PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man, a prisoner at HMYOI Glen Parva, at hospital in May 2011

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

This report considers the circumstances surrounding the death of a man at hospital in May 2011. He was found hanging in his cell at HMYOI Glen Parva on 8 May. He was 21 years old at the time of his death, and was being held as an immigration detainee awaiting deportation to Nigeria. I offer my condolences to all those who knew him.

The investigation was conducted by an investigator. A review of the man's clinical care was provided by a clinical reviewer on behalf of the local PCT. Glen Parva and HMP Woodhill, where the man was previously held, cooperated fully with this investigation. I am sorry for the delay in the publication of this report.

The man received an extended sentence in May 2010. He had been held on remand since January of the same year, and his release date was calculated as October 2010. However, steps were taken to deport him, a Nigerian citizen, and so he remained in custody beyond his planned release date. Between October 2010 and April 2011, he was detained at HMP Woodhill and was then transferred to HMYOI Glen Parva.

On the evening of 7 May 2011 the man made a small cut to his neck using a razor blade. He was made subject to self-harm monitoring. The next morning, just before 11.00am, he was discovered in his cell with torn bedsheets around his neck. A sustained and coordinated resuscitation effort obtained a pulse. He was taken to hospital but, sadly, died a few days later.

The investigation raises concerns about the management of the man's risk of self-harm and whether information was properly communicated to Glen Parva when he transferred from Woodhill. It was not made apparent that he had harmed himself three months before his transfer, nor was it mentioned that he had set a fire in his cell. It is unsatisfactory that the self-harm monitoring documents which cover these incidents are missing.

It is also of concern that not all staff at Glen Parva appeared aware of his immigration status, despite this clearly playing on his mind. Nor was all information regarding his previous risk of self-harm properly communicated between prisons, and even that which was available was not effectively used. There was also little continuity of care offered to help him, a clearly vulnerable and troubled young man, address his mental health needs. While we cannot conclude that his death would have been prevented had these failings be avoided, there is considerable learning to be drawn from this sad case.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2012**

CONTENTS

SUMMARY

1. The man was arrested in January 2010, convicted in March, and sentenced in May. His release date was calculated as October the same year. As a Nigerian citizen, he was subject to deportation from the United Kingdom after his prison sentence.

2. He completed his sentence at HMYOI Aylesbury. He continued to be detained in prison custody under immigration powers pending a decision about possible deportation. In October, he transferred to HMP Woodhill.

3. Soon after his arrival at Woodhill, the man became infatuated with a woman prison officer. He spoke to her whenever he had the opportunity and asked her questions about her personal life. Within a few days of his arrival, it became apparent that he had developed an inappropriate attachment towards the officer, who repeatedly tried to distance herself from him. His inappropriate behaviour continued throughout November and December and the officer reported it to the prison's security department on a number of occasions.

4. On 23 December, he was served with a notice of deportation which he appealed against.

5. His infatuation with the prison officer continued. He knew that his feelings were unwelcome and inappropriate but said that he could do nothing to control them. Several members of staff raised concerns about the possible risk that he posed to this officer. Steps were taken to reassign the officer to work in other parts of the prison, but this was not completely effective.

6. During January 2011, the man's behaviour seemed particularly volatile. On 11 January, he refused to go to work and had to be restrained after he became aggressive. The next day, he was involved in a fight with a prisoner and was subsequently taken to the prison's segregation unit. He talked to a doctor about his strong feelings towards the prison officer. On 14 January, he moved to the prison's first night centre where he became aggressive and had to be restrained again. A mental health nurse saw him and agreed to offer him regular support. He began to be monitored as at risk of self-harm.

7. The next day at around 1.30pm, he lit a fire in his waste paper basket. He was quickly removed from the cell and the fire was extinguished. While this was happening, he used his socks to try to hang himself. He was discovered almost immediately and did not lose consciousness. He was taken to the healthcare unit where he stayed for the remainder of January. On 25 January, he became extremely upset and agitated when he saw the female prison officer with whom he was infatuated. His self-harm monitoring was stopped on the same day. The reasoning behind this decision is not known because the Prison Service has been unable to find the relevant documents.

8. Throughout February and March, the man continued to see the mental health nurse. His mood was variable and his identified problems remained complex,

involving unresolved feelings of grief about the death of his mother, his concern about deportation, and his inappropriate attachment to the female prison officer.

9. On 10 March, he was told that his appeal against deportation had been rejected and, on 7 April, his solicitor confirmed that he had exhausted all avenues of appeal. He would be detained until he was removed from the UK.

10. Throughout this period, the man had continued to pursue the officer with whom he had developed a fixation. Because of continuing concerns about this, he transferred to HMYOI Glen Parva on 14 April.

11. Although he seemed to be a popular with other prisoners, he remained volatile and continued to fixate on the prison officer from Woodhill. On 26 April, he was seen by two nurses because he was very distressed and was crying so much that he struggled to speak. He told the nurses about his unresolved grief and the feelings that he had developed for the prison officer at Woodhill. The nurses discussed the possibility of self-harm monitoring, but they did not believe that he showed any intent to harm himself at that time.

