



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMYOI Glen
Parva in November 2011**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the circumstances surrounding the death of a man who was found hanging in his cell at HMYOI Glen Parva. I offer my condolences to his family and friends.

The investigation was led by one of my investigators. A clinical reviewer conducted a review of the man's clinical care at Glen Parva. Glen Parva co-operated fully with this investigation. I apologise for the delay in issuing this report.

The man was sentenced to two years detention in a Young Offender Institution (YOI) in November 2011. He had no previous convictions and it was his first experience of custody. He spent a week at HMP Nottingham, on the vulnerable prisoner landing, before transferring to Glen Parva on 14 November to serve his YOI sentence. The next day a newspaper clipping identifying him and his offence was passed around the induction unit and he was assaulted by another prisoner. As Glen Parva does not have a separate unit for vulnerable prisoners, he was moved to another unit to try and protect him and a transfer was arranged to another YOI. The man was found dead in his cell before that move could take place. The man left a note indicating he was unable to bear the verbal abuse from other prisoners.

The investigation has identified some worrying issues about the safety and management of vulnerable prisoners at Glen Parva. This is a matter I raised recently in another investigation report into a death at Glen Parva. I am, therefore, not convinced that, in the absence of a vulnerable prisoner unit, Glen Parva is providing sufficiently robust arrangements to protect young adults at risk from others. While many staff clearly took their duty of care towards the man seriously and identified him as being at risk from others, he was not identified as at risk of suicide or self-harm nor was he moved immediately. In these circumstances, I cannot be satisfied that sufficient was done to support and protect him. These are matters that need close examination, both nationally and locally, to ensure that Glen Parva is an appropriate place to hold young adult prisoners identified as vulnerable.

The month before the man's death my office issued a thematic report on learning to be found from deaths in custody involving violence reduction, bullying and safety. It is a great sadness that a number of the themes identified in that report are repeated in this investigation, and I hope that some important lessons can be learned from the man's death.

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.

CONTENTS

Summary

The investigation process

HMYOI Glen Parva

Key events

Issues

Conclusion

Recommendations

SUMMARY

1. The man was convicted on 7 November 2011, and sentenced to two years detention in a YOI. He was taken to HMP Nottingham for allocation to a YOI. He was held in the vulnerable prisoner unit at Nottingham.
2. On 14 November, the man transferred to HMYOI Glen Parva. The next day a local newspaper clipping with his photograph, name and offence was passed around the induction unit. We do not know the source of this newspaper clipping. That afternoon he was assaulted by another prisoner.
3. The man was moved to another unit the next day. The day after that, on 17 November, the unit senior officer interviewed him and arranged a plan for the man's management. The man asked to be kept away from the other prisoners and was unlocked separately for his meals. It was agreed that he would remain in a single cell in Glen Parva. The same day, a transfer to another YOI was arranged for the following week.
4. There was no specific staff interaction with the man on 18 November to check on his wellbeing, but staff did not report any incidents of bullying by the other prisoners. The man was observed collecting his meals and appeared to be okay.
5. The next morning, the man was found hanging in his cell. He had made up the top bunk so that it appeared that someone was sleeping in it. His body was at the back of the bunk beds and not immediately obvious to anyone looking through the observation flap. He appeared to have been dead for some time. He left a note for his family in which he referred to 'calling' (verbal abuse) from other prisoners and said he could not take any more of it.
6. The emergency response was prompt but too late to save the man. A local disciplinary investigation conducted by Glen Parva about checking prisoners at night concluded that roll checks were not carried out in line with local security instructions. However, it is not possible to know whether more active checks would have prevented the man's death.
7. The investigation raises serious issues about the safety and management of vulnerable prisoners at Glen Parva. We make five recommendations about these matters.

THE INVESTIGATION PROCESS

8. We were notified of the man's death on the day of his death. On 21 November, the investigator spoke to the Deputy Governor A, by telephone. Notices about the investigation were issued to staff and prisoners at Glen Parva and those who wished to see the investigator were invited to make themselves known. No response was received. The investigator spoke to the detective constable by telephone on 2 December 2011.
9. The investigator first visited Glen Parva on 24 November and discussed the circumstances with the Deputy Governor. She visited the unit where the man died, spoke informally to the two staff who discovered him and collected copies of the man's prison record and other relevant paperwork. The investigator also spoke to a member from the Prison Officers' Association.
10. A clinical reviewer was commissioned to carry out a review of the man's clinical care at Glen Parva. The clinical reviewer interviewed relevant staff.
11. The investigator visited Glen Parva on 6 and 13 December and interviewed nine members of staff and five prisoners. She later obtained further information by telephone, post and email.
12. One of our family liaison officers spoke to the man's mother on 2 February to explain the investigation process and asked her if she had any questions or concerns about her son's treatment in prison and the circumstances of his death. The investigator and another of our family liaison officers met the man's family on 7 March. They:
 - Asked why the man had been allocated a single cell at Glen Parva.
 - Were concerned how quickly after the man's arrival a newspaper clipping naming him and giving details of his offence was circulated within Glen Parva
 - Were concerned about claims on social networking sites that the aunt of the victim worked at Glen Parva and had made threats to harm the man.
 - Asked what action was taken against the prisoner who assaulted the man on 15 November.
 - Asked why the man had been allocated to Glen Parva when it had no vulnerable prisoner unit
 - Were upset that they had received a letter addressed to the man dated 1 March, from the Independent Safeguarding Authority. They felt that Glen Parva should have informed all agencies of the man's death.
 - Were upset that they had learned some details of the circumstances surrounding the man's death from news reports before they were given them personally.

The family commented that the man was a quiet young man whose friends called him a gentle giant. He had just started a third year at college on an NVQ entry level to a construction course which he enjoyed. They said he tried very hard to overcome his disabilities and enjoyed the gym and being with his family.

HMYOI GLEN PARVA

13. Glen Parva holds a maximum of about 800 convicted and remanded young adult male prisoners aged between 18 and 21. There are ten residential units holding a maximum of 80 young prisoners. The residential units for sentenced prisoners each have three landings accessible from stairs leading from the main association area. The landings are not visible from the unit office but there is closed circuit television (CCTV) coverage on some of the units.
14. Unit 15 is the induction unit. It is a more modern design with galleried landings visible from the main association area. There are nine other residential units plus a segregation unit and a healthcare centre. There is no in-patients unit. There is no dedicated unit for vulnerable prisoners who might be at risk from others because of their offence or other reasons. At the time of the man's death, Glen Parva was operating very close to maximum capacity.

