160. Based on the progress made during the man's time on Unit 1, the multi-disciplinary nature of the review, and the agreement of all concerned that there was no need for him to the subject to the ACCT process, the document was closed. This does not appear to me to have been an unreasonable decision. Although the process is intended for those at risk of self-harm or suicide, it is also a flexible document that should be closed when the risk is thought to have reduced or is no longer present. The man had been on Unit 1

for three weeks, had made progress in terms of integration into the regime, and was no longer thought to be a serious risk of harming himself.

161. Although a post-closure review was held on 5 May, this does not appear to have been a multi-disciplinary meeting. It was chaired by the SO and also attended by a prison officer. The man was also present but mental health staff were not. No concerns were raised during the review, and the SO did not think it necessary to re-open the ACCT document. It is not clear whether either of the officers read the man's wing history sheet for the period between the closure of the ACCT and the post-closure review. Certainly, no mention is made in the record of the review. Given that observations in the ongoing record would have ceased on 28 April, the wing history sheet seems a sensible document to consult in order to check for any concerns raised in the intervening period.

162. In this particular case, the officer had made an entry in the man's wing history sheet on 3 May, stating that he had had an unsettled week and had not gone to work on two occasions. The entry did not provide any further context or clarification, and whilst the SO may have spoken to the officer or considered the document in the review, there is no evidence that this was the case. The issues here are twofold. When an ACCT is closed, observations are quite properly no longer documented in the ongoing record, and so it is essential that any concerns are fully documented elsewhere, particularly in the period between the closure of the document and the post-closure review. It is equally important that, where such concerns are recorded, they are considered as part of the post-closure review process, and the result of these considerations is recorded on the review document.

163. It is easy to attach retrospective significance to the officer's entry in the man's wing history sheet, whereas it is quite possible that at the time, there was no reason for immediate concern. However, this demonstrates further the need for such entries to be comprehensive and unambiguous, particularly in the period between the closure of the ACCT and the post-closure review meeting.

The Governor should remind staff that documents such as wing history sheets should accurately and clearly record any concerns, particularly in the period between ACCT closure and post-closure review.

In addition, the Governor should ensure that staff attending an ACCT post closure review consider all the evidence, including the wing history sheets, about the prisoner's wellbeing since the ACCT procedures were closed.

Single cell accommodation

164. On 23 February, after the man had been released from and subsequently recalled to Portland, he self-harmed by burning his arm with a cigarette lighter. This was the second occasion on which he had harmed himself in this way. The following day, an Immediate Action Plan was completed by two officers and the nurse. They indicated that, in terms of cell sharing, the man

was a high risk due to the nature of his self-injury. Ostensibly, the man could have caused harm to a person sharing his cell because his method of self-harm involved the potential for fire.

165. When the man arrived at Glen Parva on 31 March, the CSRA concluded that he was a medium risk. No mention was made of the way in which he had harmed himself at Portland some five weeks earlier, and there is no reason to believe that this information was available to the reception officer completing the assessment. That said, the man was, at the time of his arrival at Glen Parva, subject to the ACCT document opened on 23 February at Portland after he burned his arm. Even a cursory look at the document would have revealed the reasons why it was opened, and this may have had some bearing on the decision regarding cell sharing.

Reception officers completing the CSRA for ACCT prisoners should check the document for concerns about cell sharing

166. As a result of being assessed as a medium risk on the CSRA, the man was not prohibited from sharing a cell. Indeed, he was located in a shared cell both on the induction unit and on Unit 1. This did not appear to create any problems at first. The man got on well with his cellmate, when located on the induction unit, and they continued to share a cell when they moved to Unit 1 at the same time. The cellmate told my investigator that he had a good relationship with the man and considered him a friend. He said, however, that the man was often drowsy and slept a lot due to his medication, and so did not always provide the best company. As a result, the cellmate eventually asked to be moved to another cell, though he remained friends with the man. Another prisoner moved into the man's cell.

167. On 27 May, a cell sharing risk review was instigated after the nurse approached the SO. The nurse had spoken to the man, who had told him that sharing a cell was affecting his state of mind. The review acknowledged this and also mentioned the possibility of injury to the man's cellmate as a result of the man's mental health problems. Single cell accommodation was identified as a specific need.

168. Five days after being granted single cell accommodation, the man was found hanged in his cell. His mother has expressed concern that he was in a single cell and feels strongly that, given his mental health issues and risk of suicide, he should have been sharing with another prisoner.

