Investigation into the death of a man in May 2010, in Leicester Royal Infirmary, whilst in the custody of HMYOI Glen Parva

Report by the Prisons and Probation Ombudsman for England and Wales

October 2011

This is the report of an investigation into the circumstances surrounding the death of the man who died aged just 19 years. He was serving a sentence of 28 months and it was his first time in custody. The man was found hanging from the window bars of his cell on 17 May 2010. He was resuscitated by staff and taken to Leicester Royal Infirmary. He died seven days later without regaining consciousness.

I offer my condolences to the man's family and friends. I am sorry that my report has been delayed and I regret any additional distress which this has caused.

The investigation was led by one of my investigators. I am grateful to the clinical reviewer for providing a clinical review of the healthcare offered to the man in Glen Parva. The clinical reviewer attended all the interviews at Glen Parva with my investigator. I received his final report on 14 January 2010 and the delay in issuing this report is mine alone.

I am also grateful to the Governor, who provided a high standard of liaison for my investigator, and to the Governor and staff for their co-operation with the investigation.

The man was a very young man in prison for the first time. He had lived in the UK for a number of years with his parents, sister and older brother and had no close relatives in his native Poland. He was extremely distressed by routine notification from the United Kingdom Border Agency (UKBA) that he would be considered for deportation at the end of his sentence. Despite the best efforts of staff at Glen Parva to look after him and keep him safe, it appears that his anxiety about being deported was a significant factor in his untimely death. This is not the first case I have investigated in which a foreign national prisoner has reacted so drastically to communications about possible deportation.

I make one recommendation on this issue and I endorse a recommendation in the clinical review about barrier protective masks. I will also send a copy of this report to the UKBA for their attention.

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

Thea Walton
Acting Deputy Ombudsman **October 2011**

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SUMMARY

The man came to live in this country with his family in 2005. He had never been in trouble with the police until he was charged with offences relating to the possession with intent of an imitation firearm. He was remanded into custody on 19 November 2009 and went to HMYOI Glen Parva to await sentence.

There were early indications that he might be vulnerable in the prison environment. He had previously led a rather aimless existence and admitted to feeling depressed. He had worked casually for his older brother but mostly stayed at home drinking and smoking cannabis. He reacted to the thought of his first time in custody by attempting to tie the sleeve of his sweater round his neck when still at court and said that he would kill himself rather than return.

This information was passed to the prison but the man denied thinking about suicide when he arrived and he was not assessed as being at serious risk of harm. The first few months of his time in prison were characterised by outbreaks of anti-social behaviour. The man often challenged prison rules and his manner was described as confrontational.

His negative attitude changed when he was sentenced to 28 months imprisonment by Coventry Crown Court in February 2010. The man was shocked at the length of sentence and publicly doubted his ability to cope. He began to share thoughts of self harm with staff. In early March his depressed mood was compounded when he received written notice that he could be deported back to Poland when his sentence ended in January 2011.

The man became more distressed and disclosed that he thought constantly about dying. On 31 March, Assessment, Care in Custody and Team (ACCT) procedures were opened by the prison doctor after concerns about him increased. He remained subject to the close observation and enhanced support provided by ACCT until his death nearly two months later.

I have found that healthcare and discipline staff worked hard to help the man manage his feelings of despair. Among other initiatives, he was allowed to share his cell with a Polish cellmate throughout, had access to the therapeutic day centre and a Polish speaking volunteer for support, was encouraged to keep busy through a range of leisure and educational activities and prescribed anti-depressant medication.

Despite these efforts, the man took the opportunity of his cellmate's absence on 17 May to tie a ligature made from a bed sheet round his neck and attach it to the window grill. His cellmate raised the alarm on his return to the cell. Although he was not breathing when found, a very competent emergency response by wing and medical staff resuscitated the man sufficiently for him to be admitted unconscious to the local hospital. He died there seven days later.

My recommendations concern advice to prisoners when they receive official correspondence and provision of disposable masks for use when administering cardio pulmonary resuscitation.