HM Inspectorate of Prisons' report

15. Her Majesty's Inspectorate of Prisons (HMIP) last published inspection report of Glen Parva is of a full unannounced inspection in November 2009. A more recent short follow up report has not yet been published. At the 2009 inspection HMIP concluded that Glen Parva had made some progress towards providing a generally safe and respectful environment for its population, but acknowledged that the population was volatile and difficult to manage. There were relatively high levels of bullying and violence, despite a robust approach towards reducing this. HMIP found that some young prisoners with offences that potentially made them vulnerable were successfully integrated into the main population. However, there were others for whom this did not work and HMIP found there was no specific strategy to ensure their safety. They recommended that Glen Parva introduce a clearer strategy for managing vulnerable prisoners to ensure their safety.
16. HMIP recommended that CCTV should be installed on stairwells and landings on residential units because prisoners reported feeling unsafe in these areas. This had been installed at the time of the man's death.

Independent Monitoring Board

17. Every prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who monitor standards to help ensure that prisoners are treated fairly and humanely. In the 2011 IMB annual report the IMB commented on an increase of anti-social behaviour. This coincided in an increase in number of prisoners allocated to Glen Parva from other parts of the country and meant that Glen Parva was often close to its maximum capacity, especially towards the end of 2011. The IMB noted that this reduced management flexibility to deal effectively with internal transfers between units.

18. The IMB considered the Tackling Anti-Social Behaviour (TAB) scheme and the Safe and Fear Free Environment (SAFE) policy, introduced in 2009 appeared to be working but the IMB did not comment specifically about the management of vulnerable prisoners.

Previous deaths at Glen Parva

19. The man's was the first of two apparently self-inflicted deaths to occur at Glen Parva in the space of two weeks. The investigation into the other death also indicated some concerns about how well vulnerable prisoners were managed and protected.

Managing vulnerable prisoners at Glen Parva

20. Glen Parva's local policy for managing vulnerable prisoners is set out in the SAFE policy (safe and fear free environment). The belief underpinning the policy is that vulnerable prisoners should be managed and supported in the main population so as not to isolate them as this might increase their vulnerability. There is no dedicated vulnerable prisoner unit. Options for managing prisoners who are victimised by other prisoners are limited. They can be moved to another unit and given an individual support plan. Particularly vulnerable prisoners can be moved to the prison's segregation unit. If it is considered not possible to keep a prisoner safe, he can be transferred to another YOI.

Night checks at Glen Parva

21. The local policy for night checks on prisoners at Glen Parva is contained in the local security strategy document (LSS). There are four routine roll checks at night. The first is at the start of night duty (at approximately 8.45pm), the next before midnight, another before 3.00am and a final one before day staff come on duty (approximately 6.30am). The checks are logged on a dedicated form (the F81 report form). According to paragraph 2.73 of the LSS, the purpose of the roll checks is to ensure prisoners are in their cells and the number of prisoners is accurate. According to paragraph 2.76.2, prisoners must be visibly accounted for and a response obtained before declaring a correct roll. The paragraph specifies that the response should be either observed movement or dialogue, and staff must satisfy themselves that all is well.

KEY EVENTS

22. On 7 November 2011, the man was sentenced at Derby Crown Court to two years detention in a young offender institution (YOI). He had no previous convictions or cautions. The same day he was taken to HMP Nottingham, a local adult male prison that also holds young prisoners.
23. A member of staff conducted the man's first reception health screen at Nottingham when he said he had no current or previous mental or physical health problems. He said he had never tried to harm himself and had no current thoughts of suicide or self-harm. The member of staff recorded that the man was mentally alert and coherent and had told her he was afraid of being in prison. She said she had reassured him about this and had no immediate concerns about him. She assessed him fit for 'normal location' (a standard wing), fit for work and able to share a cell.
24. The man spent his first night in Nottingham on the first night centre for new arrivals. An officer interviewed him and completed a first night interview checklist. The form shows that the man told him that he was dyslexic. He said he felt okay but it was his first time in prison and because of his offence he was scared. The officer explained that he could talk to staff, or to prisoners trained by the Samaritans to provide confidential peer support (Listeners) and that he could ask to use the Samaritans phone (a hands free telephone with direct access to the Samaritans). The man said that he had no history of self-harm and he had no thoughts about harming himself or suicide. It was agreed that because of his offence, the man would be treated as a vulnerable prisoner (VP). This would mean that he would be kept only with other VPs on the VP wing and would not mix during association (social time out of his cell) or at meal times with the general population.
25. On 8 November, another officer interviewed the man as part of his induction and recorded on the electronic prison record (P-NOMIS) that the man told him that he had no thoughts of suicide or self-harm and had no issues or concerns. The officer wrote that the man required a full induction programme because it was his first time in prison. (The induction process introduces new prisoners to what they can expect from prison life, the daily routines and what activities they can take part in.)
26. Nottingham is an adult local prison that also holds young offenders pending their allocation to a YOI. Young offenders are normally allocated to the YOI nearest to their home and, for that reason, on Monday 14 November, The man transferred to HMYOI Glen Parva. Senior Officer (SO) A was responsible for reception that day and told the investigator that his practice is to get information about each new prisoner before they arrive, particularly to identify any information about risk factors such as histories of self-harm, violence, bullying, or drug misuse and the type of offence. The SO said he makes a list and gives a copy to all members of staff who take part in the reception process.