169. At the time of the cell sharing risk review, the man was no longer subject to the ACCT process. Members of staff involved in the administration of that document, including mental health professionals, felt that the man's risk of self-harm or suicide had diminished to such a degree that the additional monitoring and support was unnecessary. When he was given access to a single cell, he was not thought to be at risk of harming himself.

170. Even if the man had been considered at risk of self-harm or suicide, this would not by itself have been sufficient reason to locate him in a shared cell.

Prison Service Order (PSO) 2700 is clear that, when managing a prisoner likely to self-harm or attempt suicide, it is not an appropriate risk management strategy to place the person in a shared cell and expect their cellmate to shoulder the burden of responsibility for monitoring and support. Whilst cell sharing can help to reduce feelings of loneliness and provide the prisoner with someone to talk to, this must not be used as an alternative to staff-prisoner interaction.

171. In the man's case, the decision to move him to a single cell was made because of his mental health symptoms rather than in spite of them. The cell sharing risk review was prompted by a nurse, a mental health professional, who had spoken to the man about his concerns. Members of staff must, of course, be aware of the possibility that such requests might be made in order for a prisoner to more easily implement a plan that they have formulated for self-harm or suicide. However, in this case the man was not considered to be at imminent risk, the review was multi-disciplinary in nature, and the decision was taken with the intention of alleviating concerns arising from his mental health issues. I am, therefore, satisfied that the SO and nurse acted not only in good faith but also reasonably, with regard to the review process and the decision reached.

Prison transfers

172. The man spent the majority of his prison sentence in Portland, though he also spent time in High Down, Feltham, Dorchester, and of course Glen Parva. A summary of these transfers is set out below.

DATE	STATUS
7 April 2008	Received into High Down on remand
12 June 2008	Transferred to Feltham after conviction
24 July 2008	Transferred to Portland one week after sentencing
6 January 2009	Released on licence from Portland
21 January 2009	Received into Dorchester after licence recall
28 January 2009	Transferred to Portland
24 March 2009	Transferred to Feltham
31 March 2009	Transferred to Glen Parva

173. It is not uncommon for prisoners to be remanded in one prison and transferred to another after conviction. After being sentenced in July 2008, the man transferred to Portland and remained there for more than five months until he was released in January 2009. After being recalled to custody, just a fortnight after his release, the man spent a week at Dorchester before being transferred to Portland, where he remained for almost two months.

174. The main area of concern relates to the man's transfer from Portland to Feltham on 24 March, and then to Glen Parva seven days later. At the time of

these transfers, the man was subject to the ACCT process. During interview, the SO, who chaired a number of the man's ACCT reviews at Glen Parva, mentioned that it was unusual for prisoners subject to open ACCT documents to be transferred between prisons. Certainly, this practice is not encouraged unless there are specific and valid reasons relating to the continued care of the prisoner at risk.

175. Regarding the man's transfer from Portland to Feltham, there does not appear to be a great deal of clarity about the reasons behind the move. He was told on more than one occasion that the purpose of transferring him to Feltham was to facilitate better support through location in the healthcare unit. However, the nurse wrote in the clinical record on 17 March that whilst there was a possibility of the man transferring to Feltham, this would "not be under a clinical move".

176. Chapter 15, paragraph 15.7.3 of PSO 2700 states that "the proposed transfer, and issues arising from it, must be discussed at a case review with the prisoner". Paragraph 15.7.4 goes on to say that "the prisoner should be given information about the regime and facilities of the new environment". Whilst the transfer to Feltham was discussed with the man at ACCT reviews, the focus seemed to be on the more comprehensive provision of healthcare, with a strong implication that he would be managed as an in-patient at Feltham's healthcare unit. However, there is no evidence to suggest that the man had been assessed for suitability prior to his transfer.

177. In terms of information sharing in advance of transfers, chapter 15, paragraph 15.7.2 of PSO 2700 states:

> "The intention to transfer a prisoner on an open ACCT Plan … must be discussed with the receiving establishment, a record must be retained in the sending establishment to show this has been done (as well a record [sic] made in the ACCT Plan), and relevant information must be conveyed either with or ahead of the prisoner."

178. My investigator asked a Safer Custody officer at Portland, to ascertain whether or not any such discussion took place. The Safer Custody officer explained that, when transferring a prisoner subject to ACCT, his office would usually fax the documents to the receiving prison in advance of the transfer, and keep a copy in the Safer Custody department. Although the officer had recorded on a spreadsheet that he had faxed the man's paperwork to Feltham on 23 March, the day before his transfer, he was not able to locate the documents themselves. There is no mention in the man's ACCT document of a discussion about the proposed transfer, particularly with regard to assessment for healthcare admission. This raises the possibility that staff at Portland made a decision to transfer the man to Feltham in the hope that he would meet the criteria for the healthcare unit.

