Investigation into the circumstances surrounding the death of a man at HMYOI Glen Parva on 4 July 2007

Report by the Prisons and Probation Ombudsman for England and Wales

August 2009

This report considers the circumstances surrounding the death of a man at HMYOI Glen Parva on 4 July 2007. He barricaded the entrance to his cell and started a fire in the early hours of the morning. Despite attempts by staff to rescue him, he was pronounced dead at 4.32am. I offer my sincere condolences to the man's family and to others who have been touched by his death.

My investigator, who was assisted by her colleague, conducted the investigation. I must apologise for the considerable delay in issuing this report and any additional distress this may have caused the man's family and staff at Glen Parva. A lengthy police investigation prevented my investigator from concluding her enquiries until July 2008 and the clinical review was not finalised until January 2009.

I would to thank the Governor of Glen Parva for the cooperation of his staff during the investigation. I am also grateful to Leicestershire County and Rutland Primary Care Trust (PCT) for conducting joint interviews with my investigator and providing a clinical review of the man's care at Glen Parva.

Although the man's life was short, he had experienced a difficult and traumatic time which contributed to a history of offending, self-harm and alcohol misuse. He internalised much of his emotional distress, making it difficult for his family and those responsible for his care to gauge how vulnerable he had become. Despite knowing that he was deeply cared for by his family and friends, the man left letters indicating that he could no longer live with the burden of past events.

The man had spent several short periods in custody. On each occasion, he had seriously harmed himself and spoken of suicide, although he was not always subject to self-harm and suicide monitoring and support measures. Despite this, he was always open with staff about his feelings, and they were aware of the need to look out for any signs of special vulnerability. He also had a strong relationship with the chaplaincy team at Glen Parva and had spoken candidly of his past with two of the chaplains.

There can be little if any doubt that the man decided to take his own life. He left letters explaining his actions, and had made it very difficult for staff to gain access to his cell to rescue him. Despite his clear intentions, and the difficulty this raises in identifying what could have been done to prevent the man's death, I have serious concerns about the robustness of the suicide and self-harm monitoring procedures and the provision of mental health support at Glen Parva during 2007.

I make eleven recommendations in this report, five relating to healthcare, three to suicide and self-harm monitoring processes, one regarding cell moves and two on fire safety. I have also noted one area of good practice, recognising the courage of the staff who tried to rescue the man.

Death caused by a cell fire is thankfully rare, and this is only the second time I have investigated a death caused in such a manner. There are no common lessons to be drawn from the two investigations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2009**

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SUMMARY

The man was a troubled and vulnerable young man with a history of self-harm, suicide attempts and alcohol misuse. In 2001, he began offending. He was taken into prison custody five times during his short life.

On 11 June 2007, he was arrested and returned to custody at HMYOI Glen Parva. During the reception process, he told a nurse that he had no current thoughts of self-harm or suicide. He also said he had a mental health problem, but was adamant that he did not want to talk to anyone about it.

After a week on the induction unit, the man moved to Unit 11. He spoke to a nurse and a substance and alcohol misuse worker. He said that he did not view his past drug taking as problematic, but said that he was a recovering alcoholic. Assistance and support was offered, but he declined any further interventions.

The man spent a lot of time with the chaplaincy team. Outside of prison he had been a member of the Jesus Army (an evangelical church), and at Glen Parva he was an active participant in Christian services. He spoke more freely with the chaplaincy team about his past. In particular, he told them about a traumatic incident six years before when he had been sexually abused. On Friday 22 June, the man said the anniversary of this event was in two days time. He said that at this time of year he could feel suicidal and used to harm himself as a coping mechanism.

Later that day, the man wrote a note which he handed to an officer on his unit. It said that he felt suicidal and explained about the anniversary. He also said he did not feel supported by staff on the unit, and that he had been self-harming and did not get on with his cellmate. The first line of the note contained the word “suicide”. The Officer did not read beyond this line before trying to talk to him about the note. The man was unwilling to discuss what he had written. The Officer contacted healthcare and asked for someone to conduct a mental health assessment.

A general nurse spoke to the man. The mental health nurse was already with another prisoner, so the general nurse decided he would undertake the assessment and then share his findings with the mental health team. He did not think that the man seemed withdrawn, upset or anxious. The man admitted self-harm, but denied wanting to kill himself. The general nurse recommended opening an Assessment, Care in Custody and Teamwork (ACCT) document (a suicide and self-harm monitoring and support form), and suggested a referral to the mental health team.

The man returned to his cell with the same cellmate. An ACCT was opened and he was subject to hourly checks, each to be noted on the form along with three meaningful entries per day. (A meaningful entry should document a conversation or observation to demonstrate that the person has been spoken to.)

The next morning, a second nurse conducted an ACCT assessment. She did not believe the man when he said he had no thoughts of suicide or self-harm. The second nurse noted that the man did not get on with his cellmate and, in interview, said she told the senior officer on Unit 11. The second nurse referred the man to the mental health in-reach team with a view to further counselling.

On Sunday 24 June, it was noted in the man's wing history sheet that unit staff had been told it was the anniversary of a difficult event. It is not clear whether any special support measures were put in place for him on this day. Although there is evidence that the man spent time with the chaplaincy, records do not document anything other than that he was seen.

The following day, the man spoke to the prison Reverend. He said that he was feeling better. In interview, the Reverend said the man had returned to his "bright-eyed", bubbly and normal self. The man's cellmate moved and he was assessed for the possibility of single-cell accommodation. In the meantime, he shared with another prisoner.

Over the next few days, staff reported that the man seemed more positive and was gaining confidence. On 2 July 2007, it was decided that his risk of harm was now low and the ACCT could be closed. There was no reference to whether he had been seen by amember of the mental health in-reach team as previously recommended.

The next day, the man met with another prison Reverend for a one-to-one session. The Reverend did not think the man appeared anxious or upset. On the same day, the man received a warning because he had returned to the unit early from education. In his interview, the officer who issued the warning said that the man appeared jovial and gave him no cause for concern.

During the night, an Officer saw that the man was awake at 2.00am. He asked him if everything was alright. The man said he was fine and was doing a gym workout. The officer walked by the man's cell again at 2.30am and saw he was still awake. They spoke and the man said he did not feel tired. Half an hour later, the Officer patrolled the landing and told the man he should try and sleep. When the Officer returned to his office a cell bell call sounded from the man's cell. (A cell bell is an alarm point used to gain staff attention.) When the Officer reached the landing he saw dense smoke billowing from under the man's cell door. He used his radio to contact staff and request urgent assistance.

Five members of staff and a nurse arrived on the unit to help extinguish the fire. The emergency services were contacted. Gaining access to the man's cell was difficult because he had placed a barricade of mattresses and two burning lockers against the cell door. Staff eventually managed to open the cell door and find their way through the thick smoke to pull the man out. Sadly, despite the efforts of staff and the emergency services to resuscitate him, he was pronounced dead at the local hospital at 4.35am.

Fire safety at Glen Parva has been one of the main issues considered in respect of the man's death. Investigations by the Crown Premises Inspection Group and the police have focussed on it. It was concluded that, whilst there was no permanent fire officers in place and measures had not been taken to address issues raised in a previous fire safety audit, there were no grounds for prosecution regarding gross negligence.

I have addressed fire safety in this report, but this was not my only concern. I have also focussed on the lack of mental health care and poorly managed ACCT process. Although there is no evidence to suggest that either of these shortcomings directly contributed to his death, I am concerned that the man did not receive adequate support when he was at his most vulnerable.

THE INVESTIGATION PROCESS

1. My investigator opened the investigation on 17 July 2007 and arranged to visit the prison the following day with a colleague. During the visit, the Acting Governor organised a roundtable meeting for my investigators with key members of staff involved with the death in custody process at Glen Parva. The purpose of the meeting was to provide a briefing on the events surrounding the man's death and to make arrangements for the investigation. Subsequent to the meeting, my investigator was provided with all the documentation relating to the man's time in custody.

2. One of my family liaison officers (FLOs) first contacted the man's family on 30 July 2007. His mother and sisters welcomed a visit to discuss their concerns surrounding his time in custody and the cell fire. The man's mother had instructed a solicitor, but she was not present during their visit to the prison on 23 August.

3. The family has asked for a detailed account of what happened on the night of the man's death. Specifically, they have asked for the following information:

    - Did the furniture that the man set alight produce toxic smoke?
    - Did he have his own clothes or was he wearing prison clothing?
    - What property did he have with him in prison?
    - Did he have a lighter in his cell?

4. The question about the furniture is covered in the body of the report. In answer to the others, the man was a smoker and during the reception process prisoners are offered a smoker's pack, which, amongst other items, contains tobacco and a lighter. He was also issued with prison clothing on reception at Glen Parva. Any personal property (including clothing) that he took into prison would have been put into a property box for storage during his first week. After the induction week, he would have had the opportunity to make an application to have items of his property in his cell. My investigator has seen the man's property card and it does not say that he had any of his personal clothes in possession. This means that it is highly likely that he was wearing prison issue clothing when he died, although my investigator has not been able to establish this for certain.

5. My investigators returned to Glen Parva in late September 2007 to begin interviewing staff. They met a Detective Inspector beforehand to discuss the police investigation. During the meeting, my investigators were made aware of concerns regarding fire safety at Glen Parva. A report had been prepared by the Crown Premises Inspection Group (CPIG) that suggested that Glen Parva could be considered liable for manslaughter by gross negligence in failing to provide sufficient fire safety at the prison. Given the severity of the concerns and continuing police investigation, I suspended my enquiries until all staff involved in the rescue and the Acting Governor had been formally interviewed. My investigation resumed in May 2008.

6. My investigator conducted interviews at Glen Parva in May, June, August and September 2008. The interviews were spread over this period due to difficulties with staff availability and in co-ordinating the joint interviews of healthcare staff with the doctors at Glen Parva and Gartree. The doctor based his clinical review on interviews with staff and the man's prison record. The review was not concluded for some months after the September 2008 interviews as the doctor was attempting to trace a locum doctor who saw the man the day before his death as well as his last doctor in the community. The search proved fruitless and the doctor's final report was submitted in January 2009.

7. During the period of suspension, my investigator maintained contact with the Detective Sergeant (DS) who conducted a police investigation into gross negligence for consideration by the Crown Prosecution Service (CPS). the man's family were involved throughout the CPS process. In late 2008, the CPS determined that there was insufficient evidence to proceed with prosecution. The DS concluded his investigation by producing a full report for the Coroner submitted in January 2009.

Crown Premises Inspection Group (CPIG)

7. The Crown Premises Inspection Group (CPIG) is responsible for the enforcement of general fire precautions on Crown premises (for example, prisons) in line with the Health and Safety Executive's requirements. CPIG enforces legislation and risk management based on intelligence gathered by Fire and Rescue Authorities on responding to an emergency incident. The relevant Fire and Rescue Authority uses information gathered to inform local risk management plans and firefighter intervention strategies. Any findings are shared with CPIG (when a fire has occurred on Crown premises).

8. Before 1 October 2006, the Prison Service had no statutory duty under fire safety legislation for the safety of prisoners. Up to this date, manslaughter by gross negligence in prisons had not been a matter for CPIG. However, the Regulatory Reform (Fire Safety) Order 2005 came into force on 1 October 2006 and the Prison Service was given a statutory duty to provide general fire precautions for all persons on their premises, including those in custody.

9. CPIG have highlighted concern regarding fire safety at Glen Parva and the man's death. The main areas of concern are:

    - Cells are not fitted with any suppression facility (e.g. sprinkler system). This means that entering the cell is the only way of extinguishing a fire.
    - There are no smoke detectors in the cells.
    - Officers did not request the fire and rescue service for an estimated 15 minutes.
    - Officers were not equipped with personal protective equipment and breathing apparatus.
    - There were insufficient staff trained to respond to a fire.

