Investigation into the circumstances surrounding the death of a man on 18 August 2005 whilst a prisoner at HMYOI & RC Glen Parva

Report by the Prisons and Probation Ombudsman for England and Wales

April 2006

This is the report of an investigation into the death of a man at the Leicester Royal Infirmary on 18 August 2005, whilst a prisoner at HMYOI & RC Glen Parva. He was on remand awaiting trial at the time of his death. He was found hanging in his cell and died a few days short of his 20th birthday.

I wish to offer my sincere condolences to the man's family for their loss.

This investigation was conducted by one of my senior Investigators. I would like to extend my thanks to the Governor, and his staff at Glen Parva for their help and co-operation during this investigation.

A clinical review was undertaken by the South Leicestershire Primary Care Trust into the medical care that the man received. I am grateful to the doctor for his report.

Although this report contains some indications as to the man's mood in the period running up to his death, his intentions can only be guessed at. Although he had asked to speak with a prisoner Listener (a prisoner trained by the Samaritans to offer support to others) just a few hours before he died, there was little to suggest that he was in immediate danger of suicide or self-harm. Indeed, in his behaviour and attitude, there was little to mark him out from many of the young men at Glen Parva and in other young offender institutions.

I make four recommendations as the result of this investigation. Other recommendations are contained within the clinical review.

This version of the report has been amended to remove the name of the man who died and those of the staff and prisoners involved in my investigation.

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

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Summary

1. Rotherham Magistrates' Court remanded the man into custody on 8 April 2005. After a number of remands and changes of location, he arrived at HMYOI & RC Glen Parva on 27 June.

2. On 18 August, he had a visit from his brother and his family. The visit went well and his brother had no concerns about his well being when they left.

3. That evening at about 7.45 pm, the man asked a member of staff if he could speak with a Listener. There were security concerns relating to the man, his associates and the unit Listener, and he was told that he could not see that Listener. He was offered the use of the Samaritans phone, which he declined. The staff started to make arrangements to move the unit Listener out and bring in two others. The man was asked if he had any thoughts of harming himself to which he replied that he did not. He also said that he would wait and see a Listener in the morning.

4. The man was seen in his cell shortly after 8.20 pm. At 9 pm, an Officer Support Grade noticed that his cell light was out as he made his rounds. He knew of the man's request and believed that he had probably settled himself down for the night.

5. At 9.32 pm while making his rounds, the OSG flicked on the man's cell light to check on him. He could not see him in the main part of the cell, but when he looked into the toilet area he saw him hanging from the light fitting. The alarm was raised and the cell entered. The man was cut down and staff started Cardio Pulmonary Resuscitation (CPR). An ambulance was requested but there was a delay in getting through to the emergency services. CPR was continued until the paramedics arrived at 10.10 pm.

6. the man left Glen Parva at 10.35 pm and was taken by ambulance to the Leicester Royal Infirmary where he was pronounced dead at 10.55 pm.

Investigation Methodology

7. The investigation was opened at Glen Parva on 24 August 2005. The Governor and his staff produced the man's core record and a large number of other documents for examination. Notices were distributed around the establishment notifying staff and prisoners of the investigation.

8. A number of prison staff were formally interviewed on tape. Interviews were also held with several prisoners, but these were not taped at their request.

9. My investigator liaised with the officers from Leicester Police who were conducting an enquiry on behalf of Her Majesty's Coroner.

10. Her Majesty's Coroner was contacted to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist with his enquiries into the man's death.

11. One of my Family Liaison Officers, contacted the man's family to inform them about my investigation. On 15 September, my investigator and the FLO travelled to Leicester to meet with them at the man's brother's house. My investigator summarised the events surrounding the man's period in custody at Glen Parva and his death, as he had discovered during his investigation so far. He was able to clarify a number of matters for the family and noted some concerns that they had. One of the matters raised was that they had been told that the man had been assaulted in the showers by a group of prisoners from the Bestwood area of Nottingham. My investigator spoke to the officer who had told the family of the incident. The incident was apparently less violent in nature than the family had believed and had not happened recently.