179. Feltham's Safer Custody office explained to my investigator that the prison's protocol for transferring prisoners subject to ACCT involves identifying a specific person in the receiving prison and sending the documents to them in

advance of the transfer. In this case, the allocations officer at Feltham faxed the man's ACCT documents to the SO at Glen Parva on 30 March. There is no indication, though, that any meaningful discussion took place between the two prisons about the way in which the man would be managed.

180. On the subject of the transfer from Feltham to Glen Parva, the reasons for the move are not at all clear. The man's ACCT Caremap was updated on 30 March. The entry related to reducing anxiety, and suggested that he should move to Glen Parva at the earliest opportunity because he wanted to live in Leicester upon release. However, this was clearly being considered as early as 25 March, only one day after the man's arrival at Feltham, when an officer wrote in his ongoing record:

> "Mood is clearly low, and I fear that it is unlikely to improve for some time, as any news we are in a position to tell him will not be what he expects to hear. I believe the plan is for him to go to Glen Parva, which will be bad news for him if true."

181. The day after this entry was made, the man was told during an ACCT review that he would be transferred to Glen Parva. The full wording of the review document is as follows:

> "The man has been informed that he will not be going to Lapwing, and he will be going to Glen Parva at the earliest opportunity. The man accepted what he was told and will be seen again tomorrow."

182. It is clear from the ACCT documentation that the man was keen to be accepted in the healthcare unit, and that news to the contrary would be unwelcome and upsetting. It is, of course, impossible to glean in full the overall tone of an ACCT review by consulting the paperwork, but the wording of the form gives the impression that the review was little more than an exercise in conveying information. The form states that the man "accepted what he was told", but does not give any indication as to his general demeanour, his response to the news, or any concerns regarding the transfer.

183. On 31 March, the man transferred from Feltham to Glen Parva. As mentioned above, the reason for the move was that he wished to live in the Leicester area upon release. However, he was not due to be released from custody until October 2009, and so I am sceptical about the benefits that another unsettling transfer could offer, particularly only a week after arriving at Feltham.

184. I am concerned about the apparent lack of meaningful communication between the prisons regarding the transfer of a prisoner subject to an open ACCT document. I am also unconvinced about the benefit of the transfers themselves. Even if relocation to Glen Parva was considered a positive move for the man, involving Feltham in the process seems only to complicate the issue. Between 24 and 31 March, a period of only a week, the man was transferred twice. By 7 April, he had moved from Glen Parva's induction unit

to a normal residential location. Such a succession of transfers was far from ideal for someone considered to be at an elevated risk of self-harm or suicide.

Clinical care

185. The clinical reviewer, from Leicestershire Partnership Trust, completed a clinical review, which is annexed to this report. The purpose of the clinical review was to consider the circumstances of the man's time in custody and his death from a medical perspective and to consider whether the clinical care received was equitable to that which would have been received in the wider community.

186. The clinical reviewer thinks that the man's death was not preventable. He noted that the man suffered from depression over a prolonged period, and thought it would have been very difficult to predict that his low mood in the days before his death might lead to a suicide attempt. The clinical reviewer also judges that the man's medication was appropriate. He believed the man's clinical care was equivalent to what he would have received in the community.

187. The man had regular mental health support throughout his time in custody. Although he was not on the MHIT caseload for much of his time at Portland, the primary healthcare team was extensively involved. At some points, RMN was seeing the man twice daily. When he arrived at Glen Parva, the man was seen by a psychiatrist and this was followed up with two further appointments. He was accepted on to the MHIT caseload and was seen by a nurse on a number of occasions.

188. The man was prescribed a number of different anti-depressants whilst he was in custody, but they did not seem to improve his mood for significant periods. Regardless of the type of medication he was taking, the man seemed to experience fluctuations in mood and, at certain points, was very low indeed.

189. Regarding the healthcare staffing at Glen Parva, the clinical reviewer acknowledged that the separate teams were to be consolidated, providing a streamlined service. Progress had also been made in terms of the staffing levels for the healthcare centre.

190. The structure of the MHIT at Glen Parva was such that, if the nurse was away from the prison for any reason, there was nobody to cover her appointments. Although they could be covered by the primary mental health team, there was no specific diary system to allow such contingency measures to be easily enacted. Responding to the draft report, Leicestershire Partnership Trust noted that at the time, there was a vacancy for a further permanent staff member to assist the nurse with appointments for those on the MHIT caseload, and that an additional nurse did attend the prison and could cover the nurses appointments when necessary.