- Glen Parva had been advised that the general fire precautions at the prison were inadequate (in line with the above comments) 12 months earlier.

10. CPIG approached the police to see if there was a case of gross negligence manslaughter that should be presented to the Crown Prosecution Service. As noted, a Detective Sergeant led the police investigation. This has now been presented to the Crown Prosecution Service and the Coroner, and the man's family have been made aware of the decision that there were insufficient grounds to prosecute.

11. Although I am unable to comment on the case presented to the CPS, the questions raised from CPIG's report have also been considered as part of my investigation.

HMYOI GLEN PARVA

General

12. Glen Parva is a young offender institution located near Leicester, holding a maximum operational capacity of 808 either un-sentenced, convicted or remanded young men aged between 18 and 21 years. The establishment opened in 1974 and has always held young offenders. All prisoners who arrive at Glen Parva spend their first six nights in a dedicated induction unit. In total there are 12 residential units.

13. My office has been responsible for investigating deaths in custody since April 2004. Prior to the man's death I had investigated four other apparently self-inflicted deaths at Glen Parva. Since his death another young man has died.

Healthcare

21. Leicestershire and Rutland Primary Care Trust (PCT) provide healthcare at Glen Parva. There is a primary mental health team which is recruited for and managed by the healthcare department and Leicestershire Partnership Mental Health Trust provides a dedicated primary mental health in-reach team.

Chaplaincy

22. A full-time Anglican chaplain leads the chaplaincy team. Statutory duties are shared among a multi-denominational team of chaplains. All prisoners are seen within 24 hours of their arrival. In addition to religious services, a range of faith and non-faith based activities included general discussion and relaxation groups, Bible and Qur'an studies, bereavement counseling and a pre-release course are available.

HM Chief Inspector of Prisons

23. The HM Chief Inspector of Prisons, undertook a short unannounced follow-up inspection in June 2007. She found that Glen Parva had shown marked improvement since the previous inspection in 2004. Out of the 57 recommendations, 37 had been fully implemented and ten had been implemented in part, but the remaining ten had not been addressed.

24. Despite the improvement, the HM Chief Inspector of Prisons said there were still some areas that required urgent attention. Although suicide and self-harm prevention arrangements had undergone change, and a new full-time coordinator had just been appointed, the suicide prevention team meeting lacked focus and the local strategy document was weak (albeit in the process of being updated). At the time of inspection there were only five Listeners, although further Listeners were due to be trained. (Listeners are prisoners trained by the Samaritans to provide confidential support and counseling) The HM Chief Inspector of Prisons found the number of open Assessment, Care in Custody and Teamwork (ACCT) self-harm monitoring documents to be high (24

open during the inspection). The ACCT documentation inspected was not generally completed to a high standard, and entries and some reviews tended to focus on process rather than quality. I have discussed my own concerns regarding the use of ACCT documents at Glen Parva in this report.

25. The HM Chief Inspector of Prisons found that mental health provision had improved greatly since the previous inspection. The mental health team, now led by a highly motivated team leader, aimed to provide a community-led service to prisoners, and support for unit and prison staff. The team leader had developed a mental health awareness training programme for prison staff. Two Leicestershire Partnership Mental Health Trust RMNs provided in-reach services. The primary and in-reach teams worked well together to meet the mental health needs of the prisoners. Access to the teams was quick and weekly referral meetings were held, although only nursing staff currently attended. Medical support was provided by a doctor who was in the prison from Monday to Friday, and by two visiting psychiatrists, funded by the PCT. The psychiatrists provided excellent support to nursing staff while in the prison and informally outside of contracted sessions, but there were no formal arrangements for out of hours psychiatric cover. There were no daycare facilities.

26. Unfortunately, my investigation found that, despite a number of referrals for mental health assessments, the in-reach team did not see the man. As a result, I am unable to offer such positive comments. However, I do appreciate that between April and July 2007 the mental health provision at Glen Parva was still under development and my comments will be in that context.

Independent Monitoring Board

27. The most recent annual report issued by the Independent Monitoring Board (IMB) at Glen Parva relates to the two year period from December 2006 to November 2008. The Board believes that Glen Parva is a prison that has continued to improve. However, they express concern that the Measuring the Quality of Prison Life survey conducted in February 2008 produced results which the Board considered to be 'unpalatable'. They are also critical of the standard of accommodation, finding some areas uninhabitable.

KEY EVENTS

HMYOI Brinsford

28. The man was detained at HMYOI Brinsford on two occasions. When he arrived at Brinsford on 11 May 2005, staff were made aware of his history of self-harm and suicide attempts. He was placed on self-harm and suicide monitoring. At this time, the Prison Service used a form F2052SH for such monitoring in which all observations would be recorded. Staff would be required to record interactions with the prisoner concerned to monitor and assess the risk of self-harm or suicide. The severity of risk would dictate the level of observation. For example, someone actively suicidal and inflicting self-harm would be observed more regularly than a prisoner who was low in mood and considering self-harm. It is important to note that only a small minority of prisoners subject to observation are placed on constant watch.

29. Within 72 hours of a F2052SH being opened, the man was assessed by a trained member of staff and a case review took place. The purpose of these meetings was to determine the level of support required and how to provide it. During the meetings the man said that he did not know how he would cope in prison. He said that he could not guarantee that he would not harm himself. The man explained that there had been a traumatic event in his past that he had not come to terms with.

30. It was decided that the man could be based in a shared cell and frequently observed by staff. There were times when he preferred not be based on his unit because he found it noisy and complained of being bullied. He was moved and offered a cell in healthcare. He chose to remain in the main prison and there was no further mention of any bullying.

31. Staff reported that the man's mood generally improved during June and July. On 8 July 2005, a case review referred to some superficial cuts on his arms. The man said he had cut himself because he could not sleep at night. He said that he was now seeing a psychiatrist, which his probation officer (who was present at the review) considered had resulted in a change for the better. The following week, he was noted to be happy and cheerful during the review. He had started attending education and the gym. He said that he no longer had thoughts of self-harm and wanted the F2052SH to be closed. Given his improved mood, the panel agreed.

32. The F2052SH was reopened the following day as the man had made further superficial cuts to his arms. He said that he had cut himself because he was bored at night, not because he felt suicidal. The man said that cutting was a coping mechanism for a past trauma. It was decided that he needed to be kept occupied during the night and he was given a pack of cards. He later said that they had helped him and that he no longer felt the need to cut himself at night. The man was also given a model kit of a bike to build.

33. On 26 July, it was decided that the F2052SH could be closed again. The man no longer presented as a risk and he was soon to be released from prison.

That night, he took an overdose of tablets. His cellmate raised the alarm when he saw what the man had done. The man told staff that he took the tablets because he wanted to sleep and never wake up. The F2052SH was reopened and he was placed on constant watch in one of the gated cells on the healthcare centre.

34. Three days later (30 July), a review was held and the man said that he no longer had suicidal thoughts. He wanted to leave healthcare and return to the wing. The man moved back but the F2052SH remained open until he was released from prison. During that time his mood improved and he said he felt a lot happier. Although he continued to have thoughts of harming himself every day, he said that he had stopped cutting.

35. The man was released from Brinsford in November 2005. During February 2006, he was caught carrying a bladed weapon and was given a conditional discharge for 18 months. The man was caught again in June in possession of a bladed weapon, breaching his conditional discharge. He appeared in court in September and was given a community supervision order. A pre-sentence report written by his probation officer recommended that he should not be returned to custody. She argued that it would have a negative impact on his already vulnerable state. The man had attempted suicide by overdose four times, the most recent being four months earlier (referring to the attempt during July in Brinsford). He was given a further supervision order for 12 months.

36. During October 2006, the man was caught stealing. The offence breached his community orders and, as a consequence, during a court hearing on 13 December he was sentenced to four months in a YOI. The man was taken into custody at Glen Parva and was eligible for release with a home detention curfew after 13 January 2007.

Glen Parva, December 2006

37. On 13 December 2006, as a routine part of the reception process, the man was given a health screen. The nurse wrote an entry in his medical record that he was reluctant to engage in meaningful conversation. He did say that he had recently been prescribed sleeping tablets and had been treated for a mental health problem, but would not say what the problem was. He told the nurse that he had seen a psychiatrist at various stages in his life since the age of eight, the last time being two years before. The man said that he did not want to be referred to anyone, but the nurse decided to refer him to the mental health in-reach team. When asked, the man said that he did not have any current thoughts of self-harm. The nurse noted that the man did not present as a risk to himself at that time.

38. After going through the reception process, the man was allocated a cell on the induction unit (Unit 15). The rules and regulations were explained to him and he was issued with a smoker's pack and a PIN phone number and a nominal amount of telephone credit. The following day, the man met a Sister from the chaplaincy. He remained on Unit 15 until 20 December when he moved to Unit 5.

39. On 28 December, the man complained of not being able to sleep. He was given sleeping tablets and placed on a sleep watch for three nights. (As its name suggests, a sleep watch is regular monitoring during the night to see if a prisoner is sleeping.) There is also a sleep watch record for 23-25 December, although this is not referenced in the man's main clinical record.

40. There are no further entries in his personal history sheet (entries are completed by staff when there is anything significant to note) until 2 January 2007. An officer then noted that the man had settled in and was mixing well with staff and prisoners. He had asked to go on an education course, which the officer would help sort out. The man started attending numeracy lessons and was given approval to apply for a job. He passed a forklift truck driving course on 25 January.

41. The man received warnings on 31 January, 1 and 2 February, for refusing to attend a follow-up course to accompany his forklift truck training. He explained to a member of staff on 2 February that he did not want to go to the lesson as he was having some trouble with a few of the prisoners on the course. The nature of the problems is not recorded in his history sheet, but it was agreed that he could attend alternative employment until he was discharged from Glen Parva. There is nothing further in his history sheet between this entry and his release on 9 February.

Glen Parva, April 2007

42. The man returned to custody at Glen Parva on 13 April, following another arrest. He was remanded until his court hearing on 30 April. A Nurse conducted the first part of the man's health screen and another nurse completed the second section. The first nurse told my investigator that she could not recall why she did not finish it. The man told the second nurse, (from the substance misuse team), that he had been drinking 45 units of alcohol per week, using cannabis and had tested positive for heroin on 12 April before coming into custody. He said that he had been experiencing chest pains for the last four days and his doctor had prescribed codeine phosphate (a mild painkiller and cough suppressant). On being asked about his mental health, the man said that he had tried to commit suicide a fortnight before using paracetamol. His reason was that he had felt fed up. He told the nurse that he no longer felt like harming himself.

43. Based on this assessment, the man was not referred to the mental health in-reach team and an Assessment, Care in Custody and Teamwork (ACCT) document was not opened. The nurse noted in the man's medical record that he would be seen again the following morning. The man was then taken to the induction unit (Unit 15).

44. The nurse spoke to the man at 11.30am the following day. The man said he was still experiencing chest pain. They talked about his past and the man said that he had first tried to cut his wrists at the age of ten. He added that he had started drinking and using drugs at age 13 and that his reasons for doing so

were private. Although he had seen psychiatrists and psychologists, he told the nurse he found that they provided little help to him. He explained that self-harming was a form of release and helped take his mind off his problems. Although the man had overdosed two weeks earlier, he said that he had no thoughts of self-harm at this time. The nurse concluded that the man appeared settled, relaxed, and happy to talk about his past. Later that afternoon, the nurse wrote in the medical record that a referral had been made to the in-reach team to discuss his self-harm. The man saw a member of the chaplaincy team during the day.

