Circumstances surrounding the death of a young man at HMYOI Glen Parva in July 2005

Report by the Prisons and Probation Ombudsman for England and Wales

August 2006

This is the report of an investigation into the circumstances surrounding the death on 28 July 2005 of a young man, apparently by his own hand, in a cell he shared with another prisoner at HM Young Offenders Institution Glen Parva. He was just 19 years of age.

The young man was found by his cellmate just before 8pm. He was hanging from ventilation holes in the door of his cell. Training shoelaces had been fashioned into a noose and wrapped tightly around his neck. The young man had given no indication that he might take his own life. He left an undated letter, probably written just before he died, to his twin daughters.

I offer my sincere sympathy and condolences to his family who have suffered the tragic loss of a much-loved member of their family. The family is closely-knit and I know they will always mourn his death. Staff and prisoners at Glen Parva share their feeling of loss and incomprehension that the young man, who to all outward purposes seemed to be coping well in prison, apparently took his own life.

At the time of his death, the young man was serving a sentence of 15 months imprisonment in addition to completing an earlier sentence of 30 months imprisonment, from which he had been released early on licence. The licence was revoked when he committed further offences. At the time of his death, the young man had been at Glen Parva for about two months. He had been there on a previous occasion and was well known to staff.

The investigation was carried out by one of my investigators. A comprehensive clinical review on behalf of the South Leicestershire Primary Care Trust, for which I am grateful. My thanks go also to the Governor and all staff at Glen Parva.

I make two recommendations of my own in section 9 of this report, and draw attention to four of those in the clinical review. In the tragic circumstances giving rise to this investigation, I have also been pleased to identify three areas of good practice in respect of the exemplary actions of four members of Glen Parva staff.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2006**

Summary

The young man was born in Ireland. His family moved to Peterborough when he was four years old, and he was brought up there. Immediately before being sent to prison, he was living with his partner and mother of his twin baby girls. It was clear from telephone conversations just before he died that it was unlikely that he would return to that home. Without doubt though, he could have returned to live with either his parents or other members of his extended family, to whom he was very close. They supported him throughout his sentence. Their letters were many, and consistent in their affection and commitment to help him get back on his feet.

The young man's relationship with his partner, in the four years they were together, was variable. His parents told my investigator that it was 'on and off', and that, following arguments, he would move out of the family home, returning some time later when the pattern would repeat. The young man drank heavily and alcohol always played a part in his offending. He was often in trouble with the police, and from 2001 had been the subject of several sentences in the community and in custody.

The circumstances leading to the sentence which the young man was serving when he died arose when in May 2004 he was sentenced to 30 months imprisonment for an offence of affray. He was released early from that sentence on licence, in January 2005. In March, he committed another offence of affray and his licence was revoked. In May, he was sentenced to 15 months imprisonment, to run consecutively to the unexpired part of his earlier sentence. He was due to be released from prison in January 2006.

The young man was well known at Glen Parva and, although he was capable of showing his frustration, staff thought well of him, describing him as 'quiet and respectful'. He worked as an orderly in the wing laundry and was trusted to get on with his work. He wrote and received many letters, and was in constant touch by telephone with family and friends who visited him regularly at the prison. He committed no misdemeanours, and to all intents and purposes was quietly serving his sentence.

Things changed somewhat in the days leading to the young man's death. His relationship with his partner came to an end. Transcripts of telephone conversations, recovered later, show that she instigated the separation and that initially he appeared to accept the position. Telephone calls to his sister and to his mother during the two days before he died paint a different picture, with the young man asking questions about his partner's whereabouts and details of her new boy friend. On the evening he died, in a final call to his mother he said, 'I can't do this no more.' Within an hour or so of that telephone conversation, the young man was found hanging in the cell they shared by his cell-mate.

The young man had given no indication to either staff or prisoners that he was about to take his life. His cellmate remembers the day the young man died as being a particularly good one, and he shared the view of staff that, of all prisoners, the young man was amongst the least likely to harm himself.

It is not possible to say what was in his mind when he tied the shoelace around his neck. The transcripts of his last telephone calls show that he was more upset at the break up of his relationship than he revealed to either staff or his cellmate. The letter he wrote to his children shows also that he thought he had failed them as a father and that he had little hope for the future.

Investigation methodology

1. The investigation was opened on 4 August, when my investigator met with the Governor, Safer Custody Manager, and other staff at Glen Parva. He was given a full and very helpful briefing by the Governor on the events leading up to and after the death. Ombudsman's notices, identifying the scope and methodology of my investigation, were issued to staff and prisoners. The notices also made clear that staff or prisoners who wished to see the investigator should make themselves known by contacting the liaison officer at the prison or by contacting my office direct. Staff and prisoners in key positions or locations were identified and invited for interview. All responded willingly. The local branch of the Prison Officers' Association (POA) were briefed. They were helpful and offered constructive comment and advice. In a follow-up visit, my investigator spent a full day visiting all parts of the prison, talking to staff and prisoners, and observing the interaction between them.