191. The clinical reviewer noted that people subject to the ACCT process (a discipline-led rather than clinically led procedure) had regular reviews which

took place as planned, but the system was less robust for those only on the MHIT caseload. He made the following recommendation, which I endorse:

The healthcare manager should examine the internal system for setting review schedules for those not being monitored under ACCT, to ensure that it is watertight.

192. The clinical reviewer concluded that failing to take anti-depressant medication for just a few days would probably not have had serious effects, as it usually takes more time for the effects to be felt after withdrawing from this type of treatment. However, he thought the follow-up arrangements should be reviewed, and I endorse his following recommendation:

The healthcare manager should review the arrangements for following up prisoners who do not collect their medication. This is particularly important for prisoners who are vulnerable due to mental health symptoms.

Events of 2 June 2009

193. The man's mother feels strongly that her son should have been checked more frequently during the night. However, he was neither subject to the ACCT process nor on a list of prisoners giving cause for concern. Therefore, he would not have been checked specifically at regular or recorded intervals. As mentioned earlier, OSGs patrol the units half-hourly during the night, looking into cells at random. It is important that a balance is struck between monitoring prisoners and affording them privacy during the night, which is why only those prisoners thought to be at risk are subject to regular, frequent and recorded checks.

194. After the alarm was raised by an OSG at around 4.30am, the response was swift. Several officers arrived on the scene within a few minutes. The gate log indicates that an ambulance was called at 4.35am and arrived at the prison at 4.40am. The nurse began CPR as soon as she arrived on Unit 1 just a couple of minutes after the OSG raised the alarm, though the use of the defibrillator was delayed by a few minutes as the officer had to retrieve it from the healthcare unit. I am satisfied that this delay would not have made a difference in this case; the nurse's description suggests that the man may have been dead for some time before being discovered. However, the importance of a defibrillator being available quickly cannot be underestimated, and in many cases a delay of only a few minutes can be significant in affecting the chances of effective resuscitation.

Healthcare staff should take an emergency 'grab bag' and a defibrillator to serious situations, particularly those of a 'code blue' nature.

The Governor and healthcare manager should consider placing emergency 'grab bags' and defibrillators at strategic points throughout the establishment.

195. After the man's death was confirmed by paramedics at the scene, the contingency plan for a death in custody was implemented. There are separate, slightly different plans depending upon whether the death occurs at night or during the daytime. In this case, the daytime plan was used because the daytime regime would soon begin. A log was kept, initially of people attending Unit 1, then of people attending the specific landing, and later of those attending the cell itself. Various agencies were contacted regarding the man's death. The Chair of Glen Parva's Independent Monitoring Board (IMB), mentioned that his duty member of staff was not contacted until 7.45am, more than three hours after the man was found. The contingency plan does not specifically mention the need to contact the IMB, which may explain the delay in initial contact following the man's death. My investigator discussed this issue with a Governor, who explained that the contingency plans were in the process of being re-written and that this issue would be noted.

The updated contingency plan for actions following deaths in custody should include a requirement to contact the IMB.

Allegations made after the man's death

196. Following the man's death, a number of allegations were made about his treatment whilst at Glen Parva. Several prisoners made statements and an anonymous letter from the parent of a serving Glen Parva prisoner was sent to the Chief Inspector of Prisons.

197. The allegations were that:
- The man had been bullied by three prisoners who worked on the Unit 1 servery.
- The man been ridiculed by members of the Unit 1 staff.
- The man had an obvious and fresh ligature mark on his neck on the weekend before his death.
- Prisoners on Unit 1 had, upon realising that something was wrong, tried in vain to get the attention of the OSG on the night of 1-2 June.

Bullying by other prisoners

198. Following the allegations, the Governor asked a PO to conduct a simple enquiry. This involved interviewing the prisoners who had made the claims, as well as those accused of bullying the man. Although the PO did not come to a conclusion about whether the man had been bullied, he acknowledged that altercations had taken place with the three accused prisoners. These prisoners returned to normal location but were prevented from being employed as servery orderlies.

199. As part of the Ombudsman's investigation process, the investigator interviewed four prisoners who lived on Unit 1 when the man died. Three of the prisoners had made statements to unit staff, and the fourth person came to light as someone who had known the man well. Two prisoners who had made statements had either been transferred or released and, whilst it was not feasible to interview them, their statements were considered.