27. SO A said that he had noted the man's offence in advance. Before the prisoners left the escort van which had brought them to Glen Parva he checked with the escort staff that there had been no adverse reaction to the man from the others. The SO said that, if there had been any indication that the man's offence was known, he would have told the duty governor immediately because the man would have needed protection. As there had not, he made no distinction between the man and the other prisoners as treating him differently would have drawn attention to him and caused others to speculate about the reasons.
28. SO A remembered the man as fresh faced and young looking. He noticed that the man was very quiet and thought he was keeping a low profile, as he would have expected in his situation. He did not think there was anything in the man's demeanour that would have drawn unwanted attention from the other prisoners.
29. Officer A completed an initial interview and cell sharing risk assessment. She recorded that she had no concerns about the man during interview and concluded that he was a standard risk prisoner and suitable to share a cell. The man was offered a free telephone call and called his brother, who was not at home so he spoke to his sister-in-law. The man told her that he had been moved to Glen Parva. He asked his sister-in-law to tell his parents that he had moved. They had a conversation about what property the man had with him and his sister-in-law asked him if anyone was bothering him. The man said no one was. He told her that prison was not as bad as he thought but he did not know anything about Glen Parva yet. They discussed his potential release date. The man promised to call his parents as soon as he could.
30. Nurse A and Nurse B saw the man in reception for his first reception health screen. Nurse A recorded that the man appeared fit and well, was pleasant during the interview and had no thoughts of suicide or self-harm. At interview after the man's death, Nurse A told the clinical reviewer that she also asked the man if he had a plausible cover story for his offence because prisoners with convictions for sexual offences were not segregated at Glen Parva. She said the man said he had. Nurse B also told the clinical reviewer that they had asked the man about a cover story. (There is no record that anyone had suggested this to the man previously.) Nurse A wrote in the medical section of the man's cell sharing risk assessment that she had no concerns about him sharing a cell. The man's cell sharing risk assessment indicated that he did not mention any concerns and he was assessed as suitable to share a cell.
31. SO A recorded on a reception disability screening form that the man told him that he had dyslexia, which affected his ability to read. The man had asked for support with this and the SO referred him to the care and welfare co-ordinator, who requested that the man should be booked on an appropriate class. The man then went to unit 15, the induction and first night centre.
32. Nurse C saw the man, the next morning, Tuesday 15 November, for a routine secondary health screen. The man declined vaccinations for hepatitis B,

measles mumps and rubella and did not want chlamydia screening. He was given smoking cessation and testicular self-examination advice. The nurse did not note any problems and was unable to recall the man specifically when she was interviewed by the clinical reviewer.

33. Officer B who was working on unit 15 on 15 November, remembered the man as “a fresh faced lad” who looked very new to prison. He said it was immediately obvious that the man was not experienced in YOI life. The officer said that the man was polite and smiled but did not seem to want to talk. He said he would reply, “I’m fine boss” as if he was trying to end the conversation quickly. The officer said he did not see the man mix much with the other prisoners that morning, but that was not unusual for new arrivals who were getting used to the way things worked. He described the man as ‘unassuming’ and said the other prisoners left him alone.
34. Officer B said that in the afternoon between about 2.00pm and 4.00pm the prisoners are out of their cells for association (social time when they can mix with each other, use the shower and make telephone calls). About 40 minutes into association one of the prisoners started shouting and making threats. The officer said he did not appear to be looking at anyone in particular but was looking all around. The officer took him back to his cell and locked him inside. He said several officers saw the incident and asked what was going on. The officer asked one of the orderlies (who are trusted prisoners) who replied, “Don’t know what he was on about boss”. The officer remembered the man was sitting near the orderlies at the bottom end of the unit. He said the man showed no sign of concern or panic and seemed to be quite happy. He noticed a group of prisoners outside the telephone room who he said to another officer, Officer C, looked to be “up to something”. The group was at the other end of the unit from where the man was sitting and there was no indication that they were talking about him. Officer B said that at the time neither he nor Officer C were aware of the man’s offence and that they would not normally know unless a case was notorious.
35. Officer D was also on duty on unit 15 on 15 November. He did not come across the man during the morning, but in the afternoon it was his job to take groups over to the prison library. At about 3.00pm, he walked into the telephone room where there was a group of prisoners and saw a prisoner punch the man in the face. He immediately intervened and asked Officer B to take the man back to his cell. Officer D said the man seemed very quiet. He took the perpetrator into an office and asked him why he had hit the man. The perpetrator replied, “because he is a fucking nonce” (prison slang for a sex offender). Officer D charged the perpetrator with breaking prison rules by assaulting another prisoner and took him back to his cell.
36. Officer D said the inside of the telephone room is not visible from the unit office but there is CCTV in there. He said that when he went in the other prisoners had surrounded the man and were trying to manoeuvre him to a position underneath the camera. (The incident was recorded on CCTV but was not downloaded to disk because the perpetrator admitted to assaulting the man. The investigator was therefore unable to view it. We are concerned

that the CCTV was not kept and viewed as it is apparent that a number of other prisoners were involved in the man's assault but no action seems to have been taken against them either under disciplinary procedures or under the TAB scheme.)

37. Officer B said he took the man up to his cell and asked him if he was okay. He said the man smiled and said, "No I'm alright boss." He asked him if he had been hit and the man told him he had not. As they walked to the cell some of the other prisoners shouted "nonce" at the man. The officer said he told them to stop. He said he offered to stay and chat to the man but the man told him he did not want to. The officer said he could not see any obvious sign of injury. He told the man he would be let out separately to collect his teatime meal so that he did not have to mix with the others.
38. Nurse B examined the man in the prison healthcare centre at 3.55pm. She recorded that he had a slight swelling to his right cheek but was able to open and close his jaw without pain and had no obvious bone injury. She said the man refused painkillers. She told him to come back if he experienced further swelling or difficulty in swallowing or moving his jaw. She said she did not consider opening an ACCT form (assessment care in custody and teamwork procedures – the Prison Service's system for monitoring prisoners thought to be at risk of suicide and self-harm) as she did not have concerns about the man.
39. SO A, who normally worked in reception, covered senior officer duties on unit 15 that day. Officer D told him that the man had been assaulted and that he had witnessed it. SO A said that the fact that the officer had witnessed the assault meant he did not have to do a further investigation. Officer D told SO A that Officer B had taken the man to his cell and the man had told him that nothing had happened. He made sure the perpetrator and his cellmate were locked in their cell and instructed staff to keep them there and let them out separately to collect their teatime meal. Shortly afterwards one of the orderlies gave SO A a clipping from the Derby Telegraph. The clipping reported the man's offence and included his name and photograph. The orderly told SO A he had taken it from another prisoner and it had been passed around the unit before the man was assaulted. SO A spoke to the orderlies and asked them not to talk about the incident when the other prisoners came to collect their meals. SO A said he checked on P-NOMIS and could see no reference to the man's case being reported in the press. He did not know how the clipping had come into the YOI.
40. SO A made an entry in P-NOMIS detailing the circumstances of the assault. Officer D completed a report to the Governor for the disciplinary hearing for the prisoner who had assaulted the man. (The prisoner pleaded guilty to assault and was punished under YOI Rules.) Officer C completed a security information report which noted that Officer D had witnessed the perpetrator assault the man with a single punch to the face. He wrote that earlier in the association period another prisoner had shouted at a group of prisoners, "You fucking nonce, I'll fucking kill you, I'll get you in the showers". He said at the time staff were unaware of who the target of this outburst was.

