

**Investigation into the circumstances surrounding the
death of a man at HMP & YOI Glen Parva in June 2006**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

August 2007

This is the report of an investigation into the death of a man at HMP & YOI Glen Parva in June 2006. The man was found hanging in his cell. He was only 20 years of age.

My colleagues and I offer sincere condolences to his family and friends for their sad loss.

This investigation has been undertaken by two investigators from my office. I would like to thank the Governor of HMP Glen Parva and her staff for their participation in the investigation. Particular thanks go to Deputy Governor, who acted as the establishment's Liaison Officer.

A medical practitioner from South Leicestershire Primary Care Trust (PCT) undertook a review of the man's clinical care, and I also greatly appreciate his assistance.

The man was young and vulnerable, and had been recalled to custody following breach of licence conditions. However, there is no evidence that he had confided in staff any intention to harm himself. His death also came as a great surprise to his cellmate. I do not think the circumstances were such that staff could reasonably have predicted that he would attempt to kill himself.

The clinical review has raised a number of matters of concern. I am particularly surprised to learn that it is not normal practice for healthcare staff to obtain GP records. I am also concerned that not all staff at Glen Parva may be up to date with the most recent resuscitation guidelines (albeit the resuscitation attempt on this young man was speedily and efficiently carried out). Both these matters are of wider significance and I draw them to the attention of the authorities.

I make eight recommendations largely based on the clinical review.

Stephen Shaw CBE
Prisons and Probation Ombudsman
August 2007

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SUMMARY

The man was just 20 years old when he was found hanging in his cell at HMP & YOI Glen Parva in June 2006.

He had been sentenced to four years detention on 6 February 2004 for offences of robbery and attempted robbery. He was initially detained at HMP & YOI Werrington and was released on licence on 4 October 2005 from HMP & YOI Moorland.

In April 2006, the National Probation Directorate notified the Parole Board that the man had breached the conditions of his licence. Under the section for 'offender's detail' in the notification report, it was recorded that he 'had issues of vulnerability in custody: Self harm, allegedly tried overdoses on two separate occasions whilst on licence.' The report reached the Early Release and Recall Section (ERRS) of the Home Office on 21 April 2006. They agreed that the man should be recalled to custody immediately. The man eventually surrendered to the police voluntarily and was returned to custody at Glen Parva on 4 June 2006.

During his First Reception Healthscreen at Glen Parva, he said he had self-harmed in 2003 and it was noted that he had been on suicide and self-harm monitoring at HMYOI Stoke Heath in that year. The First Reception Healthscreen form says, 'did not actually SH (self-harm) was on 2052SH (self-harm observation regime) 2003.' The Prisoner Escort Record (PER) from the police station to Glen Parva noted a risk of self harm and said that the man had been banging his head. There was no further detail on the form. This information was not recorded on the First Reception Healthscreen form.

The man was initially located on Unit 15 at Glen Parva. He was moved to Unit 8 on 9 June, and to Unit 10 on 12 June. On 13 June, he showed distress about his return to prison and said he was finding it difficult to cope. However, he declined to talk to a Listener (a prisoner trained by Samaritans to befriend other prisoners who are feeling low). The man's concerns were discussed with an officer, and he was able to talk to his partner on the unit mobile telephone. He saw a probation officer on 13 June and 15 June who explained the recall process and how to appeal (he had received his recall paperwork on 14 June). The man asked if he could transfer to Unit 2 as he did not know anyone on his current unit. He moved there on 16 June.

On 23 June, the man spoke to an officer about his distress regarding his recall. He was asked if he wanted to speak to a Listener, but by the end of the discussion with the officer he said he felt happy enough not to need further support. That day, he had a successful visit with his partner which he described as 'brilliant' and he appeared in good spirits. His cellmate said he did not notice any signs that he was anxious that evening. They watched television together and 'had a laugh'.

The cellmate did not notice any signs that the man was distressed the following morning when he was unlocked at around 9.10am to go to chapel

and the man offered to do his cleaning job. The man's offer was declined as there were sufficient cleaners on the landing.

At around 9.30am, the man was found hanging in his cell. Resuscitation was attempted by prison staff. The man was then transferred to the local hospital, but staff in the Accident and Emergency Department were sadly unsuccessful in their attempts to resuscitate him. The man was pronounced dead soon after.