2. My investigator met with the Chair and one other member of the prison's Independent Monitoring Board (IMB). Their contribution was valuable, particularly in their description of many prisoners at Glen Parva being some distance from their homes on account of overcrowding in their local areas.

3. My investigator met local police at the prison. They shared freely all their information and interview records, as did the coroner's officer.

4. South Leicestershire Primary Care Trust carried out a clinical review.

5. My investigator, together with one of my family liaison officers met the young man's parents at their home. They were made to feel very welcome and learned much about his life, his troubled state of mind and his unhappiness at the break up of his relationship with the mother of his children.

HM Youth Offenders Institution Glen Parva

6. Glen Parva, built in the early 1970s, started life as a borstal institution. Following the abolition of borstal training, Glen Parva took on the role of a young offenders institution, holding 800 young people, both convicted and unconvicted, and serving a large catchment area of more than 100 courts. It is an extremely complex and busy place.

7. 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 gaol's design and standard of accommodation is acceptable by the standards of over 30 years ago. Things have moved on, however, and grilles in front of windows restrict entry of light. They also provide easy ligature points, as do the ventilation holes on the inside of cell doors.

8. In a full announced inspection in October 2004, Her Majesty's Chief Inspector of Prisons 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 a fundamentally safe establishment with good work going on with some of the vulnerable and disturbed young people it holds.

9. The Chair of the Independent Monitoring Board (IMB) told my investigator that Glen Parva was running well in difficult circumstances. The IMB had a good relationship with the Governor and his staff, and they felt their questions, observations and concerns were given full weight when brought to the attention of senior managers. The man was not known to the IMB. He had made no formal requests to them, nor had he otherwise come to their attention. They were notified promptly of the young man's death and the Chair visited the unit where he had died. She also attended the debriefing meeting held the day after he died and noted that all procedures were followed in accordance with Prison Service instructions. The IMB felt that, 'The incident was handled in a professional and sympathetic manner with all staff working hard as a team in very unfortunate circumstances.'

10. Suicide and self-harm procedures at Glen Parva are good. The prison has adopted recently the Assessment, Care in Custody, Teamwork (ACCT) system of managing those prisoners at risk of suicide or self -harm. At least 94 per cent of staff have been trained in the new procedures. Notices and other literature, notably in respect of access to Samaritans and 'Listeners' (prisoners trained by Samaritans to befriend other prisoners who are feeling low, and who prefer to talk to someone like themselves) 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.

11. In his follow-up visit to the prison, my investigator noted that staff and prisoners talked freely to each other. The atmosphere was good and relaxed, if businesslike.

Glen Parva is a complex establishment, and incidents of disruption occur daily. Many young prisoners are active but not always cooperative. Incidents are handled efficiently, sensitively and with the minimum of fuss by staff. A family liaison officer works in the visits hall and encourages family and friends to talk to him, or to contact him at any time, if they have anxieties about members of their family or friends in the prison. My investigator concluded that Glen Parva is not perfect, but within the bounds of what is possible the Governor and staff work hard to give young people a chance to make life-changing decisions.

Key findings

12. In May 2004, the young man was sentenced to 30 months imprisonment for an offence of affray. He was released early from that sentence on licence in January 2005. In March, he committed another offence of affray and his licence was revoked. He was sentenced in May to 15 months imprisonment, to run consecutively to the unexpired part of his earlier sentence. He was due to be released from prison in January 2006.

13. Following the revocation of his licence, the young man spent two months at HMP Peterborough. Following his conviction and sentence in May for the new offence, he was transferred to Glen Parva, effectively serving a combination sentence (the part outstanding on the old one, and the new one of 15 months). He did not seek the move to Glen Parva, but Peterborough, which is a busy local prison, must make space for new arrivals. Given the length of his sentence, it was inevitable that he would transfer to Glen Parva, the training prison within the catchment area.

14. The young man appeared to settle well at Glen Parva. He had been there before and knew many members of staff. They in turn knew him as a steady, likeable young man and anticipated that he would simply get on with his sentence and work towards his release. Although his parents said he had made an application to return to Peterborough, there is no evidence of a record of such a request. The young man was a popular young man amongst his peers and seemed comfortable enough, given the circumstances in which he found himself.