12. He started to see a prison chaplain for one-to-one support sessions on 3 May. He was assaulted by another prisoner on 4 May, and then assaulted the same prisoner on 5 May. He was made subject to anti-bullying procedures as a result. On the evening of 7 May, he made a small cut to his neck using a razor blade. Staff began self-harm monitoring and he saw a mental health nurse.

13. The next morning, 8 May, a full assessment of his risk of self-harm was carried out, during which he said that he had previously tried to hang himself. The mental health nurses due to see him that morning found information in the clinical record about his attempt to hang himself in January at Woodhill.

14. Around 10.30am, while a senior officer and the nurses were discussing the man, he asked a prison officer if he could end his association period and return to his cell. The senior officer asked for him to be relocated to a safer cell (used for prisoners thought to be in imminent danger of taking their own lives), but the manager on duty asked the senior officer first to confirm with Woodhill that the incident in January had taken place, despite the fact that it was documented in his clinical record.

15. Shortly before 11.00am, the senior officer went to the man's cell with the intention of taking him to speak to the mental health nurses. When he opened the cell door, he found that he had hanged himself with one end of a torn bed sheet tied around his neck and the other end to the window handles. The senior officer raised the alarm and a swift, coordinated resuscitation effort began. Although he was initially unresponsive, the healthcare staff managed to obtain a pulse. He was taken to hospital but died a few days later.

16. Our investigation is critical of information sharing between prisons, particularly in relation to the risk of self-harm. We have also examined how pre-existing

electronically stored information could be used more effectively. We discuss the way in which self-harm monitoring was used for the man, and the continuity of mental health support. We make six recommendations as a result of the investigation.

THE INVESTIGATION PROCESS

17. An investigator was appointed. Notices about the investigation were sent to HMYOI Glen Parva for distribution and display, giving staff and prisoners the opportunity to contact him with any relevant information. Nobody came forward in response.

18. The investigator visited Glen Parva to open the investigation on 2 June 2011. He visited areas of the prison where the man had spent time, and also collected records relating to his time in custody. He received further documentation from HMP Woodhill about the man's time there.

19. When it became apparent that an Assessment, Care in Custody and Teamwork (ACCT) self harm monitoring document from Woodhill was missing, the investigator asked Woodhill and Glen Parva to check whether the document was in their possession. Both said they did not have the missing ACCT document. He also confirmed with the Leicester Coroner's office, who had taken possession of the man's prison files from Glen Parva, that they did not hold the original copy of this document. It has therefore not been possible to locate the ACCT document for the purpose of this investigation.

20. The investigator returned to Glen Parva on 13 and 14 July, 10 and 11 August, and 1 November. He conducted interviews with 17 members of staff and one prisoner. On 2 September, he conducted interviews with four members of staff at Woodhill.

21. One of the Ombudsman's family liaison officers (FLOs), spoke to a friend of the man's, who was his nominated next of kin, to explain the purpose of the investigation and provide him with an opportunity to ask any questions about the care that he received in prison. He was concerned that, although the man was subject to self harm monitoring, staff had allowed him the opportunity to take his own life. This issue is addressed in the report. He was positive about the help and support that he received from the prison's family liaison officer after the death.

22. The local PCT appointed a clinical reviewer to conduct a review of the man's clinical care while in custody. The purpose of a clinical review is to determine whether the standard of care that a prisoner received in custody was equivalent to what might have been expected in the community. The clinical reviewer consulted the man's medical records to inform his review. He also had access to the transcripts of all the interviews that the investigator conducted. His findings are summarised in this report. The final version of the clinical review was sent to the Ombudsman's office in March 2012. Our report has unfortunately been significantly delayed as a result.

23. As part of the consultation process, the National Offender Management Service (NOMS) had the opportunity to comment on a draft version of this report. All of the recommendations were accepted and the response can be found on pages 36 and 37. One of the Ombudsman's family liaison officers tried to make contact with the man's friend by telephone and letter, but no

response was received. Subsequently, he did not receive a copy of the draft report.

HMYOI GLEN PARVA

24. Glen Parva is a young offender institution (YOI) which holds a maximum of about 800 young male prisoners aged between 18 and 21.

25. The local Primary Care Trust (PCT) is responsible for commissioning healthcare at Glen Parva. Among other services provided are nurse triage, mental health clinics and GP surgeries.

Her Majesty's Inspectorate of Prisons

26. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Glen Parva in November 2009. The report of the inspection was published in February 2010, when it was noted that:

> "In recent inspections, we have charted the establishment's progress towards providing a generally safe, respectful environment for its volatile population, increasingly focused on resettlement. This full unannounced inspection found that much of this progress had been sustained, although it was of concern that there was insufficient good quality purposeful activity to keep young prisoners properly occupied.