THE INVESTIGATION PROCESS

1. I was notified of the man's death in May 2010. The investigation was allocated to one of my investigators the following day. Notices were issued to staff and prisoners at Glen Parva telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. My investigator did not receive any response to these notices. My investigator visited Glen Parva on 27 May to open the investigation. She met with the Deputy Governor, a member from the Independent Monitoring Board and a member from the Prison Officer's Association. She also visited the man's cell and spent some time examining his prison record.

2. A clinical review of the man's medical care was commissioned from Leicester County and Rutland Primary Care Trust (PCT). The clinical reviewer was promptly appointed and undertook the review. His report appears at annex one.

3. My senior family liaison officer wrote to the man's parents asking them if they would like to meet with her and my investigator and whether they had any questions or concerns that they wanted to raise. They did not ask for a meeting at this stage, however, another family liaison officer spoke to the man's mother twice on the telephone at draft report stage. The man's mother commented that she wished she had been told about her son's previous attempt to kill himself.

4. My investigator and the clinical reviewer visited Glen Parva on 16 June and 29 September and interviewed ten members of staff. After each set of interviews feedback was provided to the prison liaison officer.

5. The Leicester Coroner held an inquest into the man's death on 3 to 5 November. A verdict of "He hanged himself while the sole occupant of a locked cell", was reached.

The man

6. I know very little about the man and his tragically short life. He was born in Poland in 1991 and moved with his parents, sister and older brother to the UK when he was aged 13. He lived with his parents in Coventry for most of that time but in 2009 he came to live with his brother in Leicester. He was clearly very close to his family and kept in contact with them by letter and telephone whilst he was in prison.

7. He left school without qualifications and worked informally for his brother in a number of Polish shops he owned in the Midlands. He told the probation officer who prepared the pre-sentence report that he was not paid a wage for his work but his brother provided food, accommodation and other material needs.

8. The man told the prison doctor at Glen Parva that he had suffered from low mood since before he was sent to prison. He said that he spent much of his time at his brother's drinking, smoking cannabis and staying in bed.

9. Staff described him as a quiet, polite and likeable young man who was very depressed about the prospect of being deported to Poland at the end of his sentence.

HMYOI GLEN PARVA

10. Glen Parva was originally built as a borstal in the early 1970s and became a youth custody centre when borstal training was abolished (a borstal was a type of youth prison abolished in 1982). It later changed designation to a young offender institution (YOI) and now holds both unconvicted and convicted male prisoners aged between 18 and 21. It has an operating capacity of around 800 prisoners.

11. The Leicestershire County and Rutland Primary Care Trust (PCT) is responsible for commissioning healthcare in the prison. Among other services provided are nurse triage, mental health clinics, GP surgeries and well man checks with access to the dentist, optician and physiotherapist.

12. The primary mental health team states that it has a philosophy of social inclusion aimed at helping prisoners with mental health problems remain in the prison environment wherever possible but supported by a range of options including access to a separate therapeutic day care centre. This provides groups addressing such issues as anger and anxiety, low social skills and learning needs in partnership with the education department.

Her Majesty's Inspectorate of Prisons

13. Her Majesty's Inspectorate of Prisons (HMIP) last inspected the prison in November 2009. The report of the inspection was published in February 2010 when it was noted that:

    "In recent inspections, we have charted the establishment's progress towards providing a generally safe, respectful environment for its volatile population, increasingly focused on resettlement. This full unannounced inspection found that much of this progress had been sustained, although it was of concern that there was insufficient good quality purposeful activity to keep young prisoners occupied."

    Further observations were that suicide and self-harm arrangements were "satisfactory" and although diversity was "generally well managed" more support was required for foreign national prisoners.

Independent Monitoring Board

14. Every prison has an Independent Monitoring Board (IMB) made up of local independent volunteers whose job it is to monitor standards to make sure prisoners are being treated fairly and humanely. Each IMB is required to report every year on their findings. In the last report on the period between December 2009 and November 2010 the following observation was made:

"The Board considers that Glen Parva continues to be a safe and respectful environment."