200. A prisoner said in interview that he had not known the man particularly well but had shared a cell with one of the prisoners who had worked on the servery. The prisoner said this prisoner talked about the way in which the man was treated differently and given smaller portions of food. The prisoner also said he witnessed the servery orderlies making fun of the man, forcing him to sing nursery rhymes to try and humiliate him. In addition, he recalled an incident when the servery orderlies banged on the man's cell door.

201. Another prisoner gave much the same account, though he had not personally witnessed anything and instead had been told by others that the man was being bullied. The statements made by two prisoners have also made reference to the servery orderlies kicking the man's cell door and shouting abuse at him.

202. Conversely, two other prisoners' were not convinced that the man had been bullied. One of the prisoners said in interview that whilst there had been some verbal exchanges between the man and the servery orderlies, these were of a good-humoured nature and much the same as any other such interaction between prisoners. He said that there had been one more serious problem, which led to the aforementioned incident involving someone banging on the man's door, but that this was resolved quickly. A prisoner said in interview that the allegations about bullying were entirely false, and had been invented by a prisoner on the unit after the man's death. He said he was close to the man and would have expected him to say if he had been bullied by other prisoners.

203. The PO mentioned during interview that the three servery orderlies accused of bullying the man were temporarily segregated whilst they were interviewed. The prisoners admitted that there had been altercations with the man about food, and that they had also approached the man about his personal hygiene. However, the PO did not feel that there had been a sustained campaign against the man. The servery orderlies were returned to normal location, though not to Unit 1 because of the possibility of reprisals from other prisoners.

204. It is impossible to be certain about exactly what happened between the man and the servery orderlies, how he might have felt about the altercations that took place, and whether their interactions were malicious or in jest. Prior to the man's death, there were no reports of bullying or intimidation, and there is nothing of that nature recorded in his wing history file or the unit observation book. It is easy to imagine the way in which a rumour can circulate amongst prisoners on a unit, and indeed some of the information obtained during interview was second hand rather than directly witnessed.

205. I do not make a recommendation in this area. However I advise the Governor and Safer Custody manager to remind unit staff that seemingly minor altercations might be more powerful when directed at someone who is vulnerable or withdrawn from the regime.

Ridicule from members of Unit 1 staff

206. The letter sent to the Inspector of Prison's Office by the parent of a Glen Parva prisoner mentioned that unit staff made derogatory comments to Levi about his personal hygiene. Two more prisoner's also mentioned this in their statements, though one of them had not witnessed anything directly and said he had heard about the issue from another prisoner. The prisoner did not refer to this in the statement he made shortly after the man's death, though in interview on 14 October, some four months later, he said that an officer had given the man "a hard time" in relation to his personal hygiene. A prisoner, however, said there had been no problems between the man and the unit staff and, similar to the allegation of bullying, felt that the man would have told him about any problems.

207. The investigator interviewed a number of Unit 1 officers and asked them about the allegations. Some officers were aware of issues around the man's personal hygiene, but robustly denied that he had been subject to any ridicule. During interview, the officer said prisoners who did not shower or clean their cells were encouraged to do so, but would never be ridiculed or mistreated because this would not only be wrong but also self-defeating.

208. There are similarities here to the allegations around bullying, as it is impossible to know exactly what unit staff members might have said to the man, and in what context. As with the bullying issue, some of the accounts are second hand. During interview, no members of Unit 1 staff recalled witnessing or engaging in behaviour involving ridicule or derogatory remarks towards prisoners in their care. In fact, several staff members seemed genuinely surprised and affronted to be faced with such allegations.

209. Although not related to seriously inappropriate behaviour towards prisoners, my investigator heard several officers routinely referring to prisoners by their surnames. This was also highlighted as an issue in the 2007 HMCIP report, which recommended in paragraph 2.59 that "staff should address prisoners by their preferred names". Whilst I do not make a recommendation about this issue, I bring to the Governor's attention the need to remind staff that prisoners should be addressed by their given names.

Ligature mark

210. Two prisoners both wrote about having witnessed a ligature mark on the man's neck, on the weekend before his death. Another prisoner also mentioned this, though it was not something he had witnessed directly. A prisoner said in his statement that he had spoken to the man about it, and believed that he had tried to hang himself on the Saturday night.

211. The prisoner said in interview that he had spoken to the man about the mark on his neck, and understood that it was the result of a hanging attempt. Another prisoner also said he had noticed the mark and had tried without success to talk to the man about it. He nevertheless felt that the cause of the

mark was very obvious. A prisoner gave a detailed and credible account of seeing a ligature mark on the man's neck, and taking him aside to talk to him about it. He said this was on the Saturday afternoon before the man's death overnight on the following Monday/Tuesday.