27. In relation to suicide and self harm, inspectors noted that action plans had been developed following previous deaths in custody, but were not periodically reviewed to ensure continuing compliance and there were no procedures to learn from serious incidents of self-harm. Levels of self-harm were not high ….but there was little evidence that the underlying reasons were discussed and addressed. The quality of assessment, care in custody and teamwork procedures was variable. There were some good assessments and more consistent case management than usual, but ongoing records included predictable checks at night. A number of permanent night staff had not been trained and many observation panels were blocked, including one for a prisoner at risk. Support was available through mental health services, day care, chaplaincy and Listeners, but there was no dedicated counselling service

Independent Monitoring Board

28. Every prison has an Independent Monitoring Board (IMB) made up of local independent volunteers, who monitor standards to make sure prisoners are being treated fairly and humanely. In their last report on the period between December 2009 and November 2010, the Board observed that "Glen Parva continues to be a safe and respectful environment".

Assessment, Care in Custody and Teamwork

29. Assessment, Care in Custody and Teamwork (ACCT) self harm monitoring is a care planning tool used in prisons to support prisoners identified as being at risk of self-harm or suicide. Any member of staff can "open" an ACCT document recording their concerns. The process encourages staff to work

together to tailor individual care to prisoners in distress. Regular checks and reviews of the prisoner's situation should take place with the ultimate aim of addressing the problems which make suicide or self-harm more likely.

Previous deaths at HMYOI Glen Parva

30. The Ombudsman's office has been responsible for investigating deaths in custody since April 2004. Before the man's death, we investigated seven other apparently self-inflicted deaths at Glen Parva. Two of the deaths occurred in 2005, one in 2006, one in 2007, one in 2009 and two in 2010. One of the deaths that occurred in 2010 involved an immigration detainee, though the circumstances were not particularly similar to that of his.

KEY EVENTS

The man's sentencing and immigration status

31. The man was born in Nigeria in May 1990. He told the United Kingdom Border Agency (UKBA) that he entered the UK when he was seven years old, although he did not have paperwork to support this. He did not enter the UK with either of his parents. In 1998, he was placed in foster care. In 2003, he was granted indefinite leave to remain in the UK. He was first convicted in 2000 for theft and driving offences. In 2004, he received a four year custodial sentence for a sexual offence. He was convicted of assault in 2008 and given a conditional discharge.

32. He was arrested on 2 January 2010 for an offence of grievous bodily harm and remanded to HMP Highdown five days later. He was initially described as a needy prisoner who required attention. He was convicted on 16 March.

33. When the man was interviewed by a probation officer for his pre-sentence report in April, he said he had been sexually abused before arriving in the UK, did not know how to grieve for his mother's death, and had been physically abused in foster care. He described how he had been subsequently placed in a number of secure units. He said that he did not have thoughts of self-harm or suicide. He said he had been diagnosed with erotomania. This is a type of delusion where the person believes that another person, usually a stranger or celebrity, is in love with them.

34. On 25 May, he received an extended sentence for public protection of 54 months. The custodial element of the sentence was 18 months, followed by an extended licence period of 36 months. Under normal circumstances, a prisoner serving such a sentence would expect to be released halfway through the custodial period. His release date, taking into account the time he had served in prison while on remand, was calculated as 8 October 2010.

35. The man was referred to UKBA because he was a foreign national, and on 7 June the Criminal Casework Unit of UKBA wrote to him to confirm that he would be considered for deportation. (The Home Secretary has the power to deport someone from the UK, even if they have been given indefinite leave to remain, if they commit a serious criminal offence.) He refused to sign the acknowledgement slip that accompanied the letter.

36. He transferred from Highdown to HMYOI Aylesbury on 16 June. At a routine health screening when he arrived, the nurse recorded that he "appeared not stable emotionally" but, conversely, that he seemed "stable at time of interview". On 6 July, he was referred for an urgent mental health assessment because of "bizarre behaviour" but the referral form was returned as it had not been completed correctly. There is no evidence to suggest that the referral was resubmitted or that he saw anyone from the mental health team. During his four months at Aylesbury, he was involved in a number of fights with other prisoners.

37. The man remained in prison beyond his expected release date. He continued to be detained while UKBA arranged to deport him to Nigeria. On 18 October, he transferred to HMP Woodhill to await deportation. An officer recorded that he was very confident during his first night interview and that there were no concerns about him. These sentiments were echoed in interviews the next night.

38. After his induction period, the man moved to A wing. Officer A, who worked on A wing at the time, told the investigator that he took an interest in her almost immediately. Although he initially asked questions about trivial matters such as television programmes, he went on to ask about her life outside the prison. She told the investigator that, during association periods, he would seek her out despite the presence of other members of staff and follow her around. She felt that he had developed an inappropriate attachment to her within a few days of his arrival on the wing. She attempted to distance herself from him, telling him that there were other members of staff to whom he could speak, and letting him know about other avenues of support in the prison, but this did not seem to have any effect.