The man

12. He was born in Nottingham on 24 August 1985. When he was 11, he discovered that his 'mother' was not his birth mother and linked his temper control difficulties at school to that time. The man was permanently excluded from his school before he took his exams.

13. He had been convicted of a number of minor drug and driving offences and had previously been in Young Offender Institutions on two occasions.

14. The man's family described him as a very neat and ordered young man who took a lot of pride in his appearance and surroundings. Whilst the man was at Glen Parva, he requested and was given paint to spruce up his cell. He had an argument with an officer because a routine cell search had left it untidy just after he had tidied it.

15. The man had been in a relationship with his girlfriend for about a year and they had been living together for six months. Since he had been remanded into custody, his girlfriend had, according to his family, been keeping in contact with him inconsistently. They believe it was an attempt on her part to 'play with his head'. After the man's death, rumours were circulating in Glen Parva that his girlfriend was pregnant by another man and there was speculation that he had heard that before his death.

16. The man's family said that they believed that he had not intended to take his life but that it was a cry for help. He was only 19 years old when he died.

HMYOI & RC Glen Parva

17. Glen Parva was constructed in the 1970s as a borstal and has always held young offenders. It now serves a catchment area of over 100 courts, holding a mixture of sentenced, unsentenced, and remand prisoners. It has an operational capacity (maximum crowded capacity) of over 800.

18. In the Prison Performance Ratings for the first quarter 2005/06, Glen Parva has a level three rating (out of four). That level is defined as: 'Meeting the majority of targets, experiencing no significant problems in doing so, delivering a reasonable and decent regime.'

19. During the time that my investigators were at Glen Parva, they witnessed friendly and respectful interaction between staff and prisoners. The introduction to the December 2004 inspection report by Her Majesty's Chief Inspector of Prisons ends with the following: 'Glen Parva, at the time of the inspection, was an establishment on the move: indeed, there was discomfort among some staff about the pace of change. Other staff, however, clearly welcomed the opportunity to develop new skills and ways of working. Managers had taken a systematic approach to the task: building on the considerable strengths of a relatively safe and ordered environment, while increasing the opportunities for young prisoners, and developing and supporting the role of residential staff. These are the key building blocks for an environment which can begin to tackle the persistently high re-offending rate among this age group.'

20. There had not been a death at Glen Parva for almost five years prior to July 2005. In July, another young man took his own life, although the issues raised by this man's death are not similar.

Events prior to the man's death

21. Rotherham Magistrates' Court remanded the man into custody for burglary on 8 April 2005. He was sent to HMP and YOI Doncaster, which is privately run by Premier Prison Services Ltd. There were no indications of him being at risk of self-harm in the answers he gave to the questions posed during the First Reception Health Screen either at Doncaster or later at Glen Parva.

22. On 5 May, a drugs dog gave a positive indication to the man's visitor which resulted in a closed visit.

23. He appeared at Nottingham Magistrates' Court on 6 May, further charged with conspiracy to commit burglary and theft. He was remanded into custody and taken to Glen Parva. After an appearance at Rotherham Magistrates' Court on 13 May regarding the original burglary matter, he was remanded to Doncaster again.

24. The man began to get into conflict with the staff at Doncaster. On 15 May, he was late to his door and was reported as having a bad attitude when challenged. On the same day, he was caught associating in another cell. Two days later, he received a formal warning for his bad attitude and for swearing at an officer. On 3 June, the man became abusive to staff when he was told to go outside on exercise and had to be escorted out. The following day, he was on the phone when he should have been outside, late to his door at lunchtime lock-up, and in the servery when told not to enter. He was given a formal warning. Three days later, he was given another formal warning for continuously being late to his door. On 9 June, the man was caught trying to open a waiting room door with his ID card before going to court. He was given another formal warning but continued to be disrespectful to the escort staff en route to court.

25. At Rotherham Magistrates' Court on 9 June, the original charges were dismissed. He returned to Doncaster and was placed on basic regime. On 9 June, the man closed his cell door on an officer's arm. He was placed in the Violence Reduction Unit on 17 June. It appears that he was well thought of on that unit, being referred to as a very polite young man in a number of entries on the file.