Against a background of continuing concern about the physical condition of some of the older residential units, the IMB was pleased to note that the prison had been upgraded to Level 4 in the most recent HM Prison Service Audit. This is the highest level of performance possible.

15. Other comments referred to a high standard of entries in ACCT documents, good quality pastoral care by the Chaplaincy and the development and integration of foreign national work into departmental core responsibilities.

Assessment, Care in Custody and Teamwork

16. Assessment, Care in Custody and Teamwork (ACCT) is a care planning tool used by the Prison Service to help monitor and support prisoners identified as being at risk of self harm or suicide. Any member of staff can "open" an ACCT by filling in certain documents detailing their concerns. The process encourages staff to work together to tailor individual care to prisoners in distress. Regular checks and reviews of the prisoner's situation are built in to the process with the ultimate aim of diffusing circumstances where suicide or self harm can take place.

Previous deaths at Glen Parva

17. Before the man died, there had been five self inflicted deaths at Glen Parva since 2005. In 2006, a young man killed himself after he had received notification about the recall process. A parallel can be drawn with this current death in that both young men struggled to cope emotionally with the impact of official decisions communicated by letter directly affecting their immediate futures. In the man's case, the letter communicated the possibility that he would be deported and, in the other case, that the prisoner would have to serve longer in prison. Both decisions were conveyed by letter and neither young man had access to consistent expert advice and support about the implications for them.

KEY EVENTS

18. On 16 November 2009 the man appeared at Coventry Magistrates Court charged with possession of an imitation firearm with intent and assault. He was given bail and a date to appear at Coventry Crown Court in February 2010. Two days later however, he was arrested and remanded to HMYOI Glen Parva. I do not know the details but the reason for his arrest was given as "unlikely to surrender to custody as a person released on bail."

19. The man arrived at Glen Parva on 19 November 2009. A suicide and self-harm warning form (SSHWF) was completed at court and travelled with him to the prison in his Person Escort Record (PER). The SSHWF recorded that the man had said that he would not be returning to the court as he was going to hang himself. Another member of court custody staff saw him attempting to wrap the sleeve of his sweater around his neck.

20. The man completed the prison induction programme the same day. His cell sharing risk assessment form (CSRA) records "no known issues". The officer who did the CSRA reported that the man told him that he had attention deficit hyper-activity disorder (ADHD – a common long term disorder often diagnosed in childhood. The main symptoms are a short attention span and hyperactivity) but had not thought about harming himself. He was judged to be a low risk to fellow prisoners and suitable to share a cell.

21. The man was also interviewed by the first nurse who took him though his first reception health screen. The nurse wrote in the man's medical record that his first language was Polish but he spoke English well. She wrote that he had received treatment from a psychiatrist outside prison and suffered from ADHD. He had been involved in a road traffic accident some five years previously and she gave him ibuprofen for a swollen foot and referred him to the prison doctor. The nurse noted "no thoughts of deliberate self harm".

22. The next morning on 20 November, the man was interviewed by a second nurse who did his second reception health screen. She noted in his medical record that he was a smoker and required a meningitis vaccination and hepatitis B screening. The nurse noted that the man's ankle was swollen and this made him unfit for work.

23. Later the same day an email was sent to safer custody staff from the custody department alerting them to the fact that the man had attempted to harm himself at court.

24. On 27 November, the man was allocated to Unit 14. On 8 December, his security file shows he and his cellmate were heard shouting racist remarks out of their window and making monkey noises. Intelligence was also received that he might be in debt to other prisoners. The

same day he was moved to unit 12 which is the unit for prisoners on remand. On 11 December, he was seen by his personal officer.

25. On 21 December, the man was reported to have refused an order to sit down in his education class and been abusive to fellow pupils. A tackling anti-social behaviour (TAB) action document was opened the same day. On 29 December, the man's personal record shows that he swore at a teacher and was sent back to his unit. He was issued with a warning and improvement notice under the TAB process. He also had a regime level review and was placed on the basic level of the incentive and earned privileges scheme. (IEPS is the scheme whereby prisoners are granted privileges if they achieve specific standards of behaviour. Basic is the lowest level on the scheme.) He was charged the next day with breaking prison rules by disobeying a lawful order.