The clinical review concludes that the man's clinical care was, overall, of an adequate standard. However, it highlights a number of areas where improvements could be made, particularly to systems of recording and sharing information. He suggests the timing and venue of the first reception healthscreen should be reconsidered. Following this, a full medical assessment should be scheduled in office hours in a more neutral environment. The clinical reviewer also considers that it should be normal practice to obtain GP records for prisoners. Finally, he recommends that barrier masks should be carried by all staff and that staff should be kept up to date with resuscitation guidelines. Nevertheless, he says that, 'the resuscitation attempt was swiftly co-ordinated and executed. The timely request for help and arrival of staff gave the man his best chance of survival.'

The clinical review contains a number of recommendations which I have endorsed.

THE INVESTIGATION PROCESS

1. My investigators studied all relevant prison records relating to the man. These included his main prison record, his medical records and statements from prison staff.
2. The clinical reviewer carried out a review of the man's clinical care on behalf of South Leicestershire Primary Care Trust. I am grateful for this review being undertaken in a most timely manner.
3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.
4. One of the investigators and one of my family liaison officers met the man's mother, his sister and his partner. They said that the prison's family liaison officer, a prison chaplain, and the Duty Governor visited them to tell them of the man's death. The man's partner, whom he had named as his next of kin, was visited first. The family said communication with the prison's family liaison officer had been excellent and they sent him a thank you card. The prison has paid towards the cost of funeral expenses. The family also said that the man's belongings had been returned in a timely manner.
5. The family expressed concerns about the man's state of mind prior to his apparently taking his own life. The family believe that he had a meeting with his solicitor the week he died, and that the solicitor told him he would not have to serve a lengthy custodial sentence. His partner described his feelings of despair during her last visit on 23 June. She said his emotions fluctuated, and at one point he put his head on the table and wept. He told her that he was finding it difficult to cope in prison and being away from her, and had found another way to do it (to end his life) in that he could put a bag over his head. This information was not given to staff at the prison. His partner said the man's mood had improved by the end of the visit and they parted on a positive note. He also asked her to be at his mother's house the following Tuesday to receive his telephone call.
6. During a telephone call before that visit, the man told his partner that he had made a rope but had thrown it away. She said she did not believe he was seriously thinking about committing suicide. The man's sister agreed and said she thought he had been 'attention seeking'. However, his mother said that, if she had known that he had made a rope, she would have taken it seriously and not regarded it as attention seeking. (There is no evidence that staff at the prison were aware of him having made a rope.) The partner mentioned that she had been interviewed by the police following the man's death.

7. The family questioned why a prison officer was not concerned when the man did not greet him as usual during his morning round, and why the man was not placed on 'suicide watch' in light of the distress he displayed. They also queried why the man was not allowed out of his cell on the morning of his death. They asked at what time he died and whether he would have experienced a lot of pain. They also questioned how he was able to hang himself as he was 6' 4" tall. The family want to know whether the telephone calls that the man made to his partner were recorded and if so, whether they are allowed to have a copy of the transcripts. Finally, his mother wants to know whether he received the money she sent to him before he died. Prior to the inquest, the man's family would like to see some notes they were told the man had crumpled up and thrown in his cell bin.
8. I hope this report and the clinical review report provide the man's family with answers to their questions.
9. My investigators discussed aspects of the man's treatment with staff at Glen Parva, with the National Probation Service and with the clinical reviewer. Ten members of staff and the man's Probation Officer were interviewed during the course of the investigation. Statements taken by the police were also obtained from the officer in charge of the police investigation.