39. During interview, Officer A recalled that she returned from a period of leave in November, and was informed by another officer that the ma had been asking about her every day. He asked her a number of questions about where she had been and told her that he had missed her. She was concerned about his level of attachment and her own welfare, and reported her concerns to the prison's security department. An entry in his security file was made on 5 November. She reported that he had told her that he wanted a relationship and could not stop thinking about her, and became upset when told that this would not happen.

40. On the same day, 5 November, UKBA sent a monthly progress report to the man, explaining that he would remain in custody while awaiting deportation to Nigeria.

41. He was restrained by prison officers on 19 December for refusing to return to his cell when required. He calmed down quite quickly and was later allowed to help with cleaning the wing. On 23 December, he was served with a notice of deportation from UKBA which set out the reasoning behind the decision to deport him. The appeals process was also explained. By this point, he had a solicitor to represent him.

42. Officer A submitted a further report to the prison's security department on 28 December. She reported that the man had continued to single her out and behave inappropriately towards her. Two days later, she issued a warning to him and another prisoner for continually play fighting. She said that he seemed particularly upset that she had been the one to issue him with a warning, and asked why she was doing it when he had only been nice to her. She said that when she explained to him that she treated him in the same way as any other prisoner he became angry and upset and had to be escorted back to his cell.

43. Officer A said he was quite volatile and it was not unusual for him to become upset or angry. However, she reflected that this sort of behaviour was not uncommon among young prisoners. Her main concern was his apparent infatuation with her. She explained that she was assigned to work elsewhere in the prison so that she would not come into contact with him. However, she said she was still detailed to work some shifts on A wing, and so the arrangement was not completely effective.

44. On 2 January 2011, an officer noted in the man's prison record that she had spoken to him about his inappropriate attention towards Officer A. Four days later, he attended an immigration forum in the prison and lodged an appeal against his deportation.

45. During mid-January, the man's behaviour seemed particularly volatile. On 11 January, he refused to go to work and then had to be restrained when he became aggressive. The next day, he was involved in a fight with another prisoner. This resulted in him being removed to the prison's segregation unit.

46. A doctor saw him on 13 January, and wrote in his clinical record that he was very emotional and was tired of being alone. He said that he had developed sexual thoughts about Officer A, and that he had attacked a prisoner the previous day because the other man had made a disparaging remark about his mother. He denied any thoughts of self-harm or suicide. The doctor prescribed sleeping tablets, and referred him to the prison's mental health in-reach team.

47. On 14 January, the man moved from the segregation unit to the prison's first night centre. An officer recorded in his prison record that, within 20 minutes of arriving, he became very aggressive and refused to return to his cell. He was restrained by prison officers.

48. A Senior Officer (SO) told the investigator that he arrived after the man had been restrained. He was very tearful and shouting. The SO spoke to him after he calmed down. He recalled that he spoke about his childhood, about being alone, and about his feelings towards Officer A. During interview, the SO explained that he appeared to be fixated on the officer and said he needed to be with her, even though he knew that his feelings were inappropriate and not reciprocated. During the course of his conversation with the SO, he became agitated and again had to be restrained.

49. The SO told the investigator that he was concerned about the man's mental health and also about the officer's safety. He said it was clear that this was not a case of a prisoner having a passing attraction to an officer, and that his feelings about the officer were obviously much deeper and more complex.

50. Staff opened an Assessment, Care in Custody and Teamwork (ACCT) document. ACCT procedures are used in prisons to provide additional support and monitoring for prisoners thought to be at risk of suicide or self-harm. In this case, it is not possible to say what support was put in place for

him because the ACCT document is missing. We address the significance of the missing document in the next section of this report.

51. The SO explained to the investigator that, after the man was restrained and taken back to his cell, he became calm and there were no further concerns raised about him that day. The SO reported his concerns about his fixation with the officer to the security department. A further report was made indicating that the prisoner whom he assaulted might have been harassing him for some time, especially during the night by taunting him from the windows.

52. In response to the concerns expressed by the SO and other members of staff, a nurse from the mental health in-reach team saw the man the same day. She told the investigator that he cried uncontrollably for much of the assessment and said he felt abandoned and just wanted to be loved. He had recently found out how his mother died and, although it had happened around a decade earlier, he spoke as if it was a very recent trauma. He also told her that he had formed inappropriate attachments to other people in the past, such as care workers. She agreed to include him on the in-reach team's caseload and decided to see him weekly.

53. On the morning of 15 January, an officer heard the man telling the prison chaplain that he could not get Officer A out of his head and needed to speak to her. The officer recorded his concerns that he posed a real threat to women in general, not only Officer A. At around 1.30pm, he set fire to the bin in his cell. The SO told the investigator that as he walked along the landing, he could smell smoke. When he looked into the cell, he saw that some paper in the bin was alight. He shouted at him to put out the fire, but his response was to kick the bin over and add more paper to the fire.