26. The man's personal officer spoke to the man about his behaviour on 4 January. He recorded that the man was polite to him but that he needed to demonstrate more consistency. The following day the man was returned to the standard regime under IEPS.

27. On 2 February, the man threw his dinner at the wall in the association area and was returned to the basic regime. The first Senior Officer (SO) noted in his TAB regime level review that he laughed throughout the review. He also refused to attend his education class. A further TAB action document entry on 9 February showed that the man's behaviour had not improved. He had received two further warnings since his previous review for shouting abuse at staff from the education block and being disruptive in class. The man was moved onto TAB level two (an increase in anti-social behaviour monitoring) and into a single cell.

28. On 19 February, the man was sentenced to 28 months imprisonment. He was said to be shocked by the length of the sentence as he was expecting to serve about nine months. A TAB review on 23 February noted that his behaviour had improved and he was returned to being monitored on TAB level one. The man's record showed much improved behaviour over the next few weeks. On 5 March, he was removed from TAB one monitoring and a post-closure review was scheduled for 12 March.

29. On 9 March, the man received a letter from the UK Border Agency (UKBA). The letter was a standard one which is sent to all foreign nationals who receive a prison sentence of two years or more. It alerted the man to the fact that he might be deported back to Poland on grounds of public policy/public decency. He was invited to make representations against deportation in the next 14 days. At interview wing and nursing staff told my investigator that the man was extremely upset by this letter. He had no family in Poland who he knew and the prospect of deportation seemed to cause him great anxiety.

30. The man complained of feeling ill on 22 March and was examined by the prison doctor. The prison doctor said that the man had a chest infection but was also tearful and told him that he had been feeling low for about 18 months. The doctor referred him to the primary mental health team and made a note to review him personally in two weeks. In the event the prison doctor saw the man again on 29 and 31 March. The man reported that he still had chest pain and was also nauseous. On 31 March, the prison doctor wrote in the man's medical record that he was low in mood and persistently thinking about killing himself. The prison doctor prescribed the anti-depressant fluoxetine (Prozac) and opened an ACCT document.

31. The man's first ACCT review took place the same day following an assessment. The review was attended by an officer, the mental health service manager at Glen Parva and the first SO. The man was noted to be visibly upset and he was not eating. He said that he had not expected to receive such a long sentence and was struggling with the prospect of being deported to Poland. A CAREMAP was devised including input from the mental health team, education classes, contact with his family and contact with the UKBA to pursue an appeal against deportation.

32. Later the same afternoon the first mental health nurse, visited the man as a follow up appointment. She wrote in his medical record that he thought constantly about suicide. He told her he had a razor blade that he had hidden in the tongue of his training shoe. He told her that he was finding it hard to cope with the length of his sentence. The nurse wrote a care plan that included daily visits from the mental health team until the man's mood improved.

33. The first mental health nurse visited the man again the next day on 1 April. He appeared slightly better and had received a Polish magazine in the post from his mother. The daily visits from the mental health team continued. On 5 April, the mental health service manager reported that the man was tearful and threatening to harm himself because he had been told that he would have to move units now he was a sentenced prisoner. The next day, 6 April, he made superficial cuts to his arm with a razor. He was taken to the healthcare centre and examined by a nurse and a member of the mental health team.

34. At interview the first SO said that the man had been very upset at the prospect of moving to a sentenced unit. In recognition of this she told him that she would try to keep him on Unit 12 and, if population pressures dictated that he had to move, he would be able to move with his Polish cellmate. She said the man was happy with this compromise. The same day, 7 April, he went to the therapeutic education group on the healthcare centre and appeared calm and settled.

35. Over the following week the man continued to go to the therapeutic group on the healthcare centre and received daily visits from the mental health team. He complained regularly of gastric discomfort and nausea and was examined by two locum doctors. On 14 April, he had an ACCT review with a second SO, a third nurse and member from the mental health team. The man said that he felt physically and mentally unwell but felt supported by his Polish cellmate. He said that thinking about his mother helped him control his urges to harm himself. The review decided that the ACCT should remain open.