41. Officer B remained on duty until he was relieved by night staff at about 8.00pm. He said there was little shouting on the wing that evening which surprised him given the earlier events. At some point during the evening he went to the man's cell and saw that he was watching TV. He said he gave him a thumbs up through the cell observation flap and the man returned the gesture and smiled at him. Before he went off duty Officer B wrote an entry in the wing observation book asking the night patrol officer to check on the man at the same time he checked the prisoners on ACCT forms (those being monitored as at risk of suicide and self-harm.) He explained the man might feel vulnerable after being assaulted. (Although he did not consider opening an ACCT for the man.) He said he also spoke to the night patrol officer about this.
42. The newspaper clipping which was circulated included the man's full name and address, details of his offence and his photograph. SO A told the investigator that once this information was in the prison he thought it was very difficult to keep the man safe. He went off duty at 5.00pm and did not come into contact with the man again.
43. SO B the senior officer responsible for unit 15 on Wednesday 16 November, arrived on the unit at about 7.30am and read the wing observation book. She asked officers for more information about the assault on the man the day before. SO B realised that the vast majority, if not all, of the prisoners on the unit knew about the man's offence and it was therefore imperative to move him for his own safety. She noticed during breakfast that the other prisoners were talking about the man. At the daily Governor's meeting with managers at 9.30 that morning, it was agreed that the man should move immediately to unit 10, with an entry made about the man's situation in the wing observation book so that all staff were aware of the difficulties.
44. At 11.17 am on 16 November, SO B wrote on P-NOMIS that all of the prisoners on unit 15 knew about the man's offence because of the local newspaper article and were talking about it. She said there were concerns for the man's safety and he was to be moved to another unit immediately with a view to transferring him to another YOI. She made another entry at 2.35pm that the man had been moved to unit 10 and a transfer to HMYOI Aylesbury had been arranged for the next week.
45. A member of staff from the chaplaincy visited the man on unit 10 the same day. She wrote on P-NOMIS that she had told the man he could have support from the chaplaincy and how to access this. Officer E spoke to the man to tell him about the unit rules and regulations and that his personal officer was Officer G. (Personal officers are allocated to each prisoner to keep a particular eye on them and to be their first point of contact and support.)
46. An entry in the unit 10 wing observation book on 16 November records that the man had moved from unit 15 without completing his induction because other prisoners had become aware of his offence.

47. SO C the senior officer on duty on unit 10 on Thursday 17 November, arrived at 7.30am and saw the entry in the wing observation book explaining why the man had moved there. He said he decided to speak to the man at some point that day. At breakfast time he noticed that the man looked nervous and worried and this reinforced his decision to find time to speak to him.
48. Later that morning SO C spoke to the man in the SO's office on his own. The man told him he was "much happier" on unit 10 but he had just seen someone arrive from unit 15 and he was worried that he would tell everyone about his offence and what had happened to him. The man said, "nothing has been said yet but I am sure it will get out". The SO said he explained to the man that a transfer to HMYOI Aylesbury had been arranged and he would move in a matter of days, but for security reasons could not tell him exactly when. He said he made it clear that it would be very soon. The SO said the man told him that he wanted to be kept away from the other prisoners as much as possible. They agreed that the man would remain in his cell and be unlocked after everyone else to collect his meals.
49. After his conversation with the man, SO C wrote entries in the wing observation book and on P-NOMIS. He reported that the man had told him that he thought he had been recognised by a new arrival on unit 10. He said the man told him that no threats had been made to him yet and he would tell staff if this happened. The SO explained the plan that he had agreed with the man. He highlighted and capitalised 'staff to be aware' twice on the entry in the observation book and wrote that there was a possibility that someone would try to assault the man. He added that the man would tell them daily how he felt about collecting his meals and coming out for association. When interviewed the SO said that he had asked the man if he had any feelings of suicide or self-harm and the man had said he did not. He said that he established that the man had no history of self-harm.
50. SO C said that he watched the man collect his meals that day and did not witness anyone saying anything to him beyond the servery orderlies asking him what he wanted. He said none of his staff reported hearing anyone shouting or making comments to the man as he was escorted from his cell to the servery. The SO said it occurred to him at some point that the man was rated as a standard risk for sharing a cell, which meant that theoretically he was expected to share a cell if the numbers in the prison demanded it. He spoke to the man about this and he said he would not want to share. The SO explained that he would keep him as standard risk but would revise his CSRA to make it clear that he should remain on his own. He said he re-emphasised to the man that it would not be long before he transferred to Aylesbury. After the interview, the SO revised the CSRA and this was endorsed by an operational manager later that afternoon. The SO was not on duty again until Monday 21 November and did not see the man again.
51. On 17 November, Officer H said he first came into contact with the man when he escorted him to the servery to collect his food at teatime. He remembered the man smiling at him and said he did not say much as they walked down. The officer said the servery orderlies were curious about why he was being

unlocked separately. The officer said he saw nothing to indicate that anyone knew why the man was being treated differently and no one said anything adverse to him while he was in his company.