26. He appeared at Nottingham Magistrates' Court on 27 June and was remanded to Nottingham Crown Court for trial. He returned to Glen Parva, telling staff that he was happy to be there. He was housed in a double cell in Unit 12.

27. On 8 July, the man pleaded guilty at adjudication to using threatening, abusive or insulting words or behaviour towards a member of staff. His punishment of loss of 50% of his earnings and loss of canteen facilities was suspended for three months. On 18 July, he pleaded guilty to a similar charge. On that occasion, his punishment was loss of 75% of earnings for 14 days, and forfeiture of canteen, association and TV privileges for 14 days.

28. On 12 July, the man was removed from the gym for two weeks for continuously upsetting the session. The entry in his personal record adds, 'very poor attitude, behaviour needs to change to have any consistency in the gym'.

29. On 19 July, the man was overheard by a member of staff to say to another prisoner, "Are you ready if those Iraqis start?" On 20 July, he put in a complaint stating that, on 17 July, five prisoners approached him in an aggressive and threatening manner. Also, that on the 18 July, after witnessing an assault on an Iraqi prisoner, an Iraqi prisoner came to his cell and told him that the 'Iraqi lads' were going to change his face. The assault he was referring to involved some aggressive verbal posturing by a prisoner I shall call Y, towards a prisoner of Iraqi appearance, backed up by other prisoners, including the man. The man's cellmate then threw hot water over the Iraqi man. As a post script, the man who is the subject of this report added that he could not go to the Muslim service for fear of trouble and therefore he was unable to pay his respects as a Muslim.

30. The man was interviewed on 22 July and told the officer that unidentified Muslim prisoners were preventing him from attending Muslim prayers by threatening him. He admitted that he had not applied to attend Muslim prayers. The man's declared religion was Church of England but the officer told him that he could apply to change his religion and that applications to attend Muslim prayers were taken on Fridays.

31. On 25 July, it was noticed during breakfast that the man's new cellmate had felt pen drawn on his face and neck. The man found it highly amusing saying he had done it for a laugh, but his cellmate was very distressed. The man was moved to another cell on his own and placed on the second stage anti-bullying scheme. Stage two of the scheme is designed to encourage prisoners to alter their behaviour through target setting and personal/landing officer intervention. The man's attitude improved over the next few days and he was removed from the scheme on 5 August.

32. On 14 August, an entry in the man's personal record states, 'Refusal to speak to staff and immature attitude'.

33. On the morning of 18 August, another prisoner who was a friend of the man's asked to be put into the cell with him as he thought the man was feeling 'a bit

down'. The prisoner was told to put the request in writing as required by the procedure. The officer, of whom the request was made, believed that it would have been unlikely that the two would have been allowed to share as they both had been perceived as engaging in bullying.

34. That afternoon, as the man was walking to his visit with his brother and his brother's partner, he asked an instructional officer in workshop four, to try and get him into the workshop the following day. The officer asked the man if he was alright and he replied that he was. The visit went well and his brother left, believing the man to be in good spirits and having no concerns about his well being or mental state.

Events surrounding the man's death

35. At about 7.45 pm on 18 August, the man asked to speak with a Listener. An officer put an entry in the unit observation book at 8 pm as follows: 'the man has asked to see a Listener, seems very down and reluctant to speak. Has been told that Listener is not available until morning. Declined Samaritans phone and wishes to see Listener in morning. Needs to be observed regular intervals during tonight. In morning must see Listener on another unit not ours.' The last was underlined, and then the following was written in red, 'Asked directly if he will self harm or kill himself and the man replied, "No".'

36. The officers on duty had concerns about the man's request. The Listener on the unit was apparently being threatened over a debt his brother owed. The person suspected of making the threats was prisoner Y. The subject of this report was thought to be part of prisoner Y's group and it was feared that the request to see a Listener was a means of being alone with that particular prisoner. As a result of those concerns, attempts were made to move the unit Listener off the unit and bring in two from another unit. At the same time, he was offered the use of the Samaritans phone, which he declined. The man agreed that he would wait and speak with a Listener in the morning. During later interviews, staff said that the man appeared to be his normal self and that they had no concerns that he would self-harm in any way.