HMP & YOI GLEN PARVA

10. Glen Parva was built in the early 1970s as a borstal. Following the abolition of borstal training, it became a youth custody centre and then a young offender institution, holding both convicted and unconvicted. Glen Parva serves a large catchment area of more than 100 courts and is a complex and busy institution.
11. All prisoners spend their first six nights in an induction unit before moving to accommodation and activity designed to address work, training and offending behaviour needs. The prison's design and standard of accommodation is acceptable by the standards of over 30 years ago. However, grilles in front of windows restrict the entry of light. They also provide easy ligature points, as do the ventilation holes on the inside of cell doors.
12. The most recent report by HM Chief Inspector of Prisons was published in December 2004 following an announced inspection conducted in September 2004. The report noted that Glen Parva held a large number of potentially volatile young men and was in the process of considerable change. Although her report found shortcomings in education and noted the lack of an effective personal officer scheme, it identified that many staff were embracing change. Senior managers had a systematic approach to progress, and Glen Parva was seen as a fundamentally safe establishment with good work shown with the vulnerable and disturbed young people it holds.
13. Suicide and self-harm procedures at Glen Parva are good. The prison has adopted the Assessment, Care in Custody and Teamwork (ACCT) system of managing prisoners at risk of suicide or self-harm. Notices and other literature, notably in respect of access to Samaritans and Listeners, are widely displayed and available throughout the prison. The suicide and self-harm committee meets monthly, has a full and appropriate agenda and is well attended by staff, prisoners, and Samaritans.
14. The provision of healthcare within Glen Parva is the responsibility of the South Leicestershire PCT. Primary care clinics are delivered by GPs and visiting consultants. The healthcare centre has the opportunity to draw upon the broader expertise and range of healthcare services at the local hospital. The healthcare team consists of doctors, nurses and healthcare assistants.
15. There is an in patient ward where all cells have integral sanitation. The ward is staffed by registered mental health nurses. They provide care for patients with mental health needs (and some with physical needs) which require 24 hour nursing presence.
16. There had not been a death at Glen Parva for almost five years prior to July 2005 when there were two apparently self-inflicted deaths.

KEY EVENTS

17. On 6 February 2004, the man was sentenced to four years detention. He was released on licence on 4 October 2005, having served 18 months of his sentence. His licence was revoked on 21 April 2006, after a recall review by the Early Release and Recall Section (ERRS) of the Home Office.
18. Probation records show that he had not conformed with the requirements of his licence: 'the man has failed to attend probation appointments on three separate occasions dated 14 November 2005, 16 December 2005 and 10 April 2006. On 14 November and 16 December, he agreed to attend appointments with the Employment, Training and Education officer. He did not attend or offer any explanation for these absences which are classed as automatically missed. On 10 April 2006, he arrived late for his Think First group work programme.' The man had been sent a final written warning on 20 December 2005, and on 5 April 2006 he had been told that any further absences would result in recall.
19. The man's probation officer explained that she saw him in February 2006 and had concerns about his relationship with his partner. She said it was a difficult for him to cope with, and she recalled the man talking about harming himself after a particularly bad time in the relationship. She said she saw him on one occasion after he had broken up with his partner. He had told her he had taken a few pills which had made him 'woozy' and she advised him to see his GP. She recorded the information on the Probation Service's computer system. The probation officer explained that, if she had had serious concerns about the man's mental health, she could have referred him to the Mental Health or Personality Team. She said he had previously received two warnings about attending meetings and there had been a number of occasions when he had been given the benefit of the doubt about late and missed appointments. She said he was due to attend the Think First programme on 10 April 2006 at 2.15pm, but had arrived a lot later.
20. The probation officer said the man told her he was late for the appointment because his partner had stomach pains and he had taken her to hospital. When he could not find a parking space, he had driven home and got a lift back to the probation offices. The probation officer said she told the man he should have made alternative arrangements to get his partner to hospital as his probation appointments took precedence over his personal life. She also pointed out that he was breaking the law by driving unaccompanied in a car with only a provisional driving licence. She then explained to him she was going to recommend his recall to custody for breaching his parole licence. This was his third unacceptable absence and he had driven without a licence. (The Probation officer said acceptable reasons for missed appointments could be if the Probation Service were informed

beforehand, attending medical appointments or in cases of emergencies.)