212. None of the prisoners said that they reported what they had seen to unit staff. A prisoner thought some members of staff had noticed the mark and arranged for the man to be seen by someone from the healthcare unit. However, there does not appear to be a record of any such action. The Unit 1 officers interviewed did not remember a mark on the man's neck and were clear that action would have been taken had one been noticed. The prisoner mentioned three officers as the people who might have reported the mark to the healthcare unit. Two of the officers were not working on the weekend before the man's death, and there is no officer under the third name. However, this could refer to the officer with a similar name, who was working on Unit 1 on the weekend before the man's death.

213. In interview, the officer was very clear that he had not noticed a ligature mark around the man's neck. He said that if he had noticed anything of this nature he would "have had him out of that cell straight away … got in touch with healthcare [and] had him on an ACCT". He went on to say that such immediate action would be common sense, and that a ligature mark would be an indicator of serious risk. The officer was also of the opinion that all of his colleagues would treat such an observation very seriously.

214. There is nothing documented in either the man's discipline file or clinical record to suggest that a mark on his neck was noticed by members of staff. A number of prisoners report seeing this mark, and their statements cannot be discounted. However, the concerns were not brought to the attention of officers on the unit. It does not seem that members of unit staff saw a mark on the man's neck and failed to act; rather, they were unaware of any such mark.

Allegations about staff response on the night of the man's death

215. The anonymous letter sent to the Chief Inspector's office made the following claim:

> "On the night he committed suicide the lads next door realised that something was wrong and did all they could to get attention and help. Nobody responded until the morning when of course it was too late."

216. The cells on Unit 1 have clear observation panels in the doors, rather than privacy flaps. For this reason, it is possible to look from one cell into the cell directly opposite. A prisoner said in interview that he thought another prisoner, who was opposite the man, had seen him hanging in his cell and tried without success to raise the alarm by using his cell alarm. The prisoner however said that he heard a cell alarm bell earlier in the night but was not sure whose cell it came from. He later heard officers on the landing outside the man's cell, and the nature of the conversations made it clear that

something was wrong. It was at this point that he looked through the observation glass and saw officers cutting the man down. He said he heard later that the man had pressed his cell alarm to try to summon help but none had arrived.

217. Another prisoner said, in interview, that he was woken at around 4.30am by the commotion on the landing. He said that a board on the landing was illuminated, indicating that a cell alarm had been activated. The prisoner could see the light from the board, but was not able to see which cell it related to. He said that when cell alarms are deactivated by members of staff, the light on the board goes out. For this reason, he assumed that Levi had attempted to alert a member of staff to his situation but had not elicited a response.

218. My investigator asked an OSG if, prior to discovering the man at around 4.30am, there had been any cell alarms or noise from prisoners. He said there had not, and that it had been a quiet night on Unit 1 until that point. The electronic records show that the OSG patrolled the landings at roughly half-hourly intervals. It therefore seems unlikely that he would walk directly past a cell where the alarm had been activated, and do nothing to address the issue.

219. When a cell alarm is pressed on Unit 1, a red marker drops down at the end of the landing in question. An electronic panel also located at the end of the landing, also lights up to indicate which cell has activated the alarm. In the unit office, a red light indicates which of the three landings has activated a cell alarm, but does not give details of the specific cell. The lights are extinguished when the alarms are deactivated. The system does not make a permanent electronic record of cell alarms. Between the hours of 9.00pm and 7.00am, if cell alarms are not answered after three minutes, an electronic notification is sent to the gate. The gate officer is then able to alert the unit officer to the unanswered alarm.

220. The information provided by prisoners on this matter is largely speculation and assumption based on the piecing together of partial facts. The letter is third party information based on the same speculation. The OSG gave a credible account of the sequence of events, and the content of his interview was consistent with that of other officers. He patrolled the landings half-hourly as required, and did not recall any prisoner unrest or cell alarms. There is no reason to believe that the events of 1 to 2 June unfolded in any way other than as described by the OSG and other members of staff.

Issues raised by the man's family

221. The man's brother and mother raised a number of issues with my investigator and family liaison officer (FLO). The issues concerning ACCT monitoring, single cell accommodation, checks during the night, resuscitation attempts, and the ligature have been covered earlier in the report. The remaining issues concern serious assaults against the man, his location in the prison, and family liaison following his death.