45. Two days later, a nurse saw the man for the routine second health screen. He said that he was feeling well and did not want any input from the in-reach team. There is nothing further in his medical record for this period in custody and he was not seen by anyone from the in-reach team. There is an entry in the man's wing history sheet that says he appeared to be coping well. The man moved to Unit 12 on 26 April and was again seen by a member of the chaplaincy team. At a court hearing on 30 April, the man was released from custody having received a sentence of 26 weeks suspended for two years.

Glen Parva, 11 June 2007

46. On 11 June, the man was arrested for a further offence and taken back into custody. The suspended sentence was activated and varied to 20 weeks. A further 16 weeks was added for possession of a bladed article. This meant he would serve 36 weeks consecutively. Although his sentence end date was February 2008, an automatic release date was set for 14 October 2007. (Prisoners sentenced to 12 months or less are automatically released after serving half their sentence.)

47. When the man came into reception at Glen Parva he was assessed by a nurse. She told my investigator that she remembered the man from his assessment in April. The man told the nurse that he did not have any current thoughts of self-harm or suicide, but that he did sometimes scratch his arms if he felt like it. He said that he did not need to talk to anyone about these urges. The man said that he did have a mental health problem but did not want to discuss it. He referred to having previous appointments with "a psycho" (meaning psychiatrist) but had not attended.

48. Part of the routine reception process is to complete a cell sharing risk assessment. This is to determine a prisoner's suitability to share a cell in terms of the risk he would pose to others. On this occasion an Officer completed the form. Based on information that the man gave, the officer noted that the man had previously been subject to self-harm and suicide monitoring. The man told the officer that he had never tried to kill himself and had only self-harmed by scratching. During the reception process staff do not normally have access to prisoners' previous records, so the information recorded is purely based on what the prisoner says, how they appear and any documentation provided by the police, courts or prison escort staff. The Officer would not, therefore, have known anything other than what the man told him.

49. The man was allocated to a shared cell on Unit 15, the induction unit. An officer wrote on the man's wing history sheet that he was a very polite and well-mannered young man. The following day (12 June), the man was taken through the induction process by another officer. The officer wrote in his wing history sheet that the man was "a strange sort of young man". My investigator asked her what she meant by this and she said that the man did not want to engage in conversation. There was nothing deeper meant by her comment and she said there was nothing else noteworthy about their session.

50. On the same day, the man told a nurse that he was a recovering alcoholic, but did not need any intervention. He held out his hands to the nurse to show his tremors which are one of the signs of alcohol withdrawal. The nurse decided that it would be appropriate to refer him to the Counselling, Assessment, Referral, Advice and Throughcare service (CARATs) and the substance misuse team. (CARATs is run by organisations that work with prisoners who have a history of substance misuse, primarily drugs but also those with an alcohol addiction.)

51. A member of the CARATs team had a meeting with the man on 18 June. He said that he did not view his drug use as a problem. He said that he had started using cannabis from the age of 11 and had last used cocaine three months before. His alcohol consumption ranged from two to ten pints of lager a day. The CARAT assessor decided that the man required further intervention, but he refused any help saying that it was not needed.

52. The man's prison telephone records show that he telephoned one of his sisters and said that he had hit someone (outside of prison) with a brick and he found this funny. He called her back later and asked if she would visit him if he sent her a visiting order. He then spoke to his mother and asked for her to send him £500, some crack cocaine, a bomb and a machine gun to shoot the officers. He asked her to send him the addresses of his friends so he could write them letters (his mother told my investigator that she did not remember this conversation. My investigator explained that this information was taken from summaries of recordings of the man's telephone conversations. The prison is able to download recordings of any prisoner's telephone conversations if needed. This would have been done after his death).

53. The following day (Tuesday 19 June), the man telephoned a friend and asked him to come and visit. The man said that the person he had hit with a brick remained unconscious and he was worried that he might be charged with murder. He then told his friend that he wanted to see his family before the following Thursday.

54. The man completed his week on the induction wing on 20 June and was moved to Unit 11. This is a residential unit for prisoners on short-term sentences of one year or less. On that day he also went to the gym. When he returned to the unit he was told to take off, or cover up, a large balsa wood orange cross that he wore round his neck.

55. The man refused and said that he would never take off or hide the cross. (My investigator asked the chaplaincy about prisoners being allowed to wear religious items. She was told that this is permissible, in line with the Prison Service Order (PSO) 4550 on Religion. However, the unit rules are that any jewellery, including religious items, must be tucked into a prisoner's clothes.) He was informed that if he did not comply he would not be allowed to have a visit (I do not understand on what proper basis this penalty could have been imposed). The man received another warning the following day for refusing to attend work.

56. The next day (Friday 22 June 2007) the man spoke to a Reverend from the chaplaincy team. The Reverend told my investigator that he knew the man from his previous sentence at Glen Parva and had spoken to him on many occasions. On this occasion, the man told him that he had been a victim of sexual abuse by a peer when he was younger. He said that the anniversary of this event was approaching and it made him want to harm himself. He told the Reverend that he felt guilty for not telling the police about the incident at the time to prevent it happening to someone else. He said that at this time every year he felt like killing himself or self-harming as a means of coping. The chaplain spoke to a member of staff on Unit 11 about the conversation with the man, although in interview he could not remember to whom he spoke and he did not record it in the man's history sheet.

57. PIN phone records show that the man rang his mother that afternoon and asked her to send him a letter and some stamped addressed envelopes. He told her that a woman from Barnardos (with whom he had been in contact outside of prison) was going to visit him. Later that afternoon, an officer wrote in the man's wing history sheet that he had overheard the man begging other prisoners for some tobacco. The officer told my investigator that the man often ran out of tobacco and borrowed from other prisoners when he did so.

58. Shortly before 5.00pm, the man handed an officer a note that said:

> "Suicide is of the essence and is getting clearer, it is exactly six years this Sunday the 24th of June 2007, since something happened in my life. No one on Unit 11, including all members of staff is approachable. I am cutting up my arms and legs. It is not because I am in prison. I have nobody to talk to and being padded up with who I am padded up with is just making me feel even more suicidal. I need time on my own to greave [sic]. Or I need to be padded up with someone who is sound. I am requesting that my padmate is moved in with another padmate or another padmate is moved in with my padmate and I go into his cell on my own, or you can move either of two others with me please. I already know that the answer is probably going to be 'fuck off'."

59. The officer read the first line of the note and went to speak to the man in his cell. The man was unwilling to discuss what he had written, so the officer rang healthcare and asked someone to come and undertake a mental health assessment.

60. A general nurse went to speak to the man on the unit. The nurse told my investigator that he conducted the assessment because the mental health nurse who was on duty was already with another prisoner in crisis. He said that he had sufficient knowledge and was confident to undertake a mental health assessment and that, when it was complete, he agreed to show it to the mental health nurse for her opinion.

61. The general nurse took the man to a quiet room on the unit to talk to him about the note he had written. (It is important to make clear that the general nurse was not given the note to read before he began the assessment.) The man said that he had a history of self-harm, mostly superficial cuts and scratches. The general nurse recorded on the assessment sheet that the man had no known psychiatric history apart from post-traumatic disorder after witnessing his father's death. He assessed the man's current mental state as being animated and willing to talk. The general nurse did not consider him to be withdrawn, upset or anxious. The man admitted self-harm but denied wanting to kill himself. He said that the note he had written had been misinterpreted. He said that the staff on the wing were "wankers" and were not taking him seriously.

62. Although the man said he did not intend to kill himself, the general nurse felt sufficiently concerned to recommend opening an ACCT document. He also suggested a referral to the mental health team. As it was a Friday evening, the referral would not be acted on until Monday. The general nurse asked the man to tell him if he intended to harm himself. The man said he did not and the general nurse believed him. The general told my investigator that he felt content for the man to return to his cell as he was sharing with another prisoner and would not be on his own.

63. It is not clear what then happened to the note. My investigator spoke to an officer, the unit manager and other wing staff about it. It appears that the note was not read in full and nothing was done to address the man's request for a change of cellmate or cell move. Likewise with the comment regarding his finding staff unapproachable or them not taking him seriously, and he continued to live in the same cell. The general nurse told my investigator that the note he saw was not the typed version shown to him at interview. He believed that it was handwritten. This means that at some stage the handwritten note was typed up and the original lost. My investigator has been unable to determine what happened to the handwritten note.

64. An SO opened the ACCT document on the general nurse's recommendation. Any member of staff (healthcare, discipline, chaplaincy or voluntary) can open an ACCT. My investigator asked the general nurse why he did not open the ACCT himself. He said that, although he knew how to open the form, he thought that it was an officer's task.

65. When an ACCT is opened an immediate keep safe action plan should be completed as soon as possible. It puts support measures in place until the first assessment and case review takes place, which should be within 24 hours of opening the form. The SO wrote on the immediate action form that the man should remain with his current cellmate and be checked hourly. Each check

should be written in the observation record, along with three meaningful entries per day. (A meaningful entry should document a conversation or observation to demonstrate that the person has been spoken to.)

66. The following morning (a Saturday), a registered mental health nurse, conducted an ACCT assessment. (This attempts to identify why the person is at risk and if there are any obvious triggers. The findings from this assessment are used to consider what action should be taken by staff and the prisoner to reduce the risk.) The man told the nurse that he was approaching the anniversary of a traumatic event that had taken place six years earlier. He said that he did not want to discuss the matter in detail. he explained that he cut himself to forget the pain he felt inside. He said that he had taken an overdose of paracetamol a month earlier, but had no current thoughts of self-harm or suicide. He explained that his close relationship with his family prevented him from harming himself more seriously.

67. The nurse noted that the man said he did not want the ACCT to be open, but she thought that it was necessary for at least a week's support during this sensitive period. She told my investigator that she did not believe the man when he said he had no thoughts of suicide or self-harm. The nurse explained that, because he was not fully answering her questions, she felt he was holding back. She noted on the ACCT that he would attend the chapel the following morning, that he would like to be in a cell with a Listener to keep him company, and that he did not get on with his cellmate. (A Listener is a prisoner trained by the Samaritans to provide confidential support.) The nurse told my investigator that she told the senior officer on Unit 11 that the man was having problems with his cellmate, but she was not aware if anything was done to address this. The nurse said that she wanted to refer the man to the mental health in-reach team with a view to further counselling and he agreed to the suggestion. She told my investigator that she believed her referral was made verbally on the Monday. It is not written in the man's medical record.

68. Immediately after the assessment an ACCT case review was held. The man, the nurse and the SO were present. Again it was noted that the man had no current thoughts of self-harm, but that the following day was the anniversary of an upsetting event. He told the SO and the nurse that he would speak to unit staff if he felt vulnerable. There was no reference to his problem with his cellmate. A follow-up case review was set for 2 July.

69. There is a tick box on the case review form to indicate whether a mental health referral is necessary. Although the nurse had recommended one during the earlier assessment, the box was not ticked. However, the nurse did accept responsibility for making a referral on the CAREMAP. (The CAREMAP is an action plan to reduce risk and provide support.) There is no mention on the CAREMAP or elsewhere in the ACCT that consideration was actively given to moving the man away from his cellmate.

70. The next day (24 June), an officer wrote in the man's wing history sheet that unit staff had been made aware that it was the anniversary of a difficult event. It is not clear from entries in his history sheet, the ACCT document or medical

record, whether special support measures were put in place. There is evidence that the man spent time with the chaplaincy. However, the chaplaincy records do not document anything other than that he was seen. My investigator asked the chaplaincy team why no observations were recorded in the man's ACCT for this day. My investigator was told that this was because they did not have sight of the ACCT record which remained on his unit. (At the time there was no requirement at Glen Parva for the ACCT record to follow a prisoner around the prison.)