52. Officer H saw the man again at teatime the next day, Friday 18 November. He thought that the servery orderlies were less curious about the man that day. Because he was the last prisoner to get his food, they asked him if he wanted extra portions. He did not see or hear anything that suggested the man's offence was known.
53. SO D was on duty on unit 10 on 18 November. At interview he said he thought the man looked nervous but from the feedback he received from staff he thought they were making progress with him. He did not speak to the man personally at any length. The SO wrote in the wing observation book that there were no concerns on the unit that day. There is no logged record of any staff interaction with the man after his second interview with SO C on 17 November.
54. The investigator interviewed five prisoners on unit 10. All of them had already been interviewed and given statements to the police. None of them wished to be named or have their interviews written up. They did not provide any significant new information and we have abided by their wishes. They were all in cells close to the man's. Three of the young men said they remembered the man and knew that he was being unlocked separately. One of these had been on unit 15 with the man. One denied any knowledge of him. One said he had only heard rumours about what had happened.
55. The young man who had been on unit 15 with the man knew about the newspaper clipping and the information in it. He saw the prisoner who shouted threats to "a nonce" but had not known at that stage who the target was. He also witnessed the assault. He said that once the information about the man's offence was known on unit 15 it went round the prison "in seconds". He said that after this it did not matter where the man was held in Glen Parva. He moved to unit 10 the day after the man. He said that some prisoners knew why the man had been moved from unit 15 and why he was being unlocked separately, but some did not. He believed that sex offenders should not be allocated to Glen Parva because there was nowhere they could be kept safely and they would get hurt. He said he did not hear people shouting abuse at the man on unit 10 and thought that it was most likely that if this had happened it would have come from unit 11 which was the opposite unit.
56. One of the young men said that he had heard a rumour that the man was being bullied but did not know why or by whom. He said there was always a lot of shouting in the evenings and at night. He said he turned his TV up to drown this out. The other young man who remembered the man said he had heard about the newspaper clipping. He did not have any direct contact with the man. He accepted that the man would have most likely been on the receiving end of some verbal abuse but denied hearing any.

The day the man died

57. Operational Support Grade (OSG) A was the night patrol officer on unit 10 for the night of 18/19 November. The report of night patrol form (F81) shows that he made roll checks at 8.15pm, midnight, 3.00am and 6.00am. He wrote entries in the wing observation book after every check. At interview with an operational manager (as part of an internal disciplinary investigation), OSG A said that when he made his first roll check at 8.15pm on 18 November he got a response from every prisoner on unit 10. When he made the checks at midnight and 3.00am he did not wake the prisoners but looked for signs that they were breathing. He said he was aware that he was required to get a response from each prisoner at the final morning check (the 6.00am check). However, his routine was not to do this as he thought it was very early to wake them up. Instead his practice was to shine his torch into each cell and look for movement. The OSG said that on completion of this count he was satisfied that all the prisoners on unit 10 were alive and well and in their cells. He did not specifically remember checking the man.
58. Officer I was the early start officer on unit 10. At interview with the operational manager (as part of the same internal disciplinary investigation) he said that he arrived at the gate at 7.00am and went to unit 10. He received a verbal handover from OSG A and remembered that the OSG told him that he had counted the prisoners and “knocked them up”. The officer said that the OSG had not specifically told him that the prisoners had been woken up, but his understanding from the handover was that the OSG had checked the prisoners, counted them and had no concerns about any of them.
59. Officer I said that OSG A left the wing after their handover and he started his roll check. CCTV shows that he began checking the cells on landing three at 7.20am. Officer I said he remembered looking into the man’s cell and seeing him apparently sleeping on the top bunk. He said he believed he had seen movement.
60. Officer J and Officer H began unlocking the cells so that the prisoners could collect their breakfasts from the house unit servery just before 8.45am. They began on the ground floor landing (known as the ones) and worked their way up to the second floor (the threes). One of them took responsibility for unlocking the cells and the other waited at the end of the landing by the stairs to observe the prisoners going down the stairs. When they got to the threes that morning, Officer J unlocked the cells while Officer H waited by the stairs. A trusted prisoner followed Officer J down the landing asking the occupants of each cell to have their bins ready to be emptied.
61. Officer J had not been on duty since the man’s arrival on unit 10 but she had been told when she arrived that morning that he was being unlocked separately. She therefore walked past his cell and did not look through the observation flap. She said that the trusted prisoner then called out to her that she should come back and look through the flap. Officer J said she was immediately aware that something was wrong. She could see what looked like a person asleep in the top bunk but could also see a pair of legs sticking

out from behind the end of the bunk beds. There was a sheet draped over the end of the bunks obscuring the rest of the body.

62. Officer J called Officer H and together they went into the cell where they found the man slumped in the corner of the cell with a noose made from a bed sheet around his neck tied to the bed frame. Officer H described the man as suspended by his neck in a seated position with his buttocks off the floor. Officer J radioed a code blue – a request for emergency medical assistance where there are breathing problems. Officer H tried to lift the man to relieve the pressure on his neck but could not do this because of the confined space. The officers managed to untie the bed sheet from the bed frame and released it from the man's neck.
63. Officer K from unit 9 and Officer L who was serving breakfast on unit 10 heard the call for emergency assistance and both officers went immediately to the man's cell. Officer K was able to lift the man out from behind the bunk, helped by Officer L and laid the man on the cell floor. Officer K said the man was cold to the touch and his legs had stiffened into a bent position. Officer K said he checked for a pulse but it was clear that the man had been dead for some time. He said he and Officers H and L agreed not to start cardiopulmonary resuscitation (CPR). Within a couple of minutes the emergency response nurses arrived and took over.
64. Nurse D, the designated first emergency response nurse on 19 November, said he was carrying out treatments in the healthcare department when he heard the code blue on his radio. He went immediately to unit 10 and was the first nurse to arrive. He saw the man lying on the floor of the cell and began to assess his condition. He said he was cold to the touch, rigor mortis had set in to his arms and legs and his pupils were fixed and dilated. While he was completing his initial assessment of the man, he was joined by Sister A and Nurse E who had brought the emergency medical equipment.
65. Sister A was the nurse in charge on 19 November and had been administering medication in unit 15 when she heard the code blue on her radio. She went immediately to unit 10 and saw Nurse D assessing the man on the floor of the cell. Nurse E was administering medication in the out patients department of the healthcare centre. She collected the resuscitation trolley and went immediately to unit 10. On arrival, she said she thought immediately that the man was already dead. Sister A and Nurse E began CPR as it is nursing practice to do so in all circumstances even if the patient appears to have died. Sister A was unable to insert an airway to help give the man oxygen because his tongue was too swollen. She attached a defibrillator to the man but it advised to continue CPR. (A defibrillator detects heart rhythm and will only advise an electric shock if it detects a suitable rhythm. In all other circumstances it advises CPR is used to try to re-start the heart.) Sister A, Nurse D and Nurse E continued CPR until the paramedics arrived.
66. The daily occurrence log completed by control room staff (the staff responsible for receiving and relaying radio messages and calling for an ambulance) shows that a code blue was called from unit 10 landing three at

8.45am. The emergency response nurse was called immediately also at 8.45am and the orderly officer (the member of staff responsible for the day to day running of the prison) was also told. The log shows that Nurse D arrived on unit 10 at 8.47am. The exact time the ambulance was called was not recorded but healthcare staff confirmed that one was needed and at 8.50am asked the crew to be informed that they would be likely to be attending a death. Two ambulance paramedics went into the man's cell at 9.04am and left again at 9.11am having pronounced his death.