21. The probation officer subsequently notified the ERRS of a breach of licence and the man was recalled to custody. Under the section headed 'offender details' in the report, it was noted that the man 'had issues of vulnerability in custody: Self harm, allegedly tried overdoses on two separate occasions whilst on licence.'
22. The man arrived at Glen Parva on 4 June 2006. During his First Reception Healthscreen, he said he had previously self-harmed in 2003. It was noted that he had been on a F2052SH (the self-harm and suicide observation regime that preceded ACCT) at HMYOI Stoke Heath. It was recorded that he, 'did not actually SH (self-harm) was on 2052SH (self-harm observation regime) 2003.' The Prisoner Escort Record (PER) which accompanied him from the police station to Glen Parva noted a risk of self harm and said the man had been banging his head on the wall. There are no further details and this information was not recorded on the First Reception Healthscreen form.
23. The man's GP records were not obtained. In fact, the consent form for sharing medical information records was not signed by him as the nurse undertaking the First Reception Healthscreen was not aware of the correct protocol. The man did not have a secondary healthscreen by a doctor as he had previously been in custody.
24. When a prisoner's licence is revoked and they are recalled to prison, the receiving establishment should contact the ERRS for a copy of the recall paperwork. According to Prison Service Order (PSO) 6000, Parole Release and Recall, the recall paperwork must be issued within 24 hours of the ERRS being told of a prisoner's return to custody. The paperwork must explain to the prisoner the reasons for their recall, and include information from the Probation Officer giving details. Annex A of the paperwork explains the prisoner's right of appeal to the Parole Board. There is a form which should be returned by the prisoner to the ERRS within five days if they want to appeal against the decision to recall them to prison.
25. On 5 June 2006, the officer who works in Glen Parva's custody office, faxed a memo to ERRS asking for the man's recall paperwork to be forwarded to the prison. The paperwork was posted by ERRS on 9 June and arrived at the prison on 12 June. (The paperwork was given to the man on 14 June.)
26. The man was initially allocated a cell on the Induction Wing – Unit 15. He moved to Unit 8 on 9 June, and to Unit 10 on 12 June. There were no issues of concern until 13 June.
27. An senior officer (SO) who is also a residential wing manager, spoke to the man on 13 June, as he was very tearful and told her he was

finding it difficult to cope with being back in prison. The man had not been able to speak to his partner as his PIN was not working and he did not have any credit on his phone. The SO offered to contact her on his behalf, but she did not answer the call. The SO then arranged for a wing officer to phone the man's partner. (A new PIN with £3.00 credit was later authorised by the governor on duty so the man could make telephone calls.) The SO said the man was also very upset generally about his licence recall. He kept saying he had not done anything wrong since 2003, and felt his recall was unfair. He told her that, when he turned up for a probation meeting on 10 April 2006, he had been turned away because he was too early. He said he then had to take his then partner to hospital, but when he returned he could not park and was late for his probation appointment. (This is a slightly different account to the one the probation officer recorded.) The SO arranged for the man to see a Probation Officer working in Glen Parva. The man's partner was not his partner at that stage.

28. The SO said that, when she had finished talking to the man on 13 June, she felt he had worked out any problems that he had. She asked him whether he was feeling suicidal, which he denied. Arrangements were made to move him to Unit 2, as he did not know anyone on Unit 10. He moved to Unit 2 on 16 June.
29. The prison probation officer also saw the man on 13 June, following the SO's request. She said that the man was very concerned about being recalled to prison and did not understand the recall process. He thought he would be detained until his sentence expiry date which was 14 November 2007. However, she explained to him that the Parole Board would review his case and told him he would probably be released before Christmas 2006. She noted in his core record, 'Seen by Probation. Explained recall process. I will phone outside probation officer (PO) and see the man on Thursday. Upset, talked of being desperate.' The probation officer explained to my investigators that the man had told her he was desperate because he thought he was going to be in prison for a long time. However, she said he was a lot happier after she had explained the recall process. She said the man did not indicate he had any thoughts of self-harm.
30. As noted above, the man received his recall paperwork on 14 June. The prison's probation officer saw him again on 15 June. She said she went through the paperwork with him, specifically explaining the reasons for his recall and the risk management plan for how the Probation Service would manage him on release.
31. The man saw a doctor on 13 June, complaining of back pain which had developed while he was in the gym. The doctor assessed him and concluded there was little of significance with this injury. A request was made to 'get old notes' relating to an injury sustained six weeks previously. There is no evidence this happened. The entry in the

medical record is dated, but the signature is illegible and the doctor's name is not printed.