71. The following day, the man spoke to the Reverend. He said that he was feeling better. During interview, the Reverend was clear that he believed the man had only been vulnerable over the period of the anniversary and that he had returned to his "bright-eyed", bubbly and normal self. The man's cellmate moved (my investigator was unable to ascertain whether he was discharged from prison or simply moved to another unit). As a result, the man was moved to share a cell with another prisoner. After he moved cells, an entry in his history sheet by an officer said he seemed to be more cheerful and relaxed. Later that day, the man was assessed for the possibility of single-cell accommodation.

72. When a prisoner is on an open ACCT it is good practice for staff to make sure they share a cell with another prisoner, unless there is sufficient evidence to demonstrate that they would not be vulnerable on their own. (Although prisoners are mostly required to share cells out of necessity due to the pressures on the prison population.) One of the questions asked was if the man had any thoughts of suicide. He denied any intention of killing himself. He said that he self-harmed to distract himself from painful memories, adding that the support he received from the chaplaincy helped him, as did his own faith. It was agreed that if he felt like harming himself he would speak to unit staff. (There is no outcome for the suitability of single cell accommodation noted, but it is clear from the ACCT observation record that the man remained in a shared cell until 2 July.)

73. The man also saw a locum doctor on 25 June. It is not clear from the entry in his medical record why this appointment took place. However, the doctor did make reference to the man's previous overdose of paracetamol and blood tests were taken. The doctor made no note of the man's existing mental state and did not refer to the nurse's which was available in his medical record.

74. An officer had a long conversation with the man on 26 June. They discussed his faith and self-harming. The man told the officer that he liked to play the acoustic guitar and that he used to play at his church. The officer told my investigator that she tried to encourage the man to speak to the chaplaincy staff about playing the guitar in the chapel band, or having one that he could keep in his cell. She said that he was fickle; sometimes he thought this was a good idea but on other occasions he was uninterested.

75. Over the next few days, staff reported that the man seemed more positive and was gaining confidence. His phone records show that he telephoned his mother and said that he would send her a form to request a visit. He also

asked for a photograph of his sister in her school prom dress, and for his birthday money to be sent early so that he could buy a stereo.

76. On 2 July, an SO and the Reverend conducted an ACCT case review with the man. It was decided that the man's risk was now low and that the ACCT could be closed. The SO wrote:

> "Myself and the Reverend spoke with the man at length. He now seems happy in himself and he is happy to be on Unit 11. He said he has no thoughts of self-harm or suicide and if things changed he would speak to staff. The anniversary of the event he was concerned about has now passed and is a distant memory."

A post-closure review date was set for a week later on 9 July. There was no reference as to whether he had been seen by a member of the mental health in-reach team as recommended in the mental health nurse's referral.

77. The next day the man met with a second Reverend. This Reverend is trained in spiritual direction, which is a similar discipline to counselling and is confidential. A different Reverend had recommended that he see the man for a one-to-one session. The man was comfortable talking to the chaplains about his problems so it was thought that the first Reverend would be able to help him. Their initial session was not a deep discussion. In interview, the Reverend said that the first session is used to determine what needs to be discussed and further sessions cover any issues.

78. The man explained that he was experiencing a difficult situation with his church outside of prison, the Jesus Army. He had started a relationship with a young woman and the church disapproved. Although the chaplain knew that the man had very recently been on an ACCT they did not discuss it as part of the session. The Reverend told my investigator that the man gave him no cause for concern. The man did not appear anxious or upset, in fact after the session he seemed brighter and was smiling. The Reverend said it seemed appropriate for the man's ACCT to have been closed. If he had had any concerns, the Reverend said he would have advised staff to reopen the ACCT. It was decided that he and the man would meet again on 17 July.

79. On the same day, the man received a warning because he had returned to the unit early from education. There was no further action besides the warning. He said that he just did not want to do any more for the day. The officer that issued the warning told my investigator that the man appeared jovial and was laughing and joking. He had given him no cause for concern by returning early to the unit.

4 July 2007

80. At Glen Parva there is a dedicated night patrol team made up of two groups who work the night shift on rotation. An orderly officer (the night manager) manages the team along with two assist orderlies. The orderly officer is based in the centre office so that he can move freely about the establishment, and he

carries a full set of keys. The two assists are based on the north and south areas of the prison. An officer or operational support grade (OSG) patrols each unit. Officers cannot move from unit to unit without being escorted by the orderly or an assist as they only have keys for their individual areas. All staff (with the exception of the OSGs) have a cell key in a sealed pouch. Cells are only opened at night in special circumstances (for example, medical attention, emergency response, or if a Listener is required) when two or more members of staff are present and with the authority of the orderly officer.

81. An SO was the orderly officer on 3 July. An Officer was based on Unit 11. During his patrol of the first floor landing, the Officer saw that the man was still awake at 2.00am and asked if everything was alright. The man was alone in cell 2-15. The Officer saw that the man had pulled one of the mattresses off the bed (there were two beds in the cell) and put it on the floor. He asked the man what he was doing, to which he replied that he was doing "bar work" (pull-ups) and a gym workout. (Prisoners are often awake late at night and do use the beds for exercising, so this was not an unusual sight.)

82. The Officer walked by the man's cell again at 2.30am. He noticed that the man was still awake and asked if he was having trouble sleeping. The man said that he did not feel tired. Half an hour later, the Officer patrolled the landing and saw that the man was still awake. He said that the man should try and get some sleep, to which he again replied that he did not feel tired.

83. When the Officer finished his patrol of the unit he returned to office and decided to look at the man's history sheet. (The officer told my investigator that he felt compelled to read about him as he had started to think the man was behaving oddly.) As soon as he sat down with the file a cell bell call sounded from the man's cell. (A cell bell is an alarm point used to gain staff attention.) The Officer responded to the bell and went up to the man's landing. As he got to the landing the Officer saw dense smoke billowing from under the cell door. He opened the observation flap on the door, but could see nothing. The Officer used his radio to contact the orderly officer before going to get the fire hose at the end of the landing.

84. The SO responded to the Officer's call and made his way over to Unit 11. On his way, the SO was joined by another Officer . When they got to the landing, a further Officer was bringing the fire hose over to the cell. He explained that the man pressing his cell bell had alerted him to the situation. The Officer collected the key to the inundation point from the office. (The inundation point is a hole in the cell door through which a fire hose can be placed to pump water in and suppress a fire.) The SO then opened the inundation point and an Officer took control of the fire hose. They shouted to the man but got no response apart from hearing him coughing. It was at this point that the officers noticed that a barricade had been placed behind the man's door. He had placed both mattresses against his door and the water was being pumped straight into them.

85. An Officer left the landing and went to collect another Officer whilst two more Officers made their way to Unit 11 having heard the emergency call over the

radio. He also collected a nurse from healthcare who brought an emergency response pack (including defibrillator) with him. As the officers and nurse returned to the unit, the SO radioed the gatekeeper, and requested the emergency services. He then proceeded to open the cell door, using the sealed cell key, to try and get the fire hose beyond the barricade. At this time an Officer arrived and brought a second fire hose to the cell. The three officers managed to force the door open sufficiently to gain access into the cell and remove the barricade of now sodden mattresses.

86. One Officer left the landing because he was unable to breathe in the smoke, and he went to the gate to wait for the emergency services. Two other Officers instructed the other prisoners on the landing to put towels and bedding at the foot of cell doors to stop smoke entering their cells. They were also instructed to open and stand by their windows to allow ventilation and prevent smoke inhalation. (There are 20 cells on the landing holding 30 prisoners that night. Six of which were in cells on their own, including the man.)

87. The man had placed two small lockers in front of the mattresses, one of which was flaming and smoking. Burning furniture used as a barricade were removed from the cell. The corridor filled with smoke and water. Visibility in the cell was limited (about six inches in front of the face) by acrid smoke and so more water was pumped into the cell to try and suppress the fire. The SO decided to go inside and try and locate the man. (Fire safety instructions tell staff not to enter a cell which is on fire, but to wait for the emergency services.) He went in first and another Officer went in behind him holding a belt between them so that they did not lose contact. A third Officer held on to the second Officer. The cell was filled with thick smoke and the officers had to feel their way around. Their first attempt to find the man had to be aborted as the officers were forced back out by the smoke. (In the second Officer's statement he says that he felt a kick to his lower leg when they were in the cell and that he told the SO that the man had done this. He said this is why they retreated. No other statement refers to the man kicking out.)

88. The SO and the second Officer re-entered and managed to reach the cell window. The window had been sealed with toothpaste and paper to prevent smoke from escaping. The officers managed to open the window. They were about to withdraw again to escape the smoke when the SO spotted the man's foot and said that he had got hold of him. The man was face down under the sink. With the help of the second Officer, the SO managed to pull the man out of the cell.

89. Once out into the corridor, the nurse and the SO began cardio-pulmonary resuscitation (CPR). The man was unconscious and had no pulse. The nurse started chest compressions whilst the SO tried to help him to breathe. The nurse had brought the defibrillator but was unable to use it because the corridor was flooded with water from the fire hoses. (Using electrical equipment such as the defibrillator would have posed a risk to everyone out in the corridor.)

90. The emergency services arrived within minutes of each other at approximately 3.40am. An Officer first escorted the paramedics via the laundry and visits

area, because there is only one gate to negotiate on that route and then there is a clear path to Unit 11. However, industrial cleaners on this side of the building had parked directly in front of the gate. The cleaners had to be found and asked to move their van before the ambulance could drive through to the unit.

91. When the paramedics arrived at the unit, an Officer was waiting. He escorted the paramedics up to the landing whilst another Officer escorted the fire engine round to the unit. This Officer wrote in his statement that, when he arrived back on the landing, it was two - three inches deep in water and there was a thick haze of smoke. The SO and Nurse were still performing CPR and the paramedics were just about to take over. An Officer heard the paramedics say that they could not find a pulse and needed to get the man to hospital. He was taken to the local Infirmary by ambulance.

Events after the cell fire

92. An Officer accompanied the man to hospital. Another Officer remained with fire service who extinguished the remaining fire, whilst a further Officer remained with the police. The duty governor was notified of the situation and came in to the prison.

93. After the man was taken to hospital, staff began checking all the prisoners on the unit. An Officer was called from Unit 12 to conduct a roll check (this is to count the number of prisoners). She and two Officers and the SO spoke to all other prisoners on Unit 11. The prisoners were not taken out of their cells until the police had finished in the man's cell. Once they were allowed out, the normal prison regime was suspended for the morning to clear up the water on the landing and in the cells, to issue clean and dry bedding, and so that prisoners could take showers. Staff spoke in more detail with all prisoners on open ACCTs, and a case review was held to make sure that no one felt vulnerable in the wake of the man's death.

94. After the roll check, the Officer from Unit 12 supported staff before they were taken to hospital to check for carbon monoxide poisoning from smoke inhalation. One Officer was treated for asthma. In addition to receiving a general check up, a second Officer required urgent attention as he had received an electric shock from a light switch whilst helping check the remaining prisoners on the landing. A second ambulance was called for this Officer.

96. At 4.35am, the deputy governor was told by the hospital that the man had never regained consciousness and had been pronounced dead. A prison nurse and the Principal Officer went to the hospital to identify the man's body. The deputy governor decided that a member of staff who knew the man well should identify him, just to be certain, before informing his family. The Governor, a Reverend and a family liaison officer went to the man's family home to inform them of his death at 10.00am.

95. A memorial service was held at Glen Parva on the day after the man's death (Thursday 5 July 2007). The chapel was full. A post mortem took place on the same day. The pathologist concluded that the man had died as a result of smoke and fume inhalation. There was minor bruising to each side of his neck that might have been caused when he was pulled out of the cell, or by a attempt at self-hanging. The pathologist's report states that if the man had tried to hang himself there would have been evidence in his cell and no such information had come to his attention. However, in photographic evidence taken by the police there is a ligature made from a thin strip of green material hanging from the side of the cell window. It is understandable that officers did not notice this during the rescue as the room was filled with dense smoke. However, it is strange that the police did not mention it to the pathologist.