36. The man continued to go to the therapeutic group in the healthcare centre. He was visited regularly by mental health staff. The first mental health nurse who could speak to him in Russian, took the man for walks in the prison grounds. He also visited the chapel regularly where he spoke to a Polish speaking community volunteer. He continued to complain of feeling physically unwell but, despite undergoing blood, faecal and urine tests, no physical illness was discovered. His ACCT was reviewed weekly and remained open.

37. Towards the end of April and early May, the ACCT record shows that the man's mood appeared to pick up a little. He went out of his cell for association with his peers. During one of his walks in the grounds with the first mental health nurse, she reported that he was cheerful and looking forward to a visit from his mother. On 5 May, however, he again made superficial cuts to his arm with a razor. His ACCT was reviewed and the man was tearful, telling staff that he could not get his sentence into perspective. His ACCT observations by staff were increased to half hourly.

38. The next day the first SO spoke to him at length and reported that he was quite cheerful by the end of their conversation. The man's reviews were returned to hourly at irregular intervals.

39. On 11 May, a first office noticed that the man had marks on his neck. He said that he had tied some bedding around his neck and tried to kill himself. He was moved temporarily to the anti-ligature cell on unit 10. The member from the mental health team visited him there. She reported that he was very tearful and had a friction burn to the back of his neck. At an ACCT review later the same day the man said that he had scared himself and did not want to die. He returned to his cell on unit 12 and promised to tell staff if he felt that he could not cope. He also went to the chapel to see the Polish speaking volunteer and was reviewed by a fourth nurse.

40. Over the next few days the man appeared to settle down. Staff reported that he appeared to have been genuinely scared by his suicide attempt and pleased that he had not succeeded.

Events on 17 May

41. On 17 May, the man was seen by wing staff three times between about 7.00am and 8.30am and no concerns were reported about his mood. At 9.30am, however, he did not report to collect his medication. He was seen by a member from the Community Health Service and signed a disclaimer about not collecting his medication. The man said that he was being bullied by another prisoner on a different unit although he did not identify them by name.

42. At 10.00am, the man was reported to be in good spirits when a second officer asked him if he wanted to go out of his cell for morning association. The man refused but his cellmate accepted the opportunity. At 11.21am his cellmate returned to his cell and immediately alerted staff that the man was hanging from the window bars.

43. The first officer on the scene reached the cell. He looked through the observation hatch and saw the man suspended from the window grill facing towards the window. He used his radio to call for help and opened the cell door. The officer used his left arm to take the weight of the man's body and cut the ligature which was made from a bed sheet with his anti-ligature knife.

44. The first officer on the scene described in his statement to the Governor that he then laid the man on the floor as gently as possible. He could not see any signs of breathing and he transmitted this information on his radio. The second officer on the scene had arrived by this point and both men started cardio pulmonary resuscitation (CPR). The second officer on the scene gave chest compressions and the first officer on the scene the rescue breaths. They continued CPR until the nursing staff arrived to take over.

45. The first nurse on the scene had been designated 'Hotel 1' with specific responsibility to respond immediately to a call for medical assistance. The first officer on the scene had identified the situation over the radio as a 'code blue' which the first nurse on the scene recognised as emergency shorthand for when a patient is not breathing.

46. While the officers continued CPR in the cell, the first SO arrived and cleared the landing of a number of prisoners who had started to gather. She arranged that they and prisoners from other landings returning from association should collect in the wing television room, thus clearing the landing and giving easier access for medical staff.

47. On arrival at cell 17, the first nurse on the scene took over mouth to mouth resuscitation from the first officer on the scene. He left the cell and went to the landing stairwell where he met the third officer on the scene who was carrying the defibrillator and the 'Ambu Bag'. (A defibrillator sends an electrical impulse to the heart to detect signs of

activity. It instructs the user if it is possible to attempt stimulation of any heart beat. An Ambu Bag contains equipment to ventilate a patient and help them with breathing). The first officer on the scene took the defibrillator and returned to the cell to give it to the medical staff.