32. On 16 June, the man moved to Unit 2, cell 3-15, which he shared with prisoner A. On 20 June, the man saw a doctor again. He complained of shortness of breath but no cause was found. Again, the signature in the medical record is unclear and the doctor's name is not printed.
33. A prison officer told my investigators that on 23 June he spoke to the man in the morning about a number of concerns. He explained that the man had returned early from working in the kitchens and was visibly upset and crying. They spoke for between half an hour and an hour. The officer said the man told him he should not be in prison and had been recalled unfairly. The man said that he had taken his partner to hospital, suffering an apparent miscarriage. The officer said the man seemed fairly stressed. He mentioned his current partner and said they had a 'roller coaster relationship'. The man said, 'I don't know what she's doing, she is going to be cheating on me, she is going to be doing this, she is going to be doing that.' The prison officer said they spoke about his lack of trust in the relationship and other issues. Out of the blue, the man said that if he could speak to his mum everything would be alright. (His partner has clarified that she was not the partner the man mentioned taking to hospital).
34. The prison officer explained that the man was returned from working in the kitchens because he was upset, not because of any discipline problem. The officer said he assured him that he would not be placed on Governor's report (a disciplinary charge) for returning from the kitchens. He said that, after he had talked through a number of issues, he told him that he felt happy. The officer asked him if he wanted to speak to a Listener, but he said he was fine. The man's partner visited him, and when he came back he told the officer the visit was 'brilliant'.
35. The SO was working in the visits area that day and remembered witnessing the man's visit with his partner. She recalled that the man was 'quite lively' waiting for his visit and was shouting across to a friend he knew on Unit 2. She said she asked him to calm down as he was disturbing other visitors. After realising he had spoken to the SO previously, and that she had helped him with moving to Unit 2, the man calmed down and waited for his visit. The SO said the man's partner visited him with a friend and two or possibly three children (she could not recall exactly). She said, 'He was making quite close contact with his girlfriend because he was upset. Unfortunately, the rules state that they can't actually come through the table area so I mentioned it to him once and then I actually had to go over and he was miffed really that I had to mention it. His girlfriend on the other hand understood that these rules are to be abided to and she sat down and he said "this is miss I spoke to, she's helped me loads and she got me moved to unit 2."' She said the man was quite lively throughout the rest of the visit.

When she escorted him back to Unit 2, he was boisterous, chirpy and pleased the visit had gone well.

36. The man's personal officer said the prison officer had told her the man was feeling insecure so she spoke to him at around 4.00pm after his partner's visit. The man told her he was 'feeling good now,' and she assumed he meant his visit with his partner had gone well. The personal officer had a general chat with him and some other prisoners who were there. She told my investigators that the man appeared fine. The officer did not record this conversation on the man's Record of Events sheet.
37. In his police statement, prisoner A said that when the man returned to his cell following his visit he appeared fine. He said, 'The man told me that his partner had told him that she was going out that evening, but he didn't appear bothered about it.' He added that the man had written a letter to his partner which he said he would post on Monday (27 June). Prisoner A said they both watched Big Brother later in the evening and had a laugh and a joke together.

EVENTS ON 24 JUNE

38. At 9.05am on 24 June, the landing officer collected prisoner A from his cell to take him to the chapel. There were no apparent problems at this time although, according to prisoner A, the man did ask the officer whether he could be unlocked to complete prisoner A's cleaning duties. The officer did not allow him to carry out the cleaning, explaining that he was about to unlock the other cleaners to complete the task.
39. A mandatory drugs testing officer, visited Unit 2 that morning to collect a prisoner from cell 3-13 for a mandatory drugs test. He said he passed by the man's cell and thought it was a little strange that the man did not call out to him and say hello as he normally did.
40. Prisoner's B cell is opposite the cell which the man occupied. After the man's death, he told both prison staff and the police that, immediately after the landing was clear that morning, the man had covered his cell observation hatch with a towel. It appears no staff saw the towel until the prison officer went onto the landing and began unlocking the cells as usual at around 9.30am.
41. The prison officer unlocked a number of other cells before he arrived at the man's cell. He opened the cell door and left it ajar. He then noticed the towel obscuring the observation hatch and put his hand inside the cell to remove it. He saw the man kneeling, facing the wall. He was suspended from a ligature made from a sheet and attached to the window grille.
42. The officer called for medical assistance twice on his radio (this is recorded at 9.43am), and separately asked a prisoner to fetch help. He then called a third time on his radio for medical assistance and resuscitation equipment. Although the officer told my investigator he did not remember whether he had called a red or a blue emergency code (codes indicating the type of emergency), the result was the same as healthcare staff came with the appropriate equipment. (The local contingency plan states that the alarm must be raised immediately with a request for medical assistance and ambulance. No emergency codes are mentioned. The Communications Room sets the radio net to 'talk through' to enable healthcare staff to liaise with officers in the cell and attend with the correct equipment.)
43. The prison officer returned to the cell, supported the man's weight and cut the ligature away from the window. The ligature slipped off his neck.
44. The second landing officer came from Unit 1 within seconds of hearing the emergency call and was the second member of staff to arrive. She assisted the prison officer in turning the man onto his back. The duty SO then arrived and the second landing officer left to give the prison officer and the duty SO more room. The second landing officer went to