96. When the police examined the man's cell, they found a number of letters addressed to friends and family which indicated he had intended to end his life. He had also written on the smoked stained walls of his cell "smile, death is here" and in pen in another area of the cell "Grewy died in this pad".

97. A staff critical debrief was not held until 12 July. (This is a meeting to discuss any lessons learned as the result of a serious incident.) The acting Governor convened the meeting. During interview, he told my investigator that a debrief was not held earlier because all the staff involved had left as soon as possible to be given a health check at the local Infirmary.

98. The main issues arising from the debrief were:

- staff concerns over the inability to freely move between units in responding to an incident
- the lack of breathing apparatus
- the cleaner's van blocking the route from the gate to Unit 11.

96. The Officer from Unit 12 said that she was aware that Short Duration Breathing Apparatus used to be available. The Prison Officers' Association (POA) secretary said that he had been advised that smoke hoods would be introduced shortly. On the issue of the van blocking the route, the cleaners should not have been allowed to leave their vehicle on the through route. The Governor said that he would inform the cleaning company as a matter of urgency.

97. The SO acknowledged that his team had worked well during the incident and demonstrated bravery. The prison Governor also thanked staff for their efforts and reminded everyone that there was ongoing support if needed. A further debrief was to be held by Staff Care and Welfare, although my investigator was unable to establish whether it took place.

ISSUES

Clinical care

98. A Doctor conducted a clinical review on behalf of Leicestershire County and Rutland Primary Health Care Trust (PCT). .The Doctor's main findings, conclusions and recommendations are summarised below.

Reception health screens

99. In both April and June 2007, a nurse saw the man during the reception process. In April, she completed the first half of the initial health screen and then another nurse took over and finished the assessment. During interview, the nurse could not recall why she did not complete the assessment, but was able to confirm that the handwriting for the second half of the form was not hers. Whoever completed the assessment did not sign the form. It is apparent from the handwriting that the same person completed the second health screen. This was not signed either.

100. When the nurse saw the man in June 2007, she noted his history of self-harm and mental health issues. He told the nurse that he self-harmed when he felt like it and it did not mean anything. On being asked about his mental health, he acknowledged he had a problem, but did not want to discuss anything. The nurse wrote, "says has been ref [sic] to psych, has not turned up". During interview, she said that she could not remember if the man meant that the psychiatrist had not turned up, or if he meant that he had not gone to an appointment.

101. On the mental health section of the reception health screen it says, "if 'yes' recorded to questions 8, 9 or 10 (outside prison) refer for mental health assessment". The questions asked are:

- Q8 - Have you ever received treatment from a psychiatrist outside of prison?
- Q9 - Have you ever received medication for any mental health problems?
- Q10 - Have you ever tried to harm yourself?

The man had answered yes to question 10, but no referral was made to the mental health team. My investigator and the clinical reviewer asked the nurse why no referral was made. The nurse said the man was adamant he did not want to be referred. She said that she could not remember if she did make a referral or not, but added that it would have been unusual for her not to. However, there is no written evidence of a referral in either the man's medical record or the mental health team's records. The nurse was also asked why she did not sign the first or second health screen. She said that she was surprised that she had not done so, and could only guess that it was a very busy day in reception and it was probably due to time pressures.

The Head of Healthcare should remind staff of the importance to make and record onward referrals as stipulated by triggers on the first or second health screen assessment.

The Head of Healthcare should remind staff to clearly sign and date any completed documents.

Response to the fire

102. The clinical reviewer concludes that the care the man received at the time of the cell fire was at least as good as that available in the community. He says that in the community the chance of the incident being discovered so soon after the fire was started would have been reduced, and that the immediate availability of personnel to fight the fire and provide cardio pulmonary resuscitation (CPR) was even less likely.

103. Whilst it took some minutes for the Staff Nurse to get from the healthcare unit to Unit 11, this did not affect the response in administering CPR. (Healthcare is in a separate area of the YOI, and at night healthcare staff need to be escorted as they are not issued keys for security reasons. This is explained further below.) When the nurse arrived at Unit 11 with the emergency response bag and defibrillator, the man's cell was still inaccessible. The nurse was on hand as soon as he was removed from the cell.

Mental health

104. The man had a history of self-harming and attempted suicide. Throughout his short life he had suffered some very traumatic events, which he said he found difficult to cope with. Two weeks before going into custody in June 2007, he apparently took an overdose of paracetamol.

105. During previous periods in custody, the man underwent mental health assessments but declined any further intervention. On 22 June 2007, he handed a note to unit staff that made reference to suicide. Unit staff tried to talk to him about the note, but he did not respond. A request was made for a mental health nurse to speak to him. Although nurse 2 is not a registered mental health nurse, he reviewed the man, as the mental health nurse on duty was already with another prisoner. After conducting the assessment, Nurse 2 considered it necessary for the man to be further reviewed by a member of the mental health in-reach team. He also recommended opening an ACCT.

106. This mental health assessment and the follow-up procedures were a major concern during this investigation. Nurse 2 was a registered general nurse (RGN) and not trained in mental health. During interview, Nurse 2 told my investigator and clinical reviewer that he had taken the decision to conduct the assessment as the mental health nurse on duty was occupied with another prisoner. The other nurse on duty was mental health nurse. Nurse 2 said that before undertaking the assessment he agreed with the mental health nurse that he would show it to her once he had met the man. Nurse 2 said that the mental health nurse agreed to this course of action. Nurse 2 also said during

interview that he told the primary mental health team leader about the man's assessment and that he should be seen for a further review as a matter of urgency that weekend.

107. The clinical reviewer has found that Nurse 2's assessment and comments were thorough and appropriate. During interview, Nurse 2 explained that although he is not a qualified mental health nurse he did have some experience in mental health and felt equipped to perform the assessment. However, he did say that, in hindsight, particularly given the man's later actions, he would not do anything he was not qualified to undertake again. Despite Nurse 2's admission, it would be unfair to criticise his conclusions and recommendations resulting from the assessment. Nurse 2 appropriately recommended that an ACCT form should be opened and that the man should be referred to the mental health team. However, it is not acceptable that an unqualified member of healthcare undertook the assessment.

The Heads of Healthcare and Mental Health In-Reach Team should ensure that only appropriate and qualified staff undertake specialist assessments.

108. Although Nurse 2 says that he talked about his assessment with the mental health nurse, she has no recollection of discussing the matter either before or after Nurse 2 spoke to the man. Neither my investigator nor clinical reviewer was able to ascertain which account of events was accurate. There is, unfortunately, no written evidence that the discussion took place and neither the mental health nurse nor the primary mental health team leader have any recollection of it. However, regardless of which account is correct, the fact of the matter is that even though Nurse 2 recommended that someone from the mental health team should assess the man, this did not happen. More importantly, this was not the first time a referral for the man to see the mental health in-reach team had not been carried through.

The Head of Healthcare and Leicester and Rutland Primary Care Trust should ensure that all medical records are comprehensive and easily attributable to members of staff. Any referral should be clearly marked and the appropriate team promptly notified of any necessary action.

109. The clinical reviewer and my investigator spoke to the new Head of Healthcare, Head of Primary Mental Health, and Head of Mental Health In-Reach. During each interview it was explained that, at the time, healthcare and the mental health teams were both under strain. There had been a high turnover of staff and the Head of Healthcare had recently given notice. Staff reported a negative atmosphere and frustrations with insufficient resources to provide a satisfactory level of care. The mental health team was in the process of being restructured. Previously the in-reach team had been informally responsible for both primary and secondary mental health care. During June, there were two in-reach nurses in post and the primary mental health team was in the process of recruiting and inducting staff. Due to the shortage of staff, the mental health nurses were also called upon to perform more generic duties. Although these are reasons that inevitably impacted upon the delivery of healthcare at Glen

Parva during June and July 2007, excuses cannot be made for failing to meet a prisoner's need. It was acknowledged by those interviewed that the man's referrals (if they had been properly made) had slipped through the net. Whether or not this would have made any difference to the outcome on 4 July cannot be known.

110. Part of the restructuring involved setting up a distinct primary mental health team and an in-reach team. The referral systems were also subject to review. The previous referral system (a one page tick box list for referral to any of the healthcare clinics) was replaced with a more detailed form. The new forms require the reason for a referral to be set out clearly, to say whether the prisoner is subject to an open ACCT, and to indicate whether the referral is urgent. The man did not benefit from these important changes and more robust systems.

111. Three days after the assessment with Nurse 2, a locum doctor saw the man. During this appointment the doctor made reference to his previous overdose of paracetamol, and blood tests were taken. The doctor made no note of the man's existing mental state and did not refer to Nurse 2's assessment which was available in his medical record. The clinical reviewer has found this consultation to be less than satisfactory compared to that expected of any doctor in the community. Despite the clinical reviewer's efforts to trace the doctor concerned, it was not possible to find him.

112. The clinical reviewer says in his review that the man's medical records were scant and the referrals to the mental health team were not clearly documented or followed up. Good practice within health services requires timely and accurate notes that can be easily attributed to an author. Several of the entries in the man's records, including the induction screening, were not signed or the signature is illegible. However, I am pleased to learn that Glen Parva now uses EMIS (a computerised medical records system). The system is accessible by all healthcare staff and, if used correctly, should provide clear and comprehensive record keeping, reducing the instance of gaps in care and missed referrals.

The Head of Healthcare should ensure all medical referrals are recorded on EMIS.

113. The clinical reviewer comments that, whilst there were several unacceptable gaps in the man's medical care at Glen Parva, there remains a substantial risk on the part of any prisoners who have made previous suicide attempts. There is a strong probability they will continue to do so, and one day may be successful.

ACCT

114. The Prison Service uses the ACCT process as a tool for monitoring and providing support to prisoners identified as being at risk of self-harm or suicide. ACCT is now used in all prisons and has replaced the previous system for managing risk of self-harm (the F2052SH). All staff should receive basic ACCT

training and be able to open a form, as well as to make appropriate entries in the ongoing record. The basic training includes identifying signs of risk. Some staff receive more in-depth training to conduct assessment interviews and take part in case reviews. A trained member of staff should undertake the first assessment interview. Subsequent case reviews should ideally be multidisciplinary, comprising no less than two members of staff, and also include the prisoner. Once staff conducting a review determine that risk is significantly reduced or no longer evident, the ACCT document can be closed. A post-closure review should take place seven days later to confirm that the risk remains reduced. Ideally, this review should also be multi-disciplinary.

115. On 22 June, the man handed an Officer the note reproduced earlier in my report. The Officer read the first sentence, which contained the word 'suicide', and immediately went to speak to the man. However, as the man would not expand on how he was feeling, the Officer immediately asked for a member of healthcare to come and see him. Nurse 2 assessed the man and suggested to the Officer that he open an ACCT document. The Officer told my investigator that he thought the nurse should have opened the form himself. I agree. It should be clear to both discipline and healthcare staff that they are all responsible for opening an ACCT form if they identify that a prisoner is at risk and requires additional support. Nurse 2 should have opened an ACCT rather than instructing officers to do so

116. Nevertheless, the Officer himself could have considered opening an ACCT document, rather than waiting for the mental health assessment to take place. All staff receive basic ACCT training and should be capable of initiating the process. However, neither omission was significant as the delay was minimal. It was also irrelevant as the man's assessment took place straightaway and the ACCT document was opened immediately afterwards. Nonetheless, it is clear that staff need to be reminded that anyone can open an ACCT.

The Governor should remind staff that anyone can open an ACCT document if they consider a prisoner to be at risk.