67. The police recovered a note from the cell written by the man to his family. In it he apologised and said he could not take the "calling" anymore.
68. Duty Governor B, chaired a hot debrief (a meeting for those staff involved in finding and treating the man) at 4.30pm. All the staff who responded to the code blue call attended. They all said that they had been seen by the prison's care and welfare team and were happy with the support they had been offered. No specific issues were identified. Other prisoners subject to ACCT monitoring were checked and members of the chaplaincy visited the unit later the same day.

Family liaison

69. Duty Governor B and Officer M drove to the man's parents' home on Saturday morning to break the news in person. Officer M remained in contact with the family. Glen Parva offered financial assistance with the man's funeral, which was attended by staff.

ISSUES

Assessment of risk

70. The man was in prison for the first time. He was a quiet and shy young man who knew that the nature of his offence made him a potential target of abuse from his peers. On his first day at Glen Parva his offence was exposed and he was assaulted. He received verbal abuse on the way back to his cell. According to the evidence of the prisoners interviewed, the news of his offence and his identity spread around the entire YOI very quickly. The next morning it was accepted by wing staff and senior management that the man's safety could not be guaranteed and a transfer to another YOI was arranged.
71. Various staff spoke to the man following the assault. Nurse B said that she was not sufficiently concerned about him to open an ACCT. Officer B said the man assured him he was fine and denied that anything had happened in the telephone room. He did not open an ACCT but was sufficiently concerned to ask the night patrol officer to check the man along with prisoners on open ACCTs. SO C said he asked the man whether he felt suicidal or had a history of self-harm. He was satisfied that the man was happy with his management plan and would tell staff if he felt unsafe. All of the staff concerned appeared to be reassured variously by the man telling them that he was okay, giving them a thumbs up gesture or smiling at them.
72. We understand that the experience of staff and their ability to read body language and demeanour is properly part of risk assessment. However, it should not outweigh known factors that increase a person's risk of self-harm or suicide. In this case the man was in prison for the first time, was known to be vulnerable, was known to have been assaulted and verbally abused on unit 15. He had been seen looking very nervous and was shut in his cell on his own without any significant interaction with or support from staff for most of the day and night. In addition, it was accepted that his safety from assault and bullying could not be guaranteed at Glen Parva. The management plan put in place by SO C relied heavily on the man to report bullying but it appeared that he was afraid to talk further. Against this background it would be surprising if the man did not feel extremely vulnerable.
73. In these circumstances, we consider that it would have been appropriate to manage and support the man on an ACCT. We believe that SO C especially showed a proper duty of care to the man and spoke to him about how he was feeling. But in SO C's absence no one appears to have spoken to the man individually on Friday 18 November, or asked him directly if everything was okay and whether he still felt safe. We comment further on this below. We can not say that managing the man on an ACCT would have produced a different outcome but it would have formalised regular contact with staff and provided structured support for the man on a daily basis.

The Governor should ensure that staff making assessments of a prisoner's risk of suicide and self-harm should make an objective assessment of the known risk factors rather than relying solely on personal presentation.

The management of vulnerable prisoners at Glen Parva

74. Glen Parva's local policy for managing vulnerable prisoners is set out in their SAFE policy (safe and fear free environment). Section F deals with the location of prisoners thought to be vulnerable. It states:

"At HMYOI & RC Glen Parva we believe that as far as possible vulnerable prisoners should be managed and supported in normal location. This is to help them remain a part of the normal population at Glen Parva rather than become isolated and potentially exasperate (sic) their vulnerability factors.

"Where a vulnerable prisoner is bullied or victimised by another prisoner(s) on their unit consideration should be given to moving either them or the perpetrator to another unit. Usually the perpetrator(s) will be moved so as not to further victimise the vulnerable prisoner. However, it is accepted that on occasion it may be more appropriate to move the victim.

"Where a prisoner is believed to be particularly vulnerable despite a support plan being put in place they can be segregated under Prison Rule 45/YOI Rule 49 Own Protection ...

"In exceptional circumstances, where it is believed that a prisoner cannot be kept safe at HYOI & RC Glen Parva and that this is unlikely to change, consideration can be given to transferring a prisoner to another establishment. This is only appropriate where a transfer is likely to remove the risk factors."

75. While the decisions taken in the man's case followed this policy we are not satisfied that the policy is sufficient to protect vulnerable young adult prisoners at Glen Parva. Rather than ensuring vulnerable young men's safety from the start the policy seems to be based on a strategy of what the prison will do in reaction to when things go wrong. After the man was assaulted on the induction unit the perpetrator was moved to the segregation unit pending adjudication and placed on Glen Parva's tackling anti-social behaviour policy (TAB). We are concerned that no further investigation into what happened in the telephone room appears to have taken place. SO A considered that as an officer had seen the perpetrator of the assault punching the man there was no need for further investigation. However, it is apparent that a number of prisoners were involved in the incident other than the one who actually punched the man. Officer D said that the prisoners had surrounded the man and were trying to get him under the CCTV camera. There was no investigation into the actions of these other prisoners and the CCTV evidence was not kept.