54. The SO asked for assistance for other members of staff, then entered the cell around ten seconds later with a fire extinguisher. He pushed the man towards the waiting members of staff and extinguished the fire with the help of a colleague. The man was locked in a nearby interview room while the fire was put out.

55. Almost immediately, an officer called to the SO for assistance because the man had been discovered hanging in the interview room. The SO told the investigator that the man had been in the interview room for no more than 20 seconds. It appeared that, after he was locked in the room, he had immediately removed his socks and tried to tie them around his neck and attach them to a pipe. The SO and other members of staff entered the room and assisted him, who was still conscious. He was then taken to the healthcare unit. Again it is not possible to confirm what decisions were made at any subsequent ACCT reviews because the documents have not been found.

56. The man remained in the healthcare unit for the rest of January. An officer who worked in the unit said that he was difficult to manage. He was stubborn and somewhat aggressive but not particularly disruptive. The officer recalled

that he alluded to numerous long standing family problems. He mixed well with other prisoners but only for short periods of time.

57. The nurse saw him again on 18 January. She recalled that he seemed much more positive than during their first meeting, although he was still struggling to deal with his feelings for Officer A. He told her that he enjoyed music, and played a song that he had written to try and make sense of his feelings. She wrote in the clinical record that he still had complex emotional problems and felt that everyone in his life would abandon him, though he did not have any thoughts of suicide or self-harm. She also attended his ACCT review that day.

58. The next day, 19 January, UKBA sent a progress report informing him that they were in touch with the Nigerian High Commission to facilitate his return to Nigeria.

59. When the nurse saw him again on 21 January, he was not as positive as previously. During interview, she recalled that he continued to focus on the same issues; his mother's death and his fixation with the officer. He continued to gain some respite through music and often played the guitar. She wrote in his clinical record that she planned to explore issues around relationships and inappropriate attachments the following week.

60. On 25 January, the man became extremely upset after Officer A attended a nearby wing and did not respond to his calls for attention. An officer, who until this point was not aware of his attachment to Officer A, said he found his response extreme. He said he appeared distraught and could not believe that she had not acknowledged him. He had to be restrained by members of staff, but was more upset than angry. On the same day, staff ended ACCT monitoring. As the documents are missing we do not know the reasoning behind this decision.

61. Three days later, the man approached Officer A when he was supposed to be attending an appointment. An officer intervened and returned him to his cell. He said that the man was again very upset. He behaved as if he and the officer had once been in a relationship which she was now refusing to acknowledge.

62. Because of his fixation with the officer, efforts began on 13 January to arrange to transfer him to another prison. A number of prisons were contacted but a suitable transfer was not arranged at this stage.

63. The nurse saw him three times during February. She told the investigator that, after their appointment on 1 February, he returned to a normal residential wing from the healthcare unit, and appeared much more positive. He continued to write down his feelings and play music. Thoughts about the death of his mother still upset him and he wanted to speak to a bereavement counsellor.

64. The nurse saw the man a week later, on 8 February, and said he seemed positive, enjoyed writing his own music, and had a job in waste management. She made an application for him to see the bereavement counsellor at the next available opportunity. Because of his positive presentation, she decided to wait two weeks before seeing him again.

65. On 10 February, it was decided that he would not be allowed to leave his wing to attend activities. He was therefore unable to continue with his waste management course. An officer recorded on his wing record that he was angry and argumentative when informed of this arrangement. He was given a job as a wing cleaner.

66. When the nurse saw him on 22 February, he was very upset and tearful. She told the investigator that it reminded her of the first time she had seen him. He continued to have unresolved feelings of grief around the death of his mother, said he did not have any friends and so saw professionals that he worked with as friends. He continued to try and use music as a way of coping. He was concerned about his appeal against deportation, which was to be heard on 28 February. He was very worried about the prospect of having to return to Nigeria, a country where he said that he had no ties and would find it difficult to build a life for himself.

67. On 28 February, the man's appeal against deportation was heard. On 1 March, he saw the nurse and seemed more positive. He was told by his solicitor on 10 March that his appeal against deportation had been rejected. The next day he spoke to the immigration clerk at Woodhill and his solicitor about possible further avenues of appeal. The same day, he saw the nurse and was extremely upset and scared about the prospect of being deported to Nigeria.

68. On 17 March, he told an officer that he could not stop thinking about Officer A and was worried about her welfare. He said that he did not want to feel that way but could not help it, and wanted to be transferred to another prison so that he could forget about her and move on. On 24 March, he asked the immigration clerk to request a transfer to an immigration removal centre. He saw the nurse on 25 March when he seemed more stable and settled.

69. The man approached Officer A on 5 April when she was working in the chapel and he was supposed to be going to the gym. She told him to make his way to the gym, which he did. However, on the way back, he went up to her in tears, told her he had missed her and asked her how she had been. He became agitated when she did not respond to his questions.