117. It is also unfortunate that the Officer did not read the man's note in full. He passed the note to the nurse who attended to the man after the mental health assessment. After this point, no other member of staff seems to remember seeing it, although a typed and undated version was found in the man's medical record when it was handed to my investigator. Whilst the Officer acted appropriately and promptly, not all of the man's immediate concerns were addressed as the whole note had not been read. The note clearly said that the man wanted a change of cellmate. He named the cellmate with whom he had problems and the one who he would prefer to share with. Staff did not look into why he wanted the move. He stayed with the same cellmate even though he said this exacerbated his situation.

118. During the course of the investigation, my investigator referred to the report issued by HM Chief Inspector of Prisons in June 2007. The report found the use of ACCT at Glen Parva to be below standard. A recommendation made in 2004, that had only partially been met by 2007, was that:

> "… a system should be put into place to ensure that information contained with F2052SH [replaced by the ACCT form] documents follows the young prisoner to all activity areas within the establishment."

The HM Chief Inspector of Prisons found that, although residential staff notified activities staff when a prisoner was on an open ACCT, there was no evidence in any of the ACCT documents examined that they had accompanied a prisoner leaving a residential unit. None of the activities staff spoken to by the Inspectorate could recall that unit staff had ever given them this information. The inspectors were told that a current list of prisoners on open ACCT documents was available on the local intranet. However, not all activities staff had routine access to computers, and they were not able to check the information daily. Significantly, no records of comments by activities staff were found in any of the ACCT documents examined.

119. The HM Chief Inspector of Prisons made the following recommendation in her 2007 report:

> "Activities staff should always be specifically notified about any prisoners in their areas on open assessment, care in custody and teamwork (ACCT) self-harm monitoring documents. This should be documented."

I understand that this procedure is now in place at Glen Parva, and I welcome this. I remain disappointed that it did not happen in the man's case.

120. My investigator found similar weaknesses in the ACCT process to those identified by the Chief Inspector. On reading through the man's ACCT monitoring form, my investigator noticed that the standard of 'quality' entries varied. Some officers took the time to write down what they had discussed with the man, whilst others provided a general observation. In particular, the day that was causing him the most anguish (24 June, the anniversary of a significant event that he had brought to staff attention) contained entries with the least information about the man's mood. An SO said in interview that the man would probably have spent most of that day with members of the chaplaincy. At that time the ACCT form would have remained on the unit and not travelled with the man to the chaplaincy. This meant that those who spent time with him could make no entries in his ACCT form.

121. In addition, the reference to 24 June being a significant date for the man when he would require extra care and support was not highlighted in the observation book. It is referenced on the front page of his ACCT form and in his history sheet, but not in the unit observation book. There is not one single meaningful entry in the observation book on this day. A meaningful entry should demonstrate that the individual's physical, emotional and mental wellbeing is being effectively monitored. My investigator spoke to one of the Unit 11 officers on duty that day and asked if he had known that 24 June was a significant date for the man. The officer said that he was not aware of any significance. My investigator asked whether he read the first section of a prisoner's ACCT document to familiarise himself as to why the ACCT was open, what the care

plan was and what to look out for. The officer said that he did not and that it was his duty to make observations and entries in the monitoring section. This was interesting given that there were no considered entries on the form for 24 June.

122. My investigator was told by some staff that time constraints could prevent them from making themselves aware of why an ACCT is open. However, whilst I appreciate that time can be a problem, I do not understand how staff can make meaningful observations if they do not know the circumstances of a prisoner's risk or what to look out for. My investigator raised the matter with the residential governor. he was surprised by what my investigator told him and said that he would expect officers to know such information as it forms an integral part of the ACCT process.

123. Once opened, the man's ACCT document was scant in places and there were few documented meaningful assessments of his state of mind. Meaningful entries are an important requirement in the ACCT observation process and on-going record. Such entries help assess the level of risk and indicate when risk is either heightened or reduced. It is very disappointing that there are so few meaningful entries in the man's ACCT, particularly on the day of the anniversary of the traumatic event (24 June).

124. I understand that a notice to staff was issued in 2008, in accordance with the revised PSO 2700 Suicide Prevention and Self-Harm Management, about making sure the ACCT document now travels with a prisoner wherever they go in the prison. Although my investigator was told that staff had also been reminded and encouraged to make sure that 'quality' entries contain meaningful information, I still have chosen to make a recommendation regarding the importance of properly completing the ACCT. Likewise, staff should be reminded of the need to familiarise themselves with the reasons why a prisoner is at risk and the care plan in place.

The Governor should remind staff to properly complete the ACCT document and make meaningful entries as stipulated by the observation levels set and in accordance with the official Prison Service guidance. In doing so, staff should be aware of the reasons the prisoner is at risk and take note of significant dates, events and triggers.

Single cell accommodation

125. The date and circumstances of the move of the man's cellmate in July 2007 were not clearly documented. The ACCT record has entries that show that the man was seen speaking to a cellmate until 2 July. After the ACCT was closed, there is nothing in his history sheet to record that his cellmate moved out or that it was deemed appropriate for him to be in a cell on his own. He was assessed for single cell accommodation on 26 June but the outcome was not recorded. All the entry includes is that it was agreed the man would speak to staff if he felt like harming himself and that he remained in a shared cell.

126. During the course of the investigation my investigator was told that the man's cellmate moved out because he was discharged from prison. The man then remained in a cell on his own because no one else was moved in rather than because he had been allocated a single cell. This is not documented anywhere in his records. Although he was no longer on an ACCT, it had only recently been closed. There is no recorded review of his vulnerability or assessment for single cell accommodation recorded after the closure of the ACCT document. It could be said that the fact that the document was closed was testament to the man's reduced vulnerability. However, I believe there should have been a recorded review of the appropriateness of him being in a single cell when his cellmate moved out.

127. Without this evidence, it is impossible to conclude whether it was right for the man to be in a cell on his own. Only a week before his death, he was deemed to be at risk, vulnerable and was in a shared cell. I am not satisfied that the decision to leave him in a cell on his own was adequately assessed. Although it seems there would have been a continued threat of self-harm and suicide (as it had been to date in his life), it is very unlikely that if he was sharing a cell he would have chosen to end his life by starting a cell fire.

The Governor should remind staff that decisions to change the cell location of a prisoner who has recently had an ACCT closed should be appropriately assessed and clearly documented.

Staffing during the night and the availability of keys

128. One of the main concerns during my investigation was whether the response to the man's cell fire was timely and appropriate. In determining whether staff were adequately equipped to respond, my investigator spoke to both the Head of Security and Operations and the Health and Safety Officer.

129. My investigator asked the Head of Security and Operations about the keys available to officers working at night and whether officers are easily able to move around the prison in the event of an emergency response. The Head of Security and Operations said that at night only the orderly officer (the duty manager) and two assistant orderly officers (referred to as Oscar 2 and 3) have a full set of keys for the prison. This includes a "pass" key, which unlocks the entrance to a unit. Other officers on duty carry a cell key in a sealed pouch. Although all officers have cell keys, no one should enter a cell during an emergency unless there are two officers present, or without the authority of the orderly officer.

130. My investigator asked whether having only three members of night staff with a full set of keys could result in a delayed response to an emergency. The Head of Security and Operations said that there should be no delay or disadvantage to night officers in their ability to deliver a duty of care to prisoners. He explained that the orderly officer and the assists during night state are positioned to enable the most effective response. One of the assistant orderly officers is based in the north side of the prison and the other in the south. The orderly officer is based in the centre office, but can move throughout the whole

prison. The central location helps provide an immediate response to any alarm call.

131. My investigator was told during interviews with the night staff who responded to the cell fire that, until approximately three years ago, officers working the night shift all had pass keys. This changed when the numbers of operational support grade (OSG) staff at night reduced. (At night, OSGs patrol the units and provide support to officers on Units 2, 9 and 11.) To counter the reduction, two officers remain static in these units with an OSG managing the neighbouring unit. If either officer needs to leave his unit, he/she must open the gate between the two units leaving the OSG to provide cover for both wings. In doing this, a brief handover is given to the OSG before the officer is unlocked from the wing by the orderly officer or one of the assists.

132. Concerned that this process might lead to a delayed response, my investigator sought an explanation as to why the number of staff had been reduced. A Governor said that the night protocols had been reviewed when a dedicated night team was established. He said that staff levels were reduced by three OSGs and that, for the first time, two officers who would usually patrol the prison were used to patrol allocated residential units. The patrolling Oscars would visit all units throughout the night. The Oscars' set of keys has a tag with a unique code that is scanned at each unit, providing an auditable patrol register (called a pegging system).

133. The night duty manager at the time of these changes raised the issue of the potential for an unlocked prisoner to overpower a member of staff and obtain a set of keys. The manager was concerned that there were not enough staff at night to deal with the consequences of opening a cell occupied by two prisoners if the keys were taken. It was therefore decided that only the orderly officer and two assists would carry the full set of keys, and all other officers would carry a cell key in a sealed pouch. This change would help reduce the risk of compromising security. In the event of an emergency, the Oscar in the area (north or south) would collect officers from nearby units (using the "pass" key), leaving the OSGs to patrol until the response has ended.

134. My investigator asked whether any unit is ever left without patrolling staff in the event of an emergency. She was told that units always have a member of staff on patrol, be this an officer or an OSG. If officers are required to leave Glen Parva (for example, to escort a prisoner to hospital) then the duty governor would be contacted. The duty governor would assess the situation and decide whether additional staff should be called in. The orderly officer has a full list of staff contact numbers specifically for this purpose.

135. Once it was clear that nothing more could be done to save the man and the ambulance had left the prison, the two officers who did not need immediate hospital attention remained at the establishment. An Officer said that whilst the duty governor was busy on the unit putting the contingency plan into action, he and another officer had to telephone staff to come and provide cover until the day shift started. The Officer said that they were unable to leave and go to the hospital until more staff came in. Although this situation was not preventable,

given the two officers had just assisted in a traumatic incident it was not ideal or sensitive for them to personally have to find cover so that they could leave.

136. The duty governor said that, on arrival at Glen Parva, he had yet to fully assess the situation and did not know whether the man had died. He said that at first all he knew was that a prisoner was injured and had been taken to hospital. The duty governor said that he did not assess the condition of the staff who had responded until he had spoken to everyone who attended the incident, including the police. In response to the Officer' statement, he told my investigator that he instructed the orderly officer to ask staff to come in to relieve the night team so that the police could interview them. The duty governor told my investigator that the safety of staff is paramount, and that everything was done as quickly as possible to arrange medical attention for the officers.

137. My overall impression given these differences of opinion is that, despite concerns over staffing levels and response times, the dedicated night team worked very well together in this instance. It was clear from the accounts of the response and from interviewing the night team that there is a strong sense of teamwork and dedication. The team's response to events on 4 July was professional and demanded great bravery.

The Governor should commend for their courage the dedicated night team who responded to the fire in the man's cell.

Fire and emergency response policy

138. During her enquiries, my investigator asked the officers on duty why they had not evacuated the landing. Governor's Order 14/2006 states that an action to be taken in case of a cell fire, if necessary, is to evacuate the area. This is also stipulated in the prison's contingency plan for a fire at night. It was explained to my investigator by the officers on duty that there are not enough staff on duty during the night to evacuate a landing if it is necessary. At least two officers would be required to oversee the movement of prisoners. One officer would need to go to the gate to escort the emergency services to the incident, and another would need to escort prisoners. In this scenario, an evacuation would not have left enough staff on the landing containing the cell fire. It was considered that an evacuation was neither practical nor necessary in this instance.

139. My investigator said during interview with the Deputy Governor, Governer, and the Health and Safety Manager that it was fortunate that the fire was containable and that evacuation did not become necessary. The response was that the night manager (orderly officer) has the option to evacuate a landing, or indeed the whole unit, after assessment. However, cell fires do not automatically warrant an evacuation. Each situation should be assessed individually. The duty governor told my investigator that, if evacuation had become necessary, there would have been sufficient staff to manage the move. Each landing holds 20 cells and a maximum of 40 prisoners. The duty

governor said there were sufficient staff on duty to both move the prisoners and escort the emergency services.