48. The first nurse on the scene moved to maintaining chest compressions allowing her colleague Healthcare Assistant (HCA) to take over the breaths. The third officer on the scene assembled the oxygen and took over chest compressions to free up the first nurse on the scene. She then inserted a Guedal airway into the man's mouth, attached the oxygen cylinder to the 'Ambu Bag' and called for the defibrillator.

49. The two healthcare staff continued to do 30 compressions to two breaths and attached the defibrillator. At this point, the first nurse on the scene said that there was no pulse and no discernable breathing. Neither the defibrillator nor stethoscope examination showed a heartbeat. However, after "several cycles" of CPR a carotid pulse was found and the defibrillator indicated to carry on.

50. At 11.28am the first paramedic arrived and they confirmed that the man had "cardiac output", meaning that his heart was still functioning. The first nurse on the scene and HCA continued CPR using the 'Ambu Bag', mask and oxygen and stopped only when the full ambulance crew took over at about 11.40am.

51. The man was then taken to Leicester Royal Infirmary by ambulance and arrived at Accident and Emergency at 12.05pm. His family were told about his situation and they visited the hospital later that afternoon. Sadly, he remained sedated for the next seven days and died without regaining consciousness.

ISSUES CONSIDERED

Clinical care offered to the man

52. The clinical reviewer reported that he found no issues of concern over the clinical care received by the man whilst at the prison. He said,

> "He had very good access to care for both physical and mental health issues and was able to attend Day Care more easily than he might have been in a similarly low mood in the community."

53. The clinical reviewer remarked favourably on the approach taken by the prison to try to integrate vulnerable prisoners like the man into the main prison environment. Indeed, he commented that this "offered him the best chance of surviving his depression".

54. The clinical reviewer was concerned that the Home Office had contributed to the man's emotional instability by sending a communication about deportation when he may eventually not have been subject to it. He asked that consideration be given to alerting the appropriate government agency about the often disproportionate anxiety such information may cause, especially for prisoners with mental health problems. I will send a copy of this report to the UKBA for their consideration.

55. The clinical reviewer was asked to consider whether the effectiveness of the anti-depressant medication prescribed to the man would have been undermined by interruptions when he failed to collect medication. In interview, the HCA said that she remembered the man missing his medication at least once a week. He also complained of stomach problems for part of this period which included bouts of nausea and vomiting which could have reduced the regular ingestion of prescribed medication.

56. The clinical reviewer replied that there had been a break in the man's medication between 20 April and 28 April when it was thought that the fluoxetine might be causing some of his abdominal and sickness symptoms. The man then started a different anti-depressant (Citalopram) which continued until his death. The clinical reviewer thought that, although it was possible the man could have been somewhat lower in mood whilst he was not taking the medication, it usually takes about two weeks for the effect to wear off and two weeks to resume after starting a new drug. On the days when the man declined his medication, a member of the mental health team always spoke to him about it, which was appropriate.

Support offered to the man

57. My investigator agreed with the clinical reviewer about the quality of support from both medical and other staff to assist the man to manage his distress. Once aware of his fragility, I believe that a great deal of thought and effort went into providing individualised support to try to help him. He had regular contact with wing officers, healthcare staff and doctors. Arrangements were made for him to see a Polish volunteer in the chapel when he needed and he was encouraged to go for accompanied walks in the prison grounds with members of the mental health team. He also had access to the therapeutic day centre where he took part in various support groups and educational activities.

58. His wish to share with a Polish cellmate was respected and efforts made to keep him on Unit 12 even after he had been sentenced. Once aware of his fear of moving to another unit without any Polish speakers, staff promised that he would only be moved with his cellmate. He clearly took comfort from the opportunities to speak and read Polish and he was given Polish newspapers and magazines. The man attended chapel in the prison on a number of occasions and received pastoral support from members of the Chaplaincy.

59. I am impressed by the interest shown by prison staff in the man's welfare. In interview, they came across as being fully committed to helping him as much as possible. I believe that their regret that their efforts were not successful in preventing him from taking his own life was real and profound. I draw the attention of the National Offender Management Service's (NOMS) Offender Safety, Rights and Responsibility (OSRR) team to the examples of good practice in my report.