help supervise the other prisoners on the wing. She returned later to make a written note of the sequence of events. The first landing officer arrived as the second landing officer was leaving. He told my investigators he saw the duty SO and the prison officer preparing to commence cardio pulmonary resuscitation (CPR). He said the prison officer asked him to help move the man into a better position for them to perform CPR, so he held the man's legs and moved him gently towards the cell door.

45. The duty SO commenced CPR with the prison officer. The prison officer performed mouth to nose resuscitation while the SO performed chest compressions. (The prison officer did not use a barrier mask. He subsequently explained that he had been issued with a barrier mask, three or four years previously, but it had worn out and he had not asked for a replacement.)
46. The two men continued CPR until the prison doctor, the staff nurse and the wing nurse arrived. The staff nurse and the prison doctor then took over CPR and attached a defibrillator to the man. No heart beat was found. The man was intubated to assist with providing an airway. An intravenous cannula was also inserted to enable medication to be administered as requested. In the event, a dose of adrenaline was given in an attempt to restart the heart.
47. An ambulance was requested by the prison doctor, who later said that during CPR there was no obvious sign of a pulse or independent breathing. Both a governor and a principal officer (PO) were present at this time. The PO contacted the Communications Room via his radio and an ambulance was called at 9.46am.
48. Two ambulance crews arrived and were accompanied by an Operational Support Grade (OSG). The first team arrived at the man's cell at 9.56am, monitored him, took over CPR and then moved him to an ambulance. The second team arrived at 10.02am. Two officers went in the ambulance with the man to the local hospital. One of the escort officers was in the rear of the ambulance and observed the crew continuing with CPR.
49. When the man arrived at the hospital, staff in the Accident and Emergency Department tried unsuccessfully to revive him. The man was pronounced dead at 10.45am.
50. In his statement to the police, prisoner A said he was shocked on hearing of the man's death. He said, 'there appeared no reason for him to hang himself, the man was a chatty lad who got on with everyone and was well liked. He had no problems with any of the other lads on the unit. I believe that he would have told me if he was being bullied or having any problems with anyone. I would have known if anyone was bullying him because I would have heard them shouting to him. This incident is totally out of the blue as the man was looking

forward to getting out. Although I spent only six days in a cell with the man, due to being together for long periods of time I believe that I knew him quite well.'

51. The duty governor, a prison chaplain, and the governor acting as the prison's family liaison officer (FLO) visited the man's partner and family separately to inform them of his death and to offer condolences and support. The prison's FLO maintained contact with the family and assisted with the arrangements for the funeral.

ISSUES

Family concerns

52. The family has questioned why a prison officer was not concerned when the man did not greet him as usual during his morning round, and why he was not placed on 'suicide watch' in light of the distress he displayed. They also queried why the man was not allowed out of his cell on the morning of his death.
53. To take the first point first, my investigation has found that the officer concerned did think it was unusual for the man not to say hello to him, but continued collecting another prisoner for a mandatory drugs test. I do not think he can be criticised for so doing. The man's failure to say hello was not so serious that the officer could reasonably have neglected his other duties to investigate.
54. On the second point, there is no evidence that the man had expressed any thought of self-harm or suicide to any member of staff. When he was distressed, he was supported by staff and asked if he wanted to speak to a Listener (which he declined). Although in hindsight it is probable that the man was experiencing a much greater level of distress than staff recognised, I do not think there were circumstances that should have occasioned the opening of an ACCT form. Although it is sad to admit this, many prisoners experience distress – especially when they are uncertain about their future having being recalled to custody following release.
55. On the third matter, prisoners completing cleaning duties or going to chapel are unlocked at around 9.00am. It appears that the man asked to complete cleaning duties for his cellmate but there were sufficient prisoners already detailed for cleaning duties. As the man was not attending chapel, he would not have been allowed out of his cell until staff unlocked the rest of the prisoners for association at around 9.30am. I do not believe that staff acted unreasonably in this respect either.
56. The family also asked whether the man experienced a lot of pain when he died. And they have questioned how he was able to hang himself as he was 6' 4" tall. As I have not directly addressed these issues in my investigation, the family may wish to raise them with the coroner and request they be considered as part of the inquest.
57. As noted above, the family would like to know whether telephone calls between the man and his partner were recorded and, if so, whether they can have a copy of the transcripts. My investigator has asked the Coroner about disclosure of the transcripts of telephone calls and the family should apply directly to the Coroner with this request.