140. The man had used mattresses to barricade his cell door before lighting the fire. When officers placed a fire hose through the inundation point in the cell door the mattresses filled up with water, making the barricade heavier. Even when the officers managed to push the door open sufficiently to place the hose through the gap, the mattresses made it difficult to gain enough access to put out the fire.

141. During a barricade it is possible to open a cell door from the hinge-side outwards using the anti-barricade bolt. My investigator asked the SO and the others involved whether they had considered gaining access to the cell using the bolt. The SO said that he had briefly considered it, but decided against as he thought that it would have wasted valuable time. He explained that the key is held in the unit office (there is also one in the centre) and it would have taken a couple of minutes to collect. The SO said that, even if they had retrieved the key to open the two-way lock, there was no guarantee that it would have opened the door. He explained that on many of the cell doors the lock had been sealed by dry paint. The locks had not been tested after painting the doors to make sure that they were accessible or easy to open. I draw this to the Governor's attention and suggest he plans remedial action.

142. The SO said that, given the severity of the situation, it was not a risk worth taking to try and open the door in this way if success could not be guaranteed. Instead, the decision was made to gain access to the cell by forcing the door and pushing the hose through the gap. The SO said that a second inundation hole above cell doors would have been useful. The inundation hole was blocked by the man's mattress and prevented any water getting into the cell. A second hole might have helped get water into the cell more quickly. (This suggestion was also made during the critical debrief.)

Short Duration Breathing Apparatus

143. Short Duration Breathing Apparatus (SDBA) is equipment that enables safe entry to a smoke-affected area. It is similar to the breathing apparatus used by the fire service, but has a smaller oxygen bottle. The SDBA can provide up to 15 minutes of clean air. As a result of Instruction to Governors (IG34/96), almost all prisons acquired SDBA to deal with cell fire incidents. The cost of maintaining the equipment was met by central funding up until 2006, when the cost was shared with prisons. The largest proportion of funding is central funding for annual maintenance, and prisons are expected to meet the cost of maintaining the air cylinders.

144. Regular training needs to be provided for staff to use SDBA safely, and the equipment should be worn every two months to ensure familiarity with its use. This ongoing requirement, as well as an upper age limit (up to 55 years) and the fact that no one with a beard being allowed to use the equipment, and obvious medical restrictions, has led to its unpopularity amongst operational managers. Lack of staff resources and other competing training requirements

have meant that SDBA use has not been continued in most prisons, Glen Parva included. The use of SDBA has declined to a point where only approximately 35 per cent of establishments continue to maintain the equipment.

145. Prison Service senior management have supported the replacement of SDBA with a bespoke smoke hood designed to protect staff from smoke inhalation. Prototype smoke hoods are being tested with the purpose of achieving accreditation for use and manufacturing (providing tests were successful) from the end of 2008.

146. In relation to the other death in custody as the result of a cell fire investigated by my office, the Coroner issued a Rule 43 letter to the Prison Service on 3 March 2009. In this he raised concerns over the use of SDBA. He wrote:

> "Nothwithstanding the jury's findings with regard to Short Duration Breathing Apparatus (SDBA) in this case, the confusion created by professional disagreement about when its use would be appropriate could easily give rise to the risk of deaths in the future and an urgent review therefore as to its deployment should be undertaken."

In response, the Safer Custody and Offender Policy group at National Offender Management Service (NOMS) said that the Prison Service fire strategy had been revised with regard to equipment available to staff. Clearer guidance is set out in Prison Service Instruction (PSI) 3803, about the introduction and ongoing use of cell snatch rescue equipment (CSRE) across the prison estate. The PSI was issued on 1 July 2009 and will be implemented on 1 October 2009.

147. CSRE will replace the existing Short Duration Breathing Apparatus, but will be used for the same purpose by prison staff, as part of the immediate action needed to save life during a cell fire. *It will provide staff with up to 15 minutes* respiratory protection from smoke and toxic fumes. It is intended for this limited purpose only and must not be used for general fire fighting duties or for escorting fire service staff.

148. All establishments which have closed cellular or cubicle accommodation (for not more than four persons) fitted with inundation points will have sufficient sets of this equipment issued and available. Each prison will be responsible for ensuring that sufficient staff are trained in its use, to enable any cell fire to be effectively dealt with by staff wearing CSRE at any time, both day and night. All users of the equipment must receive both initial and refresher training. The authority not to use CSRE at any establishment may only be given by the Director of Offender Manager, Area Manager or Director of High Security Prisons as appropriate.

149. As with the SDBA equipment there are some limitations on its use. For example, the equipment is unsuitable for use in closed corridors where there is no smoke extraction systems. Movement along a smoke-logged corridor to get to a cell will reduce the effective working time of the equipment. The equipment

is only intended for short rescue attempts (less than 10 minutes) and therefore can only be applied where the user can quickly access a cell. In general it should only be used when a prisoner is in imminent danger and when there are two trained members of staff being overseen by the Orderly Officer (or equivalent), who would also be trained. In exceptional circumstances, one wearer would be permitted to release the prisoner from the cell, but not enter on his/her own.

150. In terms of health and safety use of the equipment, all staff will be required to use CSRE (once trained) unless they have a known medical condition that precludes this. The CSRE is not designed to accommodate wearing spectacles. In addition, staff with beards will not be able to use the equipment. The beard may interfere with the airtight seal inside the mask, compromising safety.

151. In the case of the man's cell fire, it is reasonable to conclude that equipping staff with smoke hoods, or similar equipment, would have made rescuing him easier once access was gained. Officers had to retreat from the cell twice before they found the man due to the acrid smoke. That said, once access was gained they were able to get him out. The barricade against his door provided the biggest obstacle to his rescue. It is not possible to say whether having the equipment would have changed the outcome, but I am pleased that steps have been taken to provide replacement protective equipment so that staff will be better prepared in the future.

Fire contingency exercises

147. One of the concerns raised by the Crown Premises Inspection Group was that staff at Glen Parva did not undergo regular fire safety exercises. At the time of the man's death, Glen Parva did not have a dedicated fire officer. The officer who was in place was responsible for both Glen Parva and HMP Leicester. This was not an ideal situation and was rectified in July 2007 by the employment of a full time Health and Safety Manager.

148. Contingency exercises with the local fire service had taken place, but they were infrequent and were not rehearsed in line with night-time protocols. The contingency exercise is for the benefit of the fire service, and not for the officers. It is designed to ensure that the fire service is familiar with prison procedures, protocol and geographical layout to better deal with incidents when they occur. For example, familiarisation with the essential security checks at the prison gate before being able to enter the establishment can help reduce time on arrival.

149. The fire service is supposed to attend a prison four times a year for inspection and to conduct an annual contingency exercise. The most recent exercise conducted prior to the man's death was on 11 August 2005, nearly two years earlier. In early 2007, the local fire station officer wrote to Glen Parva drawing attention to the fact that an exercise had not taken place during 2006. As a result, an exercise was planned for 4 July 2007. However, on 26 June the

prison asked for the exercise to be put back as the new fire officer would not be in post until 9 July. A new date was set for 23 August 2007.

150. Prison Service Order (PSO) 3801 for Health and Safety Policy Management stipulates that:

> "Governing Governors must appoint a fire safety officer to provide advice on all fire matters within the establishment."

During the period in which Glen Parva did not have a fire officer the prison failed to comply with the PSO. This affected compliance with the requirement to hold an annual contingency exercise with the fire service. Whether or not these failures had any effect on the outcome in the man's case cannot be known. However, it is clear that the prison was not meeting its duty of care with respect to maintaining appropriate fire safety during 2006 and early 2007.

The Prison Service should investigate why the Governor at HMYOI Glen Parva did not comply with Prison Service Order 3801 by having a fire safety office employed at Glen Parva at all times.

151. Since 9 July 2007, a PSO has been in place for fire safety (PSO 3803). The purpose of the PSO is to ensure a system for effectively managing the risks from fire. All prisons are expected to comply with the order.

152. My investigator interviewed the new full-time fire officer. On starting his new post, he conducted an audit of the "safe systems of work" requirements used by Glen Parva in the event of a fire. The steps detail what staff should do in the event of a fire, who to notify, what equipment to use, and so on. There are different steps to take if the occupant of a cell is responsive, unresponsive, violent, or if a barricade has been used. The fire officer has also organised for three smoke detectors to be place on each unit landing and has made a recommendation (and bid) to improve smoke extraction. He told my investigator that there was only one smoke detector in each of the south block units when he started his job – one on the ground floor and nothing on the first and second landings. However, there were some in the north block of units. The man's unit was in the south block.

153. The fire officer said that he found the audit process difficult because had not been provided with staff incident reports from the cell fire and had to speak to them to find out what happened. He was told about the problem getting water into the man's cell due to the barricade. The fire officer had introduced a new fire safety procedure in the event of a barricade. The new requirement is that staff break the glass in the observation panel and place the hose through the panel. The panel is sufficiently high to be taller than any mattress against the door.

154. Since July 2007, two full fire service drills have been carried out, one on 23 August as planned and a second on 8 May 2008. Both drills were conducted during the evening and involved four cell rescues. This still does not comply with the requirement for the fire service to attend the prison four times a year.

The Governor and Fire Safety Officer should ensure that the fire service attend the prison four times a year for inspection.

155. In 2007, the fire officer arranged for 177 staff of all grades to undertake a short training course on fire safety. The course is basic and covers the different types of fires, how to use fire hoses, when to use smoke blankets, how to fight a fire, how to raise the alarm, evacuating a unit, accounting for people and so on. At the time of interview in 2008, a further 48 members of staff had trained and it was planned to train 80 more including ten new staff. Fire safety was also introduced into the prisoner induction programme. A notice detailing what to do in the event of a fire is issued with each induction pack and is available in seven languages

156. To create a fire in his cell, the man filled the two lockers in his cell with flammable materials (mainly paper) and set them alight. He pushed the locker up against a barricade of two mattresses, preventing staff from entering his cell. All prison furniture must comply with the British Standard fire retardant requirements. The fire officer explained that the furniture must be checked regularly because if it is damaged (for example a hole in the material) it is no longer fire retardant. The same applies to domestic furniture. All cell furniture is also fire retardant. There are wooden lockers in the cells at Glen Parva (which replaced metal ones) but they are fire retardant. If burnt, fire retardant furniture will smoke in the first instance rather than burst into flame. My investigator asked whether the smoke would be toxic. The fire officer said that was a question best directed to a forensic scientist. However, he did say that inhaling any kind of smoke in a confined space would be toxic in the sense that it is very harmful.

Family liaison

157. A Governor, Reverend, and family liaison officer, went to the man's family home to inform them of his death at 10.00am on 4 July. Shortly before arriving at the house, a telephone call was made asking the man's mother to come home from work because there was some news from the prison, but no detail was given. The man's mother was extremely upset by both this call being made and at being told five and half-hours after her son had died. She has asked me to explain the delay.

158. My investigator spoke to the acting governor about how the man's family were informed. The acting governor said that he did not arrive at the prison until 6.00am that morning and he was briefed that the man had died at around 5.00am-5.15am. (It is not clear who gave this timing.) On arriving at Glen Parva, he checked if there were any family liaison officer (FLO) arrangements already in place for notifying the man's family. The acting governor said that the FLO normally arrives at the prison between 7.00-7.15am, and from memory this was when he arrived on 4 July. The acting governor said that he took the decision at 6.00am to wait until the FLO came on duty and did not telephone him in advance to report the man's death. He did this because he thought that

the FLO would already be making his way to the prison. He said that he did not believe there was a delay in telling the man's mother what had happened.