Management of risk of self-harm and the ACCT process

60. When the man arrived at the prison, the fact that he had attempted to harm himself when remanded into custody was recorded in the PER that accompanied him from court. This does not appear to have been considered by staff assessing him for cell sharing risk procedures and doing the first healthscreen. However, the man, himself, denied thinking about harming himself when he was interviewed during induction procedures by officer who finished the cell share risk assessment and the nurse who did the first reception health screen. The Safer Custody team, however, was alerted the next day to the events at court although it is not clear in the documents available what use was made of this information. This is a routine process which Glen Parva have set up and again I draw it to the attention of the NOMS OSSR team.

61. The early part of the man's time in prison whilst on remand was characterised by episodes of anti-social and poor behaviour. This was addressed appropriately through the TAB process and removal of privileges though the IEP scheme.

62. I think that the shock of being sentenced to 28 months custody in February when he had only been expecting nine months significantly changed the man's mood. He shared with staff that he had suicidal thoughts and showed overt distress not just at the length of his sentence but also at the prospect of being deported after receiving the letter from the UKBA in early March.

63. When the prison doctor first opened the ACCT documents on 31 March, it was an appropriate response to an escalation in the man's distress. Thereafter, the process showed good co-operation and communication between discipline and medical staff. Subsequent ACCT reviews were multi-disciplinary and held at regular defined intervals. Observations and written entries by staff mostly show careful consideration of the man's situation and reinforced the findings of the last IMB report that the quality of assessment in the ACCT process at the prison was of a "good standard". The ACCT support and monitoring process is designed to provide individualised, multi disciplinary care for vulnerable prisoners. I judge that the arrangements made for the man fully met the provisions of the Prison Service Order.

Bullying

64. On the morning of his last suicide attempt, the man reported for the first time that he was being bullied by an unnamed prisoner on another unit. It is not recorded what form the bullying took or in what circumstances. Less than two hours later he was found hanging in his cell. I do not consider that there was a realistic opportunity in that time for prison staff to explore this with him. He spoke to a member of healthcare staff and, although he had ample opportunity to raise it with a wide range of people previously, this is the only time when bullying was mentioned.

Fear of deportation

65. The possibility of deportation on release clearly preyed on the man's mind to a recurring degree. Individual staff made efforts to reassure him and remind him that it was not a foregone conclusion but they were ultimately not effective in calming his fluctuating panic at the prospect.

66. The letter from the UKBA and accompanying information is official and serious in tone. It is understandable how frightening this might be to anyone unused to bureaucratic documents, particularly when English is not their first language. Although there are a number of comments in various documents about the man's English being good, there are, equally references to deficiencies in this area. He was consistently

encouraged to attend ESOL (English as a Second Language) classes. The probation officer's assessment of his ability at the sentencing stage identified improving English as a key aim for the future. It is likely that the man was reasonably fluent in everyday speech but not so proficient in deciphering more complex legal language that can be the hallmark of government agencies. Of course, there are reasons for this as the communication has legal status, needs to convey a serious situation and this will inevitably determine the tone. However, there does not seem to have been any thought given to a Polish translation of information either by the prison or UKBA.

67. After he received the letter from UKBA, the man was told that he would be allocated a caseworker to help him contest deportation. However, the implication was that this would be nearer his release date in 2011 and there is no record that he ever saw anyone with specialist knowledge at this early stage in the process. The local Immigration Service ran workshops at the prison but there is no evidence that the man was told this or had the chance to attend.

68. In interview, the first SO spoke about the frustration for prison staff trying to help prisoners understand ambiguous and confusing information from the UKBA. She highlighted the need for better links between prisons and government departments and said, "If we can't give them [the Young Offenders] the answers, how are we supposed to manage them?"

69. At the time, the prison did not have staff with specific responsibility to oversee deportation issues and work with foreign national prisoners to manage the psychological impact of living under such uncertainty. I understand from the IMB report that a local management plan to integrate foreign national work more closely within prison departments has been drawn up in the last year and I hope that this initiative takes into account learning from this investigation.