37. The officers considered, but decided against, opening an ACCT document. This is a document that is opened when there is concern that a prisoner may self-harm or has suicidal thoughts. Prisoners on an open ACCT document are observed at intervals and a multidisciplinary team reviews their cases on a regular basis. (There can be many reasons why a person would ask to speak with a Listener and not just because they are at risk of self-harm. A number of officers said in interview that they believe there are times when the scheme is abused by the prisoners making the request to see them.)

38. The night OSG came on duty whilst the above decisions were being made. He was aware of the request that the man had made and the final decision that he would see a Listener in the morning. He checked the man in his cell as part of his routine landing checks, probably between 8.20 and 8.40 pm, but nothing stood out as unusual. The OSG patrolled the landings again shortly after 9 pm, and noted that the light was off in the man's cell but did not think it unusual.

39. At 9.32 pm, the OSG was again outside the man's cell. He flicked on the cell night-light and looked in. He could not see him in the main area of the cell, so he looked into the toilet area. He saw the man by the toilet but he appeared

lower than if he was using it. He put out an emergency call over his radio and then kicked the cell door a couple of times but got no response from him.

40. The Senior Officer was in the healthcare unit at the time of the call, a nurse who was with him called up on the radio to ascertain if medical assistance was required. When that was confirmed, both the SO and the Nurse made their way to unit 12. Meanwhile, other officers had arrived at the cell. Three officers arrived about a minute after the emergency call. One officer opened the cell and they entered. They saw the man hanging from the light fitting in the toilet area, suspended by a torn bed sheet. His weight had pulled the light fitting away from the ceiling, although the wiring was still intact.

41. The first officer cut the ligature whilst the other officers supported the man's weight. An officer felt for a pulse and believed he found one although the man's eyes did not react when touched. One of the other officers thought that the man was breathing, so they put him into the recovery position. The nurse arrived with the SO at that time. She placed a pulse monitor on the man but there was none. Nor was he breathing. She told the SO to call the duty doctor and an ambulance. The nurse and the first officer then began cardio pulmonary resuscitation. Another nurse arrived shortly after and took over the CPR from the officer. The first nurse attached the defibrillator that her colleague had brought from healthcare. The machine instructed that CPR be continued, which it was, until the paramedics arrived at 10.10 pm. The duty doctor arrived a few minutes later. The doctor and the paramedics rotated CPR and the paramedics set up an intravenous line and administered medication in an attempt to restart the heart.

42. There had been confusion and difficulty in contacting the emergency services system that resulted in a delay in the arrival of the ambulance. The staff at the gate were dialling 9999 but were getting an engaged tone. Eventually the officers managed to contact the local police and the ambulance service was contacted.

43. At 10.35 pm, the man left Glen Parva in the ambulance and was taken to the Leicester Royal Infirmary where he was pronounced dead at 10.55 pm.

Events after the man's death

44. The police were contacted with a view to notifying the man's next of kin of his death. (his family lives in Nottingham; Glen Parva is around 30 miles away, just to the south of Leicester.) The man's father was notified and had already passed the news to the man's stepmother and brother by the time the police contacted them.

45. In the man's cell, officers found a piece of burnt letter, a crumpled letter, a recently received letter from a girlfriend of a friend, and a writing pad which may have writing indentations on. The investigating police team took the originals of all of these. The piece of burnt letter bears the following hand-written script, 'my last word's to my dearest bro matt I carnt tack this cold would' (sic).

46. All of the staff involved attended a hot debrief between 1.35 am and 2.15 am. The purpose of a hot debrief is to give staff the chance to talk through what has occurred. Staff were offered the services of the prison's Care Team. Later that morning, notices were issued to inform both staff and other prisoners of the man's death. The prisoners on open ACCT documents were reviewed and the Samaritans came in later in the day to speak with the Listeners.

47. The Governor spoke with the man's brother by telephone that morning and offered any support needed. When my investigator met with the family they said that they were happy with the response from the prison.

48. The Governor also wrote individually to the officers involved, thanking them for their efforts in trying to revive the man. The Governor visited the family a few days later, when he agreed to pay for the funeral expenses and arranged for the family to visit the prison.