Assaults against the man

222. The man's mother said she had heard that a prisoner was stabbed after being mistaken for the man. She also thought the man had been seriously assaulted during or after a game of pool. The man's mother was concerned about these issues, which she described as attempts on his life, and said they may have been racially motivated. She did not know when or in which prison the incidents occurred.

223. In order to investigate the man's mother's claims, my investigator contacted the security department at High Down, the governing Governor at Portland, the senior officer from the security department at Dorchester, and the senior officer from the security department at Feltham. There was no evidence of a prisoner being stabbed at any of the four prisons during the time that the man was there. Portland had a record of the previously mentioned assault against the man in February 2009, when he was assaulted by other prisoners on the Drake unit, but there were no other reports that he had been assaulted. The assault in February 2009, and that mentioned by the man's mother, may be the same incident, though it is impossible to be certain about this matter. Other information related to concerns around self-harm that have already been documented in the Key Findings section of this report.

224. The man transferred to Glen Parva on 31 March 2009 and remained there until his death on 2 June. There were no reports of him being assaulted during this period. My investigator asked a governor if there had been any incidents involving a prisoner being stabbed, and was told that there had not.

225. There is no evidence that a prisoner was stabbed after being mistaken for the man. Other than the assault in February 2009, it appears that he was not involved in any violent incidents.

The man's location in the prison

226. The man's mother felt that he should have been located in the healthcare unit because of his bipolar disorder, and wondered why he was instead located on an ordinary residential unit.

227. The man appeared to classify himself as suffering from bipolar disorder, and indeed this was also mentioned on occasion by members of medical staff. However, bipolar disorder is a specific mental illness and there is no evidence that this was ever officially diagnosed. Certainly, though, he suffered from depression, and at times there were serious concerns about his well-being and his risk of self-harm or suicide.

228. During the man's first spell at Portland, he spent much of his time on the Beaufort unit, a skills development area where activities such as a music room were available. Following his recall to custody, the man was located on a normal residential unit. However, concerns were raised on a number of occasions, particularly by his personal officer, that his needs could not be appropriately managed in such an environment. A number of references are

made in the man's documents regarding his proposed transfer to Feltham which suggest that the intention was for him to be located on the healthcare unit. However, this does not appear to have been agreed in advance of his transfer.

229. Upon arrival at Feltham, the man was assessed by the CMHT but was not considered suitable for admission to the healthcare unit. Shortly afterwards, he was transferred to Glen Parva, where he remained on normal residential location until his death. Whilst he was subject to an open ACCT document throughout this period, the man seemed to settle on a residential unit and his review documents indicate progress.

230. Whilst the man suffered from depression and subject to ACCT, this by itself would not indicate a need for location on the healthcare unit. It is entirely possible to look after prisoners with mental health needs on normal residential location, and in some cases location on the healthcare unit can itself be a source of stigma. Although he was on a normal residential unit, Levi had regular support from the MHIT.

Family liaison

231. The man's mother said she initially found the family liaison from Glen Parva supportive and helpful. However, following a family dispute about where the man should be laid to rest, she felt that one of the prison's family liaison officers inappropriately took her son's side. She was also concerned about a voicemail message she received from the officer, which appeared to relate to another prisoner entirely.

232. My investigator spoke to the prison liaison officer about these matters. He admitted that the family liaison with the man's mother had become difficult, though he did not agree with her assessment of why this was. The officer said that, when the family dispute arose, he felt that the man's mother tried to convince him that he should side with her. He told my investigator that it would not have been appropriate for him to become involved in what was essentially a family matter. The officer added that the man's mother found it difficult to accept that the prison was not able to cover certain expenses, in particular a wake following the funeral. He was quite clear that he did not believe he had taken sides in the family dispute, and said he had acted independently and professionally.

233. On the issue of the voicemail message, the man's mother said it was from the officer and related to a prisoner who was very much alive. She said that in the message, he referred to speaking to a prisoner about an issue. She said she was very upset to receive such a message so shortly after the man's death, and her instant reaction was to delete it. When my investigator asked the officer about this, he denied leaving such a message on the man's mother's voicemail service. He also denied the possibility that it could have been left in error, despite him working in the visits centre at the time and having responsibility for contacting families on a regular basis.

234. Given that there is no evidence of the message, it is impossible to reach a conclusion about what might have happened. With two opposing accounts, and no corroborating evidence, it is not possible to be sure about the facts of this matter. Nevertheless, the Governor will wish to remind family liaison officers of the importance of respecting family sensitivities. Consideration should be given to writing to the man's mother to apologise for any distress caused.