The Governor should ensure that prisoners are given continuing access to expert competent advice when in receipt of official letters from other government departments and agencies which could seriously affect their future (eg decisions about parole, recall, deportation, appeals etc).

Emergency response

70. The clinical reviewer commented positively that the wing officers began CPR so speedily when the man was discovered hanging. He also commended officers for their decision to start CPR without protective masks and noted that this "certainly gave the man the best chance of survival". The clinical reviewer made the following recommendation:

The Governor and head of healthcare should consider making disposable pocket masks available to those staff trained in CPR to reduce the small but possible risk of infections such as tuberculosis being passed on.

71. The first officer on the scene said in interview that it would have helped him to have such equipment immediately available and I endorse this recommendation. It must be emphasised, however, that the absence of a mask did not deter the officer from starting rescue breaths immediately. I note that I made a similar recommendation in a previous investigation at Glen Parva into a death in June 2006 which does not appear to have been implemented. I ask the Governor to look again at this issue.

72. Although the man was not breathing when he was found and the first nurse on the scene could not find a heartbeat at first, strenuous efforts at resuscitation appeared to have been successful when a pulse was detected after a few minutes. The prison doctor was on duty in the prison on 17 May and he arrived to witness CPR already being given by prison and medical staff. He described what he saw as "perfect resuscitation" and clearly felt no need to intervene medically.

73. CPR was continued by paramedics and the man was treated in hospital for the next seven days before he died. That he initially survived such a serious attempt on his own life is perhaps evidence of the effectiveness of the prison's emergency response.

74. One area of concern, however, raised by the Governor in his review for the governing Governor, was the fact that the defibrillator was not immediately available. It had been "bleeping" during the night and had been removed for re-charging. The Healthcare manager noticed its absence as soon as the emergency call came over the radio and she quickly retrieved working batteries. She then gave a second defibrillator to staff to take to the cell. In the event, it does not seem as if any appreciable time was lost on this occasion. However, the absence was only noted at 11.30am prompted by the emergency and this seems an unacceptably long gap from the night before to replace essential equipment to its rightful location.

CONCLUSION

75. This is a very sad story. The man was a very young man who could not see a future for himself if he were to be deported to Poland away from his family. His case raises issues that I am already familiar with and highlights the need for improved information sharing between UKBA and the prison staff who have a duty of care to prisoners subject to deportation.

76. I have found that the man received a very high standard of care from staff of all disciplines at Glen Parva. Their commitment to helping him and sadness at his death was palpable. I draw the attention of those responsible for safer custody in NOMS to the individualised arrangements set up to try to support the man. Tragically, despite their best efforts, it appears that he was determined to end his life.

RECOMMENDATIONS

1. The Governor should ensure that prisoners are given continuing access to expert competent advice when in receipt of official letters from other government departments and agencies which could seriously affect their future (e.g. decisions about parole, recall, deportation, appeals etc).

   The prison accepted this recommendation at draft report stage and responded:

   "Correspondence is managed correctly. There are trained legal staff that can act as a conduit to access legal advice. Matters of immigration are handled by the Immigration Service. We have a regular surgery carried out by the UKBA where support and information is offered. We will ensure prisoners continue to receive this support."

2. That HMYOI Glen Parva consider making disposable pocket masks available to those staff trained in CPR to reduce the small but possible risk of infections such as TB being passed on to rescuers.

   The prison accepted this recommendation at draft report stage and responded:

   "All Units at HMYOI Glen Parva have sealed self harm response kits that contain both disposable and multi use rescuer masks. In addition all units are provided with sealed first aid kits that contain a disposable pocket mask. These kits are held in the unit offices for ready use. All first aid trained staff and emergency first aid at work staff are provided with a disposable pocket mask when they have completed their training. Replacement masks can be obtained from the Occupational Health and Safety Department. All staff trained in first aid are informed of the contents of the kits as part of their training. This system has been in place for many years. The Officer who was the first on scene in this case was not a qualified first aid trained member of staff, so would not have routinely been issued a disposable pocket mask."