58. The man's mother has also asked whether he received the money she sent to him before he died. My investigation has found that he received £15, which was credited to his prison account on 12 June and £10, which was credited on 22 June. It has not been possible to establish whom this money was from.
59. Finally, prior to the inquest, the man's family would like to see some notes they were told he had crumpled up and thrown in his cell bin. The prison has no record of any other letters apart from those my investigator believes have been returned by the police to his family and his partner respectively. The Coroner's office has advised my investigator that they have no evidence of any letters being found in the cell bin.

Clinical Review

60. On 27 June 2006, my investigator asked South Leicestershire Primary Care Trust to conduct a clinical review of the man's treatment in custody.
61. In his review, the appointed medical practitioner notes that healthcare staff sometimes felt under pressure to complete a large number of reception healthscreens in a short time. However, they would take the time to explore issues further with a prisoner about whom they had concerns. Nevertheless, the room in which the interviews are conducted is described by the clinical reviewer as cramped and not offering full privacy - although this does not seem to have been a problem in the man's case. He notes that, 'The types of questions covered in the assessment are appropriate to identify key medical issues, mental health and drug or alcohol problems. However, staff feel that answers to the questions regarding deliberate self harm are frequently false, on the one hand prisoners wishing to conceal previous episodes and on the other prisoners wishing to invent or play-up episodes for gain. Staff would therefore rely on the presentation of a prisoner to alert them to acute risk of self harm.'
62. Decisions about a prisoner's safety must be made in the light of all relevant information. Yet there is no record that the man was asked about banging his head against the wall while in police custody, despite this being recorded on the PER. (The nurse who conducted the healthscreen said she would have asked him about it.) There was also information on the probation report that the man had 'tried overdoses on two separate occasions whilst on licence'. It is of concern that this information would not have been available for the first reception healthscreen.

The timing and venue of healthscreens should be reconsidered to enable healthcare staff to have sufficient time to conduct the reception interviews in a private area. The Governor should

consider whether full medical assessments should then be scheduled in office hours in a more neutral environment.

The Governor should review the process for making information available to staff during the reception process and subsequently, to ensure that decisions about a prisoner's safety are made in light of all relevant information.

63. The man was seen by a doctor on 13 June and there is a note in his medical record to 'get old notes'. It is not clear whether this request was to obtain records from the Accident & Emergency Department or the records held by the man's GP. There is no evidence that either happened. Nor were GP records obtained following the first reception healthscreen. The man's GP told the clinical reviewer that the man did not have any significant medical history requiring medication and did not have a history of using antidepressants. However, he did have a history of deliberate self harm and had attempted to overdose on three occasions (30 January 2006, 27 March 2006 and 7 April 2006). The clinical reviewer notes that there is no protocol or formal process in the prison for requesting medical records. It is done by health administrative staff apparently on an ad hoc basis. My investigation found it is rare for nursing staff to request information from a prisoner's GP record unless the prisoner is on medication and there is any doubt regarding dosage.

The Healthcare Manager must develop an auditable protocol for obtaining medical records from other healthcare providers when required. The protocol must outline the circumstances when it should be applied and the mechanism for doing so.

64. The man was also seen by a doctor on 20 June when he complained of shortness of breath. The reviewer says 'this consultation appears shallow with no evidence of consideration of the common diagnoses of asthma or anxiety.' He concludes, 'on balance the medical care given to the man during his time in prison could be described as adequate, but falling behind the standard of a well run GP practice.'
65. The clinical reviewer reports that the man's clinical record was not in chronological order. The two entries made by doctors on 13 June and 20 June were dated but the signatures were not clear and the names were not printed.

The Healthcare Manager must remind staff of the need to complete medical notes appropriately and in accordance with the guidelines of the professional bodies for doctors and nurses with regard for the expected standards of records and record keeping.