15. A Senior Officer, who works on Unit 2, knew the young man well. The Senior Officer has worked in Glen Parva for 15 years. Consequently he has long experience of young men in custody. He described the young man as a prisoner who behaved himself and was popular with other prisoners and prison staff. The young man worked as unit laundry orderly, a position which reflected his good behaviour and trustworthiness. He seemed to be getting on well with his sentence. Although the Senior Officer was aware the young man had fallen out with his girlfriend, he had not seen him upset. He felt that, of all the prisoners in his care, the young man was the one he would consider least likely to commit suicide. This reflects the general perception amongst members of staff that he presented a low risk of self-harm.

16. Similarly, the young man's cellmate noticed nothing untoward. He said that the day he died had been a particularly good one. He too was shocked, surprised and dismayed that the young man, the most unlikely of people, should have taken his own life.

17. The young man made four significant telephone calls in the two days before his death on 28 July. My investigator obtained transcripts. (All telephone calls from prisoners are recorded. Prisoners and those who are telephoned are notified by a voice warning when a call is connected. Few calls are monitored, although staff have the ability to listen to them at the time or later. In practice, a random small percentage is monitored. In addition some calls are targeted and monitored as a

result of security intelligence. He was a sensible and responsible young man in prison and there was no reason for staff to monitor his calls.)

18. On 26 July at about 6.30pm, two days before his death, the young man telephoned his mother. The conversation was fairly straightforward. The young man asked about his family, particularly his sister who had a new baby. He mentioned, almost in passing, his partner, asking about her and where she might be. The conversation then moved to his father's painting of the kitchen at home. Later, at about 7.30pm that evening he made a call to his partner where they discussed their relationship and agreed to split up. It was his partner who instigated the separation, he initially appeared to accept the position. He asked her if she had found someone else. She replied that she had not, and that she did not want anyone else. The young man had his suspicions, however, and said he would kill any new boyfriend even though his partner said there was no-one. The young man's main concern at that time appeared to be the welfare of his twin girls.

19. On 28 July, the evening he died, the young man telephoned his sister at about 6pm. He told her he had received the photographs of her new baby and then asked about his partner. He told his sister that she had, in his words, 'split up with me', and he asked where she was. His sister said that her mother had asked her not to tell him, but his partner now had a new boy friend whom she named. The conversation ended abruptly at that point. Ten minutes later, at 6.15pm, the young man telephoned his mother. He was anxious and said, 'I can't do this no more. I can't do this anymore. I ain't strong enough. His mother tried to cheer him up, but he became tearful. She asked him to send a visiting order so that she and his father and sister could visit him, but he continued in much the same vein, telling his mother that he loved her and his father and the children and to tell the children that he was sorry. The young man's mother continued to try to cheer him up but he kept repeating 'I love you.' The warning 'pips' were heard on the line, and the call disconnected. The young man returned to his cell where he had stayed throughout much of that evening's recreation period.

20. Just before 8pm, the young man's cellmate returned from a period of recreation to find him hanging from the ventilation holes above the door. He raised the alarm and staff arrived quickly. The first officer to arrive cut the shoelace by which the young man was suspended and along with another Officer started resuscitation procedures. A Senior Officer almost immediately took over. Urgent medical assistance was requested and an emergency ambulance was called. Two nurses arrived quickly with resuscitation equipment and a defibrillator from the Healthcare Centre. One nurse took over the resuscitation with the first Officer and continued until the arrival of paramedics and the doctor of the prison medical staff at 8.13pm. The ambulance left at 8.33pm. the young man was taken to Leicester Royal Infirmary where a hospital doctor certified him dead at 8.52pm.

21. A note, apparently written by the young man to his daughters, was found in the cell. It was retained as evidence until police arrived and took possession of it.

Following the death

22. The cell was sealed. Police arrived at 8.55pm and took control of the area. They took the note the young man had written to his children and the coroner's officer made the preliminary investigation necessary for the coroner's inquest.

23. At 8.55pm, the prison asked the police to visit the young man's partner, who had been named by him as his next of kin, at her home. Her home is a journey of about one and a half hours from the prison. The police made the visit, and his partner passed on the sad news to the young man's parents who telephoned the prison for information. A Governor returned their call and gave them the information available at that time. He visited them at their home a few days later, and they say the visit was helpful. The Governor made arrangements for the prison to pay the young man's funeral expenses. His partner, together with her sister and her mother, visited the prison and met the governor, the family liaison officer, and Sister Theresa of the chaplain's team. A memorial service, attended by prisoners and staff, was held at the prison for the young man.

24. All other actions set out in Glen Parva's contingency plan were taken. An immediate review of prisoners subject to ACCT was conducted. A debriefing meeting was held and attended by staff and the IMB Chair. Samaritans visited the prison and offered support to staff and prisoners. The prison care team was mobilised and saw every member of staff who had been involved in trying to save the young man's life.