49. The difficulty experienced by the gate staff contacting the emergency services was investigated by a Principal Officer. It appears that as the officers were dialling the 9999 number from the gate they were in fact trying to dial their own telephone. The confusion arose as the staff believed that they had a direct dial facility, which they did not. The Governor issued a notice to staff on 19 August informing them of the correct procedure to use to contact the emergency services.

Clinical review

50. A doctor was asked to complete a clinical review by the South Leicestershire Primary Care Trust. I am grateful for his report.

51. He concludes that the man's presentation at 7.45 pm on the night he died was an opportunity to initiate an ACCT document. He notes that, had the document been implemented, then the 9 pm check would have been a direct visual check and the man's actions discovered earlier.

52. Attention is drawn to the habit of issuing notices to prisoners informing them about a death. The doctor suggests that too much information could lead to 'copy-cat' attempts and refers the reader to a report in the British Medical Journal in 1999.

53. The doctor comments on the fact that a prisoner's medical record does not follow the prisoner to the prison from their General Practitioner. He also notes that it is recognised as good practice to inform the GP practice of a patient's death. In this case, when the doctor contacted the surgery in late September it was the first official confirmation of his death they had received.

54. He makes a number of recommendations at the end of his report and also draws attention to good practice he found during his review.

Findings and conclusions

55. During his time in custody, the man had the reputation for being disruptive and someone who tended to associate with the 'wrong crowd'. When, on the evening of 18 August, the man asked to see a Listener there were concerns about his motives. He had not presented as a person in crisis. In fact, his brother - who had seen him that afternoon - believed him to be in good spirits. In addition, one of the young men whom the man associated with (prisoner Y) was suspected of bullying the Listener on their unit.

56. The staff took the man's request seriously but for security reasons would not allow him to be put in the cell with the unit's Listener. They told the man their decision and offered him the use of the Samaritans phone for the night, which he refused. At the same time, they had told the unit's Listener to prepare to move to another unit whilst they rang around to arrange for an alternate Listener. He was asked outright if he was going to self-harm or kill himself and he said that he was not. At that point, the man agreed that he would wait and see a Listener in the morning. The staff did not consider his situation warranted the opening of an ACCT document. The officer who spoke with the man was a trained ACCT assessor although it was not suggested by the officer that he had conducted a full ACCT assessment during the brief conversation at the cell door.

57. I acknowledge the clinical reviewers view that, had he been on an ACCT document and checked at 9 pm, his actions might have been discovered earlier. However, neither man's family, nor the staff who saw him on a day to day basis, believed that his mood had dropped to a level where he was at risk of self-harm or would consider taking his own life.

58. When the OSG put out his emergency call, it was not clear whether medical assistance was required. A number of establishments have introduced a coded radio system to add clarity to emergency calls. Consideration should be given to introducing such a system at Glen Parva.

59. A delay in being able to summon an ambulance to the prison could have serious consequences but, the clinical reviewer noted, this was not the situation in this case. Senior management at Glen Parva reacted swiftly to rectify the situation and I commend their actions. Nevertheless, I recommend a full review of their emergency response to ensure a robust system is in place.

60. The clinical reviewer calls attention to the fact that the man's death was not officially notified to his GP's surgery. Now that the majority of prison healthcare is either provided or commissioned by the local Primary Care Trust, there is the opportunity for much closer liaison between a prisoner's GP surgery and prison healthcare. Certainly, I believe that it should be possible for a prisoner's GP to be informed of his or her death. More positively, I also

hope that a prisoner’s GP medical record can be made available to prison healthcare, more frequently and more speedily than is currently the case at present.

Recommendations

Operational

1. The Governor should ensure that all staff are aware of the correct methods for contacting the emergency services and consider a full review of the emergency response procedures to ensure a robust system is in place.

Health

2. The Governor in conjunction with the PCT should consider the introduction of a coded emergency call system to aid clarity during a medical or other emergency situation.

3. The PCT in partnership with the healthcare manager should ensure that there is a robust system in place for timely information sharing amongst health and social care agencies.

4. The Governor should take steps to ensure that the prisoner's GP is notified if he dies in custody. Prison Health should also consider implementing a similar policy across the estate.