66. The clinical reviewer concludes that the resuscitation attempt on the man: 'was swiftly co-ordinated and executed. The timely request for help and arrival of staff gave him his best chance of survival. The

prison has made great efforts to ensure the smooth running of these urgent medical situations. This is evidenced by the prompt arrival of the medical team and shortly after by the first response paramedic. All staff involved should be praised for their professionalism and the smooth management of this incident. There is one reference in records to an outdated ventilation to compression rate. The Resuscitation Council made minor changes to ventilation compression ratio guidelines in 2005. It should be noted in the man's case this issue will have had no influence on the outcome'. I am pleased to learn that most healthcare staff received training in the updated guidelines in August 2006. This training should be maintained and annual updates organised.'

The Healthcare Manager should ensure staff are kept updated in changes to resuscitation guidelines with annual updates in CPR training to maintain best practice.

67. The clinical reviewer further suggests that, as staff may be called on to perform mouth to mouth resuscitation, they must have immediate access to barrier masks. This is to reduce the chance of transmission of infectious disease from the victim to the person attempting resuscitation. There are a number of small systems that are available that could be carried unobtrusively on officers' belts. I believe masks are not issued to all staff.

The Governor should ensure that staff who may be called on to perform mouth to mouth resuscitation have immediate access to barrier masks.

68. I agree with the reviewer's conclusion that healthcare staff, prison officers and paramedic staff acted appropriately when they responded to the emergency and attempted to resuscitate the man. The prison's contingency plans for dealing with a death in custody were followed.

Licence recall

69. Prison Service Order 6000, Parole Release and Recall, Chapter 7, Summary, page 2 states that:

"When ERRS is notified that a prisoner has been received into custody, it will issue the 'representations against recall dossier' (recall paperwork) to the establishment within 1 day. The parole clerk must ensure that it is disclosed to the offender immediately upon receipt."

70. The man's recall paperwork was requested by the prison by fax on 5 June, and it was posted by ERRS on 9 June. The paperwork arrived at the prison on 12 June and was given to the man on 14 June. It is clear from my investigation that ERRS failed to provide the prison with the man's recall paperwork within 24 hours as it should have done in line with PSO 6000. The paperwork was then delayed by being posted and

there was a slight delay in passing it on to the man by the prison. The man received his paperwork nine days after the prison had initially requested it.

I recommend that the Release and Recall Section of the Home Office should be reminded of the importance of issuing recall paperwork to prisoners within 24 hours, in accordance with the target set out in PSO 6000.

71. I commend the prison's probation officer, for seeing the man twice and explaining the recall process to him. However, there is no formal process at Glen Parva to ensure that similar arrangements are made for all young men who are recalled.

I recommend that the Governor considers establishing a system where all recall prisoners are seen at an early stage by a member of staff to explain the recall process to them.

RECOMMENDATIONS

The timing and venue of healthscreens should be reconsidered to enable healthcare staff to have sufficient time to conduct the reception interviews in a private area. The Governor should consider whether full medical assessments should then be scheduled in office hours in a more neutral environment.

The Governor should review the process for making information available to staff during the reception process and subsequently, to ensure that decisions about a prisoner's safety are made in light of all relevant information.

The Healthcare Manager must develop an auditable protocol for obtaining medical records from other healthcare providers when required. The protocol must outline the circumstances when it should be applied and the mechanism for doing so.

The Healthcare Manager must remind staff of the need to complete medical notes appropriately and in accordance with the guidelines of the professional bodies for doctors and nurses with regard for the expected standards of records and record keeping.

The Healthcare Manager should ensure staff are kept updated in changes to resuscitation guidelines with annual updates in CPR training to maintain best practice.

The Governor should ensure that staff who may be called on to perform mouth to mouth resuscitation have immediate access to barrier masks.

I recommend that the Release and Recall Section of the Home Office should be reminded of the importance of issuing recall paperwork to prisoners within 24 hours, in accordance with the target set out in PSO 6000.

I recommend that the Governor considers establishing a system where all recall prisoners are seen at an early stage by a member of staff to explain the recall process to them.

Comments:

The Prison Service has not identified any factual inaccuracies in the report. Paragraph 6 has been amended to reflect that the man's partner was interviewed by the police following the man's death. Paragraph's 31 and 37 have been amended to clarify that the man's partner was not his mentioned partner at the time he breached his parole. As per paragraph 61 on page 18, the Coroner has said that he does not think it appropriate to release the transcripts of telephone calls between the man and his partner without permission of the man's partner.