76. When the man was taken back to his cell after being assaulted a number of other prisoners verbally abused him but, other than being told by Officer B to stop, they do not appear to have had any action taken against them either through formal disciplinary proceeding or through the TAB scheme. No one got together the prisoners on the unit to discuss the implications of their actions. This does not suggest that Glen Parva took a sufficiently rigorous approach to enforcing its policy of an integrated regime.
77. Because the nature of the man's offence became known he was moved to another unit where he was mostly kept apart from others until a transfer to another YOI could be arranged. We are concerned that the management of the man's case reflects some of the concerns of the last full inspection in 2009 when inspectors noted that unit managers identified approximately 55 young adults who, because they were under threat from other prisoners, did not regularly associate with others. Some had to be unlocked at separate times for meals and showers. Some of these vulnerable prisoners described to inspectors having other prisoners banging on their doors, and shouting abuse. One young man at the time of the inspection had been assaulted by others in the gym because of the nature of his offence.
78. SO C put in place a management plan that kept the man away from the other prisoners on unit 10 as much as possible. All interviewees, both staff and prisoners, accepted that once the newspaper clipping had been seen, the man could not be kept safe at Glen Parva. Despite this no member of staff spoke directly to the man on Friday 18 November, to check on his wellbeing or to ask if he had been on the receiving end of any bullying or harassment from other prisoners. We believe this was a serious failure in Glen Parva's duty of care towards the man. Unit staff told the investigator that they did not see any evidence that the man was verbally or physically bullied on unit 10 but they did not speak to him directly to ask about this. None of the prisoners interviewed would admit hearing verbal abuse directed at the man but they talked about 'calling' at night and some said they had heard rumours that the man was on the receiving end of this. In his suicide note, the man wrote that he could not take the 'calling' directed at him. It therefore seems likely that the man was the victim of threats made towards him by other prisoners shouting out from their cells.
79. While we understand Glen Parva's aim to run an integrated regime the fact that it was unable to protect the man and others like him from threats and violence does not suggest that it operates well in practice. In another recent investigation into a death at Glen Parva, shortly after the man's, we were also concerned at the arrangements for protecting a vulnerable young man in the prison and recommended that the Governor of Glen Parva should ensure there are appropriate arrangements to protect the safety of young adult prisoners who vulnerable to others. The tragic circumstances of the man's case reinforces this need. It also calls into question whether Glen Parva was ever a safe allocation for the man and whether Glen Parva should have its own vulnerable prisoners' unit rather than sending such prisoners further away from their families. We therefore repeat the recommendation made in the investigation report of the other death and make a further

recommendation to the National Offender Management Service nationally about allocation arrangements to Glen Parva.

The Governor should ensure that the full circumstances of an alleged assault is investigated and that, if the entire incident has not been witnessed by staff, CCTV evidence is kept and examined to check whether further disciplinary charges or action under the tacking anti-social behaviour policy are needed.

The Chief Executive of the National Offender Management Service should ensure that young adult prisoners vulnerable to others because of their offence are not allocated to Glen Parva unless there are clearly identified arrangements to support and protect them.

The Governor should ensure that there are appropriate arrangements to protect the safety of young adult prisoners who are vulnerable to others and which allow them to participate in an active regime. Where this is not possible they should have an immediate transfer.

Night duty roll checks

80. After the man's death, Deputy Governor A, commissioned an internal disciplinary investigation into the roll checks made during the night of 18/19 November. This was because it was apparent that the man was already dead when the 6.00am roll check was completed. The investigation was lead by the operational manager who interviewed the OSG and Officer I.
81. The provisions of the local security strategy (LSS) in operation at Glen Parva at the time of the man's death are outlined in the background section. The final roll check completed by night staff should take place at about 6.30am. Paragraph 2.73 says the purpose of roll checks is to establish that prisoners are in their cells and the numbers are correct. Paragraph 2.76.2 requires the staff to get a response from each prisoner - either observed movement or dialogue. The internal investigation found that a general practice had developed of not obtaining a response from the prisoners as it was thought too early to wake them, but the OSG said he believed that he had satisfied himself that he had seen movement in every cell on Unit 10 during the last roll check on 19 November. Officer I made another roll check at 7.20am. He said that he had seen someone asleep on the top bunk in the man's cell and believed he had seen the figure move. Both officers were mistaken about seeing any movement as the figure in the top bunk was in fact a bundle of clothes.
82. The operational manager found that there was not sufficient evidence to suggest that the failure on behalf of the OSG and Officer I to adhere to the policy outlined in paragraph 2.76.2 constituted misconduct under the code of conduct and discipline contained in Prison Service Order 8460, "failure to obey a lawful and reasonable order or written instruction". She recommended that the Governor of Glen Parva direct staff robustly on the relaxed attitude to roll checks by issuing a Governor's Order on the purpose of a roll check and

exactly what was required of staff. This recommendation was accepted and an Order issued directing staff to obtain a response at the 6.30am roll check.

83. We understand and accept that the primary purpose of night time roll checks is for security reasons, to check that the prisoner is there and is not a substantive check on their wellbeing. But security is why the Glen Parva policy requires the staff to get a response from a prisoner if they do not observe any movement. It is understandable that prison staff are reluctant to wake prisoners in the middle of the night or at 6.00am or so in the morning, particularly at the weekend. In most cases it should not be necessary or desirable. Nevertheless, it is apparent that both the OSG and the officer on Unit 10 on the morning of 19 November did not take sufficient care to establish that the man was actually present in his bed. We cannot know whether the man would have been found in time to be saved if the roll checks had been more vigilant. As there are several hours between roll checks this seems unlikely. There has already been a disciplinary inquiry and the Governor has issued a notice about roll checks so we are satisfied that appropriate action has been taken.

Emergency response

84. Officers H and J entered the man's cell promptly and immediately attempted to release him from the noose he had made. Emergency assistance was summoned as soon as possible and staff responded promptly. An ambulance was called and the paramedics arrived at the man's cell within about 15 minutes. The crew did not report any unnecessary delay in gaining entry to Glen Parva.
85. In line with Prison Service guidance officers decided not to attempt CPR because it was apparent that the man had been dead for some time. We consider this was an appropriate decision and make no criticism of this response. The nurses involved were also sure that the man was dead but considered that they were required by their own professional code to begin CPR in every circumstance. The clinical reviewer concluded that the nursing staff that responded in accordance with normal CPR guidelines
86. We understand the commendable wish to attempt and continue resuscitation until death has been formally confirmed, but it is surprising that healthcare staff should be required to carry out CPR in these circumstances. Prison Service guidance in PSO 2700 annex 13A, which applied at the time, says that there is no expectation on prison staff to attempt resuscitation when rigor mortis is clearly present. The European Resuscitation Council Guidelines for Resuscitation 2010 also state that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ..." We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is not appropriate.

Findings from the clinical review

87. The clinical reviewer has made some recommendations in his clinical review about recording emergency equipment checks and training in minor injuries, but overall found that the healthcare department appeared well managed. Although there was a high staff turnover the healthcare staff interviewed had a good understanding of their roles and of the challenges posed by working in a YOI. The clinical reviewer found that the standard of medical record keeping was good.
88. The clinical reviewer concluded that the healthcare provided to the man was equivalent to that he would have received in the community.