25. A Consultant and Home Office Pathologist, carried out a post mortem on 1 August 2005 at Leicester Royal Infirmary. He identified the cause of death as suspension by a ligature around the neck.

Clinical Review

26. A General Practitioner and Clinical Governance Advisor to South Leicestershire Primary Care Trust, conducted the clinical review. It was completed on 14 November 2005. The doctor found that Glen Parva employed all appropriate current procedures, with no major omissions, in attempting to save the young man's life. In the doctors opinion, having regard to the post mortem report's finding that the young man had died from vagal inhibition as distinct from asphyxiation, staff could not have saved him.

27. The doctor commented more generally that in his view section 1.3 of the first health reception screen process was not searching or detailed enough in its intention to establish mental health history. He recommended that medical records should be sourced from General Practitioner's records at the time prisoners are received into prison. He recommended that staff should re-accredit every three years their certificate in first aid. He also recommended that the Prison Service should give consideration to the routine monitoring of prisoners' telephone calls.

28. The doctor concluded that the young man's action was probably the result of an acute and impulsive reaction to the news that his partner had taken another boy friend.

29. Three areas of good practice were identified.

The response of staff and their strenuous efforts to resuscitate the young man were both professional and timely.

The prison has clear procedures relating to dealing with deaths in custody and these were followed appropriately.

Prison staff were very open and co-operative in the conduct of his enquiry.

Conclusions

30. On the face of it, the young man was living his life normally in prison. He had been to prison before and knew what was required. He had good support from all members of his family who wrote many letters to him and who visited him in prison. He also had many friends amongst his peers. He was a likeable young man, accepted as a good member of the prison community and had no obvious problems.

31. Staff at Glen Parva had the same view. They knew him well as a member of the prison wing on which he lived. He caused no anxiety, did not get into fights or scrapes and committed no infringements of the rules. He was trusted to get on with his job as an orderly. Although one member of staff learned that the young man had fallen out with his partner, his assessment was that he did not appear unduly distressed by the change in his circumstances.

32. The single event that appears to have knocked him off balance probably happened two days before he died when he telephoned his partner and realised that their relationship was over. He learned also on the night he died that his partner had another boy friend. It may be inferred that he became more and more frantic and distressed. His final telephone call to his mother, an hour or so before he died, found him in tears and without hope.

33. The young man gave no indication to prison staff or to his cellmate that he was considering taking his own life. He was capable, by his mother's account, of 'bottling up' his problems. It is impossible to say what was in his mind when he tied shoelaces around his neck. It may be that the all-consuming regret at the loss of his relationship led him to feel that he had no future to which he could look forward.

Recommendations

1. **Grilles should be removed from cell windows at Glen Parva. They severely restrict available light, they are depressingly ugly and they provide obvious and easy ligature points.**

   Not accepted: The young man *was not located in a safer cell as he was not thought to be at risk. There are currently 600 cells with these grilles at Glen Parva. The fixings are tamper proof and would need grinding off, this would take approximately eighteen months and have huge cost implications.*

2. **An alternative should be found to the ventilation holes inside the cell doors. As with the window grilles, they provide obvious and easy ligature points and were used by the young man to suspend himself.**

   Not accepted: *These type of doors can be found in a lot of establishments and to replace all of them in 'normal location' cells would have huge cost implications.*

I also support the following recommendations of the clinical review:

3. **Where possible, old prison medical records should be available at the time of admission for review or requested as a matter of urgency and reviewed on arrival.**

   Partially accepted: *Medical records are not held centrally and would be held in the last establishment that the prisoner was held. Medical records should be requested within 24 hours.*

4. **All staff should receive appropriate and timely resuscitation training, which should be documented and reviewed regularly.**

   Partially accepted: *Currently we adhere to the appropriate number of staff being trained in First Aid, meeting H&S regulations. All new recruits to the Prison Service are trained in Heart start which is basic resuscitation. Locally we have run two courses in Heart start for established staff.*

5. **Life support equipment should be regularly checked and where necessary be covered by a regular maintenance contract. Records of these checked should be kept.**

   Accepted: *All three machines will be covered by HCE maintenance contract. Records will be checked as an agenda item on the Clinical Governance meeting.*

Good practice

6. **Staff should be commended for their valiant and sustained efforts to save the young man's life.**

7. **The Senior Officer should also be commended. Despite not being directly involved in helping the young man, she stayed in Glen Parva until after 1.30am to support staff. She later drove one of them home and provided overnight accommodation for yet another. Her support for her colleagues was in the highest traditions of the service.**

8. **The Family Liaison Governor showed sensitivity and thoroughness in his dealings with the young man's family. He is to be commended for the obvious care and concern he puts into his work as Safer Custody Governor at Glen Parva.**