159. The FLO was briefed when he arrived for duty and it was decided that a chaplain should accompany him to the family's home. The acting governor said that before telling the man's mother they were keen to formally identify the man's body. A security manager and one of the nurses who knew the man well identified him. They were not asked to go to the hospital to do this until they came on duty at around 7.30am. They confirmed that the body was the man's 45 minutes later.

160. The Reverend, Governor and the FLO left the prison at approximately 8.30am. The journey to the family's home took an hour and a quarter. The Family Liaison Officer had tried to telephone the man's mother before they left. After receiving no answer, he left a message on her mobile asking her to contact Glen Parva. The man's mother telephoned and spoke to a Governor who told her that some representatives from the prison were on their way to her house with some news about her son. Although I understand the importance of telling the man's mother about his death in person, and the desire to make sure she was at home, I do question the sensitivity of telephoning ahead to let her know news was going to be delivered without explaining the full story. This caused the man's mother and her family additional distress and worry whilst waiting for the Governor to arrive.

161. It is not clear why the decision was taken to wait for staff to come on duty before steps were taken to identify the man's body and inform his family. Whilst I appreciate that it is imperative to get all the relevant facts before informing a family, especially confirming identify of the deceased, it would have been more sensitive to the man's family if this could have been undertaken by using staff already on duty, and by telephoning the FLO as soon as the death had been declared. Although this would have only meant the man' mother learning the news an hour or so earlier, I think this would have been worthwhile and more sensitive to her.

162. The man's family were disappointed with the level of information given by the prison about the circumstances of his death. They were also disappointed with the liaison process during the following weeks. The man's mother was upset that she was not permitted to see her son's cell before it was cleaned after the fire. Similarly, she was upset that his clothes had been laundered before they were returned to her. Whilst I understand that the man's mother was saddened by these actions, my investigator was assured that the prison acted in good faith and there was no intention to cause deliberate upset. Staff thought the family would be upset to see the cell in a poor state. However, this should have been a decision made in consultation and not by Glen Parva on the family's behalf.

163. Glen Parva met the cost of the man's funeral, which was much appreciated by his family. However, the man's mother told my investigator and family liaison officer she was not told the prison would pay at the outset. Had she been told

earlier, it would have saved her unnecessary anxiety during an already difficult and painful period.

CONCLUSION

164. The man had a short and troubled life. He had at least one other documented suicide attempt in his recent past. Whatever the psychiatric diagnosis of someone who has attempted suicide, there is always an increased risk of further attempts. Sometimes this is a means of asking for help or of reducing the intensity of feelings, and not actually about death. Unfortunately, this does not stop suicide attempts being unintentionally successful.

165. Had the ACCT document remained open, he would still have had ample opportunity between assessments to start the cell fire. An officer saw him regularly whilst he patrolled the unit because the man was still awake during the routine checks. Arguably, this was as frequently as he would have been checked had he been subject to ACCT observations.

166. The man's actions would have been made more difficult or prevented only if he had been subject to a constant watch. However, he had not given staff any concern that he was at risk of harm after his ACCT had closed, and it was entirely reasonable that the document was not reopened. In the circumstances, I conclude that the man's death on the night of 4 July 2007 was not directly preventable.

167. I have been disappointed to discover the lack of any mental health input, the poorly documented ACCT, and the failure to address all of the concerns raised in the man's note written on 22 June. It is impossible to say whether addressing any of these shortcomings would have made a difference to the outcome.

168. Those staff who rescued the man from the fire were brave and acted above and beyond the call of their duty on entering his cell. Tragically, despite their efforts, his determined actions resulted in his death.

RECOMMENDATIONS

Healthcare

1. The Head of Healthcare should remind staff of the importance to make and record onward referrals as stipulated by triggers on the first or second health screen assessment.

   This recommendation was accepted and the Healthcare Reception Team now ensure that letters are faxed through to GPs as soon as possible in order to gather information regarding a prisoner's mental and/or physical health. All staff are informed that if a prisoner has mental health problems they should be seen by a trained mental health nurse at the earliest opportunity. As a further measure, this is an objective in healthcare staff's personal development record to remind them of this responsibility. I welcome this change in practice.

2. The Head of Healthcare should remind staff to clearly sign and date any completed documents.

   This recommendation was accepted. A Clinical IT system has been put in place which clearly indicates who has seen a prisoner's notes by recording who has opened their medical notes. In addition, there are regular healthcare meetings and peer supervision during which the importance of effective record keeping is discussed. Staff are reminded that they must sign any paperwork. Again, as a further measure, this is included as an objective on all healthcare staff personal development records to remind them of their responsibilities in this area. I welcome this change in practice.

3. The Heads of Healthcare and Mental Health In-Reach Team should ensure that only appropriate and qualified staff undertake specialist assessments.

   This recommendation was accepted. All staff are reminded during regular clinical meetings about the importance of only those qualified and skilled in mental health work undertaking mental health assessments. Registered General Nurses and Clinical Support Workers are informed that they must hand over any information gleaned about a patient as soon as possible to a qualified member of staff. This responsibility is reflected in healthcare staff personal development records.

4. The Head of Healthcare and Leicester and Rutland Primary Care Trust should ensure that all medical records are comprehensive and easily attributable to members of staff. Any referral should be clearly marked and the appropriate team promptly notified of any necessary action.

   This recommendation was accepted. Since the man's death a new IT system has been installed in healthcare, which allows for better tracking of information, including recording who has seen the patient and what action has been taken. This allows for better tracking of referrals. In addition, there is a Mental Health Service Manager in place who has developed the referral system (since the

summer 2007) and this has helped ensure that any referrals are seen in a timely manner, according to the urgency.

Again, responsibilities are recorded in healthcare staff personal development records.

5. The Head of Healthcare should ensure all medical referrals are recorded on EMIS.

   This recommendation was partially accepted. Glen Parva does not have EMIS, however there is "System One" in place, and this records all referrals. A notice to staff was published informing HCC staff of their responsibilities in this area and it has been included on personal development records.

ACCT

6. The Head of Safer Custody should remind staff that anyone can open an ACCT document if they consider a prisoner to be at risk.

7. The Governor should remind staff of the importance in properly completely the ACCT document and make meaningful entries as stipulated by the observation levels set and in accordance with the official Prison Service guidance. In doing so, staff should be aware of the reasons the prisoner is at risk and take note of significant dates, events and triggers.

8. The Governor should remind staff that decisions to change the cell location of a prisoner who has recently had an ACCT closed should be appropriately assessed and clearly documented.

   All three recommendations were accepted and the following actions have been taken:

   - All staff working with prisoners have completed ACCT foundation training. A training programme is in place for new staff.
   - All staff have been issued with an ACCT procedures aide memoir. This is to remind staff of their responsibilities regarding the use of the ACCT.
   - An electronic learning tool is available on the Prison Service intranet site and is also accessible on a shared drive on staff computers.
   - A notice to staff has been re-issued to remind staff that anyone can open an ACCT document.
   - A notice to staff has been issued to remind staff to make sure meaningful entries are written on ACCT documents.
   - A Governor's Order has been reissued to remind staff to make themselves aware of the reasons a prisoner is at risk and take note of significant dates and triggers.
   - A notice to staff has been issued to remind staff that any changes to the cell location of a prisoner who has recently had an ACCT close should be appropriately addressed and clearly documented.

An additional notice to staff was re-issued detailing procedures to follow when dealing with this type of move.

- The Safer Custody Manager gave a presentation at a Full Staff Meeting in May 2009 to remind staff of their responsibilities in appropriately managing ACCT documents and procedures.

Fire safety

10. The Prison Service should investigate why the Governor at HMYOI Glen Parva did not comply with Prison Service Order 3801 by having a fire safety office employed at Glen Parva at all times.

    This recommendation has been accepted. The issue was investigated and it was found that attempts made to fill the post failed. The decision was then taken to recruit at a manager level and the present post-holder assumed their post on 9 July 2007.

    I am pleased to see that an explanation has been sought, however, it remains unacceptable that there was not a fire safety manager in post during 2006 and early 2007.

11. The Governor and Fire Safety Officer should ensure that the fire service attend the prison four times a year for inspection.

    This recommendation has been accepted. In 2007, three inspections took place. In 2008, there were five inspections and in 2009, there have been three to date. I am satisfied that the inspections are now occurring with appropriate regularity.

Good practice

1. The Governor should commend for their courage the dedicated night team who responded to the fire in the man's cell.

    The Governor has personally written to those staff who responded to the cell fire, commending them for their courage and actions.

Response to the draft report

Prison Service comments

The following comments were offered in relation to CPIG's findings regarding fire safety at Glen Parva:

"Paragraph 9 states that "cells are not fitted with any suppression facility (e.g. sprinkler system). This means that entering the cell is the only way of extinguishing a fire". This is incorrect. Fires can be suppressed by using the inundation point from outside the cell, which has been mentioned later in the report. The barricade would have made this more difficult which is why the anti-barricade device was fitted to all cell doors.

Due to the varied type and age range of the prison estate, the Prison Service has a memorandum of understanding with CPIG that each year, the Prison Service will undertake an agreed number of projects to address their major priorities and risks relating to fire safety.

With reference to the first two bullet points of paragraph 9, all new cells are being provided with smoke detection, and a manually operated hose misting system is provided in most cases. With regard to existing accommodation, cells are provided with smoke detection and a manually operated misting system on major refurbishments. In other cases, a manually operated portable misting system can be provided where, on assessment, it is considered that there is a particular increased risk. Misting is far more effective than the current inundation; the water droplets are drawn to the fire despite obstacles (which would be a barrier to water from inundation) plus there are other fire suppression benefits."

I accept these comments and welcome the changes made to increase fire safety at Glen Parva.

Family's comments

The man's mother wanted to highlight areas of bad practice and good practice in relation to her contact with staff at Glen Parva. Her initial experience with the prison was extremely negative. She again expressed her upset at how she was informed of her son's death and the time it took to inform her. She explained that initially limited information was given to her about the circumstances of her son's death and she learnt more from reading local newspapers days later. Although she acknowledged that some of the reported information was inaccurate (e.g. that her son was on suicide watch at the time), she said that any confusion over facts could have been avoided if she had been given more information when she was visited at her home.

On visiting the prison to collect he son's property, she said that she was told by the Governor who was her liaison at the prison, that she would not issue any of her son's belongings without a property checklist. The man's mother was expected to produce a written list of her son's property to check against the items the prison had before she could take his things home. This greatly distressed her because she could not be sure what her son had taken with him into prison. She said this process was

upsetting and found it to be unnecessary, particularly considering the prison had recovered what they believed to be her son's belongings from his cell after the fire. The man's mother could not understand why she had to produce the list.

My investigator explained to the man's mother during their meeting at the family's solicitors office that it was Prison Service procedure to only issue property that could be confirmed as belonging to a prisoner. Any items would need to be checked against a prisoner's property record. This record shows what items a person had been issued to have in possession or left in storage. However, given the circumstances, especially considering this was her first visit to the prison after her son's death, that more sensitivity could have been exercised.

Contrary to these negative experiences, a year later, the man's mother asked the prison if she could return on the anniversary of her son's death. She took some flowers, which she was invited to place in the chapel. Whilst there, she was made very welcome by the chaplaincy team, who arranged a memorial with a photograph and candles. A Sister spent time with her and she was told that she could remain at the chapel for as long as she wanted. The man's mother said that this was a very positive visit and she hoped to do the same again in 2009.

1. My investigator and my PPO's family liaison officer, said that this was an excellent example of both good and sensitive practice. They were pleased that the man's mother had been warmly received on this occasion and believed this made some headway to redressing the balance of her earlier treatment by staff.