Family liaison

89. The news of the man's death was appropriately broken in person by Duty Governor B and Officer M. Glen Parva offered financial assistance for the man's funeral in line with the guidance.

Issues raised by the man's family

90. The man's family asked why the man had been allocated to a single cell at Glen Parva. As part of the reception process all young prisoners undergo a cell sharing risk assessment (CSRA). The primary function of this is to make sure that prisoners who are a risk to others are identified. When he arrived at Glen Parva the man was assessed as suitable to share a cell. Although there was the possibility that could have been assessed as vulnerable to assault himself, that might have drawn attention to him. The likelihood was that he would have been required to share a cell at some stage. When he first went to unit 15 for his induction he did not share a cell but there was no special reason for this.
91. When the man moved to unit 10 after being assaulted on 15 November he was given a single cell as he wanted to be kept away from the other prisoners on the unit. SO C agreed with him that he would be unlocked separately. No one had identified the man as a risk of suicide and self-harm and we are satisfied that it was appropriate that the man was given a single cell.
92. The man's family were concerned how quickly after his arrival a newspaper clipping naming the man and giving details of his offence was circulated within Glen Parva. Although prisoners have free access to newspapers, the immediate appearance of the clipping, from a Derby local newspaper, suggests that it was sent or brought in deliberately with malicious intent to make the man's offence public. It has not been possible to discover who was responsible for circulating the clipping. The man's family were also concerned about claims on social networking sites that the aunt of the victim of his offence worked at Glen Parva and had made threats to harm the man. His family reported this to the police but they were unable to substantiate these claims. Without a name or indicator of the area of the prison where the

relative of the victim worked it has not been possible for either us or the police to establish whether this allegation is true.

93. The man's family were upset that they had received a letter addressed to the man dated 1 March from the Independent Safeguarding Authority. They felt that Glen Parva should have informed all agencies of the man's death. The investigator telephoned the Independent Safeguarding Authority and was told that they rely on the person's family to inform them in the event of a person dying. This is because they require a copy of the death certificate, which is obtained by the family. They have no expectation, protocol or memorandum of understanding with the Prison Service, probation or police that they will inform them of a person's death. While we are surprised that other criminal justice agencies do not have responsibility for this we do not consider this is something Glen Parva should have been expected to do.
94. The man's family were also upset that they had learned some details of the circumstances surrounding his death from news reports before they were given them personally. After every death in prison a standard press release is issued giving only the prisoner's name, the prison's name, and the nature of the death (if known). Further details are not released officially. We appreciate the great distress that the man's family felt at finding out further details through the media. However, we are satisfied that Duty Governor B broke the news of the man's death to his family in person, promptly and before any media reports. The prison was not responsible for providing any further details although it cannot be discounted that information came from a member of staff acting inappropriately. It may also have come from a prisoner or their family or friends.

CONCLUSION

95. It was clear from this investigation that many staff took their duty of care to protect prisoners seriously. However, there are serious issues about how well vulnerable prisoners can be protected at Glen Parva in the absence of a dedicated unit in which to manage them. Once the man's offence became known, there was a recognition that he was not safe at Glen Parva and the only option was to transfer him. This was not done immediately and more should have been done to support the man in the interim. Tragically he took his own life before a transfer took place.

RECOMMENDATIONS

1. The Governor should ensure that staff making assessments of a prisoner's risk of suicide and self-harm should make an objective assessment of the known risk factors rather than relying solely on personal presentation.

This recommendation was accepted at draft report stage. The National Offender Management Service commented:

"The Governor will ensure that staff making assessments of a prisoner's risk of suicide and self-harm should make an objective assessment of the known risk factors rather than relying solely on personal presentation. ACCT training will be reviewed to incorporate this."

2. The Governor should ensure that the full circumstances of an alleged assault is investigated and that, if the entire incident has not been witnessed by staff, CCTV evidence is kept and examined to check whether further disciplinary charges or action under the tacking anti-social behaviour policy are needed.

This recommendation was accepted at draft report stage. The National Offender Management Service commented:

"Where an alleged assault occurs that is not witnessed by staff and CCTV is available this will be reviewed to establish the facts of the incident. A group of designated staff have access to CCTV to enable this to happen."

3. The Chief Executive of the National Offender Management Service should ensure that young adult prisoners vulnerable to others because of their offence are not allocated to Glen Parva unless that there are clearly identified arrangements to support and protect them.

This recommendation was accepted at draft report stage. The National Offender Management Service commented:

"We are satisfied that there are clearly identified arrangements and well established systems in place at Glen Parva to support and protect vulnerable young adults. These arrangements begin at the point of reception and include placing vulnerable prisoners on TAB Support which is a support plan that identifies their individual needs and puts a plan of action into place. Examples of support listed in the SAFE policy include increased monitoring, an assessment of appropriate regime, activities for the prisoner to attend and providing in-cell activities to occupy their time as well as the option to segregate under R45/49 Own Protection.

"A review of the current allocation procedures at Nottingham will be undertaken to provide assurance that the system of allocation currently being used remains appropriate.

"The support plan put in place for the man was a TAB support plan although we recognise it was not labelled as 'TAB'. This support plan was well

documented and followed to the letter the following day; this was evidenced verbally by staff although we recognise that there was no daily entry on NOMIS or elsewhere. We will therefore ensure that all SAFE policy processes are followed and the documentation is completed in line with the policy to evidence the action taken.”

4. The Governor should ensure that there are appropriate arrangements to protect the safety of young adult prisoners who are vulnerable to others and which allow them to participate in an active regime. Where this is not possible they should have an immediate transfer.

This recommendation was accepted at draft report stage. The National Offender Management Service commented:

“The Governor will ensure that there are appropriate arrangements to protect the safety of young adult prisoners who are vulnerable to others and which allow them to participate in an active regime. In rare and extreme cases where this is not possible we will arrange an urgent transfer to another suitable prison. This will always be subject to space being available. In the mean time we will invoke an appropriate safety regime, such as segregation under R49 for the prisoner’s own protection.”

5. The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is not appropriate.

This recommendation was accepted at draft report stage. The National Offender Management Service commented:

“The Governor and Head of healthcare will provide staff guidance on resuscitation and the circumstances when it may not be appropriate.”