70. Officer A told the investigator that, because there were not many other members of staff around, she felt uncomfortable and feared for her safety. A member of staff from the gym intervened and escorted the man back to his unit. That afternoon, he handed an officer a letter detailing his feelings for Officer A. He said he had run into her and that all of his feelings for her had returned. The officer recorded in his prison record that the way he talked

about Officer A was very alarming and that she feared he might act on his feelings.

71. On 7 April, the man attended the prison's immigration clinic. His solicitor had faxed a letter explaining that his appeal rights had been exhausted and there was no further basis on which to appeal against his deportation to Nigeria. He spoke to his solicitor by telephone, who confirmed this. He became very upset but declined an offer to speak to anyone from the prison's chaplaincy. He went back to his wing and the senior officer was made aware of the situation.

72. On 9 April, an officer and two governors spoke to him about not being allowed off the unit. He was also told not to approach any female staff. He was reported to be irate and agitated, but later calmed down and spoke to a Listener (a prisoner trained by the Samaritans to offer confidential peer support). Early the next morning, an Officer Support Grade (OSG) (who regularly worked night shifts) recorded that he asked to talk to her every night about Officer A.

73. On 12 April, the nurse received a telephone call from staff at a hospital where the man had previously been treated for his mental health problems. The purpose of the call was to express concerns about his mental health, as he had been calling the staff and telling them about his feelings for Officer A.

74. Although he asked to see the immigration clerk on 13 April, he did not attend. The next day he transferred to HMYOI Glen Parva.

HMYOI Glen Parva

75. The man arrived at Glen Parva at 10.30am on 14 April. The person escort record (PER - a document that accompanies prisoners during transfer) had been completed by staff at Woodhill. A prominent page in the document is the risk indicator form, which lists a number of specific risks and then provides space for staff to record details. Regarding 'suicide/self-harm', the officer who completed the form at Woodhill, wrote: 'Previous ACCT – ended 25/01/11.' There were no further details about the reason for ACCT self harm monitoring nor the man's self-harm attempt on 15 January. The form contained some further warnings that he had made inappropriate comments to female members of staff.

76. A nurse completed a routine reception health screen. She wrote in his clinical record that the man appeared calm and settled, with no thoughts of self-harm or suicide. He told her that he had been involved with community mental health services at the age of 17, and prison mental health services at Woodhill. She referred him to the mental health team at Glen Parva.

77. A cell sharing risk assessment (CSRA) was also carried out when he arrived at Glen Parva. This process aims to identify any risks that a prisoner might pose to a cellmate. A number of questions are asked relating to known risk factors. One question relates to 'arson/fire setting', and 'no' was circled. The

assessor's name and signature was left blank. He was assessed as standard risk and so was allowed to share a cell with another prisoner.

78. On 16 April, the man met representatives from various departments within the prison as part of the induction process. This included a prison chaplain and the member of staff responsible for helping foreign national prisoners with immigration issues. The chaplain told the investigator that the man was unhappy about being deported to Nigeria, but that the decision had been made and there was nothing that could be done to change it.

79. Over the next few days, warnings were entered on to the electronic prisoner record system about his attachment to female officers. A message from the nurse at Woodhill explained that he had been on the mental health in-reach team's caseload. He was referred to Glen Parva's in-reach team for assessment. On 19 April, he moved from the induction unit to Unit 14. A member of staff on that unit recalled him as follows:

> "He never came to my attention other than being a very popular young man amongst his peers. Enjoyed his gym, very good footballer; he used to play football on the exercise yard with the rest of the lads. Very good at pool, played the guitar; he used to sing songs and play the guitar to the other prisoners on the unit. Very good at card tricks, which used to wow other prisoners on association; he was very, very, very good at card tricks. And he was just generally a very popular young man amongst his peers."

80. An officer who also worked on the unit had a similar impression of the man, but said that he could also become angry. He commented:

> "He came across as quite a jovial young man. We had an officer on the unit who can play a guitar and we've got a couple of prisoners who are learning it and he'd have a go on the guitar and he was a very good guitar player. He was into his card tricks, he'd show us in his cell how he'd do his card tricks. But if you told him something that he didn't want to hear he would become quite aggressive immediately. Like he was insisting he was an enhanced prisoner at Woodhill; checked up on the records and no, he was standard. Once we told him that he'd just, very, suddenly go immature and angry."

81. The officer told the investigator that the man was more likely to come across as jovial and compliant than aggressive and angry. Another officer said that although he had his "angry moments", he settled on the unit, never seemed withdrawn, and got on well with staff and other prisoners. Another said much the same, but recalled that he often asked to go back to his cell before the end of association periods. He added that this was not unusual, as some prisoners got bored and wanted to watch television or perhaps just wanted some time to themselves.

82. Another prisoner on the unit (with whom the man would later share a cell) also recalled that the man got on well with most other prisoners. He reiterated that the man was skilled at football and card tricks and was popular as a result.

83. Around 9.30pm on 25 April at his request, the man saw a Listener for around two hours. The next afternoon, 26 April, two nurses were asked to see him by staff on the unit because he was very distressed. They both told the investigator that they found he was almost inconsolable.