CONCLUSIONS

235. The man was sentenced to 18 months' imprisonment on 17 July 2008. It was his first conviction and prison sentence. The man had suffered from depression since his teenage years and was haunted by the memories of traumatic incidents that he had witnessed.

236. The man spent almost all of the first part of his sentence at Portland. He suffered from depression and fluctuations in mood, and harmed himself on a number of occasions. He was subject to the ACCT process and had regular support from mental health workers. The man was prescribed anti-depressants but they did not seem to have a sustained positive effect on his mood.

237. Although he was released on 6 January 2009, he was recalled to custody only two weeks later. After a very short period at Dorchester, the man transferred back to Portland. He continued to suffer from depression, and his medication and ongoing support did not seem to alleviate this very much.

238. The man transferred to Feltham on 24 March, and to Glen Parva on 31 March. He saw a psychiatrist on several occasions, and received support from Glen Parva's mental health team.

239. On 27 May, he requested a single cell, and this was granted. In the early hours of 2 June, he was found hanging in his cell by the night patrol officer. Other officer and a nurse attended quickly. Resuscitation was attempted but this was unsuccessful.

240. My report covers the sad story of a young man who did not seem able to find any relief from his ongoing depression. I have paid particular attention to the ACCT process, single cell accommodation, and transfers within the prison system. I also looked into several allegations that were made after the man's death. I make eight recommendations and endorse a further two made by the clinical reviewer.

RECOMMENDATIONS

1. The Safer Custody manager should remind staff that ACCT reviews should take place according to the prisoner's circumstances rather than at standard intervals.

   The recommendation was accepted. Senior officers will be briefed at their morning meeting about the timing of reviews. A follow-up notice to staff will be issued, reminding staff that ACCT reviews are determined by a prisoner's need and risk rather than at set intervals.

2. The Governor should remind all staff to complete the ACCT document properly, with high quality, meaningful entries.

   The recommendation was accepted. A notice to staff has been issued, outlining the expectations of entries in ACCT documents. This will be monitored by management checks.

3. The Governor should remind staff that documents such as wing history sheets should accurately and clearly record any concerns, particularly in the period between ACCT closure and post-closure review.

   The recommendation was accepted. Senior officers will be briefed at their morning meeting about the expectation of P-NOMIS entries, particularly for prisoners in the period between the closure of their ACCT and their post-closure review. Senior officers will relay the information to their members of staff, and compliance will be checked by managers.

4. In addition, the Governor should ensure that staff attending an ACCT post closure review consider all the evidence, including the wing history sheets, about the prisoner's wellbeing since the ACCT procedures were closed.

   The recommendation was accepted. Senior officers will be briefed at their morning meeting about the need to include all relevant sources of information about a prisoner for post-closure reviews. A follow-up notice to staff will be issued, and compliance will be checked by managers.

5. Reception officers completing the CSRA for ACCT prisoners should check the document for concerns about cell sharing.

   The recommendation was accepted. First night officers will be briefed about the importance of checking ACCT documents for concerns about cell sharing when completing CSRAs. A follow-up email will be sent to all first night officers, and compliance will be checked by managers.

6. The healthcare manager should examine its internal system for setting review schedules for those not being monitored under ACCT, to ensure that it is watertight.

The recommendation was accepted. The healthcare arrangements now include three handover periods per day to ensure that reviews are not missed or can be re-allocated if necessary. This is supported by a diary system and alerts on the clinical computer system.

7. The healthcare manager should review the arrangements for following up prisoners who do not collect their medication. This is particularly important for prisoners who are vulnerable due to mental health symptoms.

   The recommendation was accepted. All prisoners are now routinely followed up if they do not collect their medication. Prisoners are required to sign a disclaimer if they do not wish to have their medication, and discussions will take place about the reasons for this.

8. Healthcare staff should take an emergency 'grab bag' and a defibrillator to serious situations, particularly those of a 'code blue' nature.

   The recommendation was accepted. An emergency 'grab bag' is in place, and specific bags for 'code blue' and 'code red' situations are being put together. Defibrillators are now located alongside the bags for ease of access.

9. The Governor and healthcare manager should consider placing emergency 'grab bags' and defibrillators at strategic points throughout the establishment.

   The recommendation was partially accepted. It was acknowledged that this would be beneficial, but it will not be implemented at this time due to issues of ownership, cost, responsibility, litigation and accountability. The healthcare centre will continue to hold emergency equipment.

10. The updated contingency plan for actions following deaths in custody should include a requirement to contact the IMB.

    The recommendation was accepted. The contingency plan was reviewed and now includes a requirement to inform the IMB of deaths in custody.