84. Nurse A in the clinical record that he struggled to speak because he was crying so much. He was upset about the same issues that he had discussed with the nurse at Woodhill. He had unresolved issues of grief regarding the death of his mother, and an infatuation with Officer A. He also talked about the victim of one of his previous offences and how he felt that he had ruined her life.

85. The nurse told the investigator that she and Nurse B stayed with him for over an hour. Afterwards, they both discussed the possibility of ACCT self harm monitoring but did not think he showed any intent to harm himself. He had already been referred to the mental health in-reach team and the nurses thought that there was a strong possibility that he would be taken on as part of their caseload.

86. The same afternoon, an officer wrote in the man's prison record that he was angry, frustrated, verbally aggressive and occasionally tearful during conversations with staff. The chaplain recalled that he tried to engage him in conversation for around five minutes, but he became verbally abusive and threatening.

87. The next day, 27 April, Nurse B saw him on the unit and decided to conduct a follow-up appointment. He told the investigator:

> "His presentation was completely different, he was a lot calmer, although he … did have some outbursts of anger and all that, but he was a lot calmer and a lot more with it and understanding of what was going on. There were some tears at times when I did mention about his mother and I mentioned about this officer, he did cry but it wasn't inconsolable, it wasn't anywhere near like he was the previous day."

88. The nurse was aware of the incident the previous day with the chaplain. He explained the kind of support which the chaplaincy offered and told the man that he would need to apologise if he wanted to make use of this support.

89. On 29 April, the man told an officer that he wanted to apologise to the chaplain. He also asked for grief counselling. On 1 May, he pressed his cell alarm bell and asked to speak to the same Listener who he had seen on 25 April. An officer told him that he could not request a specific Listener, and he replied that he did not want to see anyone else. He did not see a Listener and declined a telephone call to the Samaritans.

90. Over the first three days of May, numerous entries were made in his prison record about strategies that could be employed to stop him becoming fixated with members of staff. These included limiting one-to-one work, warning

education tutors about the possibility of him developing an inappropriate attachment and not allowing him to see the same Listener. On 2 May, he apologised to the chaplain.

91. On 3 May, he saw a chaplain specialising in counselling. This was intended to be the first in a series of regular meetings. The chaplain told the investigator that the man talked about his feelings of grief about his mother's death, his difficulty forming appropriate relationships, the fact that he only had one real friend and his feelings towards Officer A. He also spoke about his impending deportation, and she recalled during interview that he was more angry when talking about this. She was aware of his previous inappropriate attachments to people and clearly outlined the professional boundaries and controlled environment that would be involved in counselling sessions.

92. The man was allegedly assaulted by another prisoner on 4 May. He claimed not to know the identity of the assailant. However, the next day he allegedly assaulted a prisoner in the laundry, thought to be the same man who had attacked him. He had previously been involved in fights with the same prisoner at Woodhill. Staff began anti-bullying procedures against him, who lost certain privileges such as a television in his cell and some association periods. He was moved to another cell.

93. He spoke to a Listener on 6 May. He also asked to see someone from the mental health team, but there was nobody available.

Saturday 7 May 2011

94. On the man's 21st birthday an officer wrote in the prison record that he had been out of his cell for the association period, which had passed without incident. A disciplinary hearing (adjudication) was scheduled to hear the assault charge against him, but this was postponed until the next day. The person who opened and adjourned the adjudication said he seemed fine and there was nothing in his demeanour that gave him cause for concern.

95. Later that afternoon, shortly before 5.00pm, the man pressed his cell alarm bell and asked to speak to a Listener. At 5.35pm, he again pressed his alarm to ask where the Listener was. Officer B asked him to be patient, at which point he became tearful and started to throw cutlery around his cell. His cellmate was lying on his bunk at the time and recalled during interview that the man started crying and saying that people did not care about him.

96. At 6.25pm, Officer B gave him a telephone so that he could contact the Samaritans. He moved him to an empty cell temporarily, so that he could have privacy while making the call. Ten minutes later, he pressed his cell alarm bell and, when the officer responded, he showed the officer a small cut that he had made to his neck with a razor blade. The officer said the man asked, "What are you going to do about this?" when showing him the cut and appeared very calm considering his emotional state earlier that evening.

97. Officer B alerted the unit's Senior Officer (SO) and asked for medical assistance from the healthcare unit. During interview, he described the man's wound as a nick rather than a cut and said that it was not bleeding profusely. Two nurses attended and one nurse decided that the wound did not need any medical treatment. She told the investigator that it was very superficial and was not bleeding.

98. A mental health nurse and officers from the wing then spoke to the man. Staff began ACCT self harm monitoring. The first stage of the process is the completion of a 'concern and keep safe' form. Officer B completed this, writing that he had made a minor cut to his throat and said that he had no family and the one person he loved did not want to know him.

99. The next stage of the ACCT process is to complete an 'immediate action plan'. The purpose of this is to keep the prisoner safe until he can undergo a more detailed assessment by a trained ACCT assessor within 24 hours. The action plan was agreed by the SO, Officer B and the mental health nurse. The man was moved back to his old cell on a temporary basis – sharing with a different prisoner to his cellmate - and was reminded about the Samaritans and Listeners. He was to have three meaningful conversations with members of staff during the morning, afternoon and evening, and would be observed hourly when locked in his cell. Staff planned for him to be assessed by someone from the mental health team the next morning.

100. At 8.15pm, Officer B wrote in the prison record that the man appeared much calmer. There were no further concerns raised overnight, and he seemed to be sleeping when checked by the night staff.

Sunday 8 May 2011

101. At 7.10am on 8 May, an officer wrote in the ACCT document that he had asked the man if he was okay and received a 'thumbs up' in response.

102. Around 9.00am, another officer attended Unit 14 to complete the man's ACCT assessment interview. He told the investigator that he said things had got too much for him. He talked about being deported to Nigeria, his feelings for Officer A at Woodhill, and the fact that a visit from a friend had not taken place as planned on the previous day. The officer thought that he felt hopeless with no real avenues of support. He commented during interview:

> "He was quiet initially. He wasn't crying, he wasn't emotional in that way. He was quite happy to engage in the interview and he was quite happy to talk to me about it. He understood what the process was about, he understood what we were trying to do. I also got the feeling that in the back of his mind that he thought that he really was a little bit helpless and whatever I was going to do, whatever I was going to talk to him about wasn't really going to help, but he was prepared to participate and listen to what I had to say and answer my questions."

103. The officer told the investigator that, although the man had only made a superficial cut to his neck, he had concerns about a cut to such a vulnerable part of his body. He told the officer that he wanted to be dead as he saw no future for himself in Nigeria where he did not know anybody. He said that he had not, however, made a specific plan to kill himself. He told the officer that he had tried to hang himself at Woodhill.

104. The officer talked to him about his mental health. He explained that he had been diagnosed with an attachment disorder, was very low in mood and did not sleep well. The officer told the investigator that he was very concerned about his risk of self-harm or suicide. He recommended a mental health assessment, an activity to occupy and interest him, continued support from Listeners and possible use of chapel activities. The man also signed a consent form that allowed prison staff to contact his friend and inform him that he was experiencing problems.

105. After the assessment interview, the SO joined the officer and the man in the office, where they completed the first review of the ACCT document. The meeting started around 9.30am and lasted just under half an hour. The issues raised during the assessment interview were discussed, and the SO agreed that the man did not really have any support network outside prison. His risk was recorded as 'high', and an urgent referral was made to mental health services. A further review was scheduled for 10 May. The SO completed a care map. This document identifies issues and explores goals and actions that can be used to overcome them. The goals recorded on his care map included further engagement with education classes and chapel activities and a mental health assessment.

106. During the ACCT review, the SO telephoned the healthcare unit and asked for him to be assessed as soon as possible. He expected the assessment to happen the same morning. After the ACCT review, he briefly returned to his cell before being unlocked for the association period. The SO explained that, as a prisoner subject to anti-bullying procedures, he would not normally have an association period on Sunday morning, but in light of recent events, the SO wanted him to be able to associate with other prisoners on the unit.

107. Following the ACCT review, the SO telephoned the duty governor and requested permission to move the man to a safer cell. This is a cell which has been designed to significantly reduce the number of available points which a prisoner might hang himself from. The SO explained to the duty governor that the man had said he had attempted to hang himself while at Woodhill.

108. The duty governor asked the SO to telephone Woodhill and corroborate the information. During interview, the duty governor pointed out to the investigator that the man's act of self harm the previous day had not involved hanging, and that safer cells do not prevent other types of self-harm such as cutting. When he spoke to the investigator, the SO argued that a safer cell provides a change of location, allows a prisoner to reflect on matters and gives members of staff a better opportunity to monitor the prisoner.

109. The SO recalled seeing the man on the unit at around 10.25am. He told the investigator that he still looked somewhat tearful but was calmer than during the ACCT review.

110. Two nurses planned to see the man later that morning because of his attempt to harm himself the previous evening. Because neither of them had met him before, they consulted his clinical record and found reference to the incident at Woodhill on 15 January, during which he had set a fire in his cell and then attempted to hang himself. The two nurses arrived on Unit 14 around 10.30am, and went to speak to the SO in his office. They were concerned about the man's suitability for a shared cell in light of the information about him starting a fire. They were also worried about his propensity for self-harm.

111. The SO was unable to find reference to the events at Woodhill in the prison record. He telephoned the duty governor, told him about the information contained in the clinical record, and again asked for him to be moved to a safer cell. The duty governor again asked the SO to verify the information by telephoning Woodhill. The duty governor told the investigator that two other governor grade members of staff were present at the time and they agreed with his decision. The SO said that he would speak to the man again and try to verify the information with Woodhill.

112. Around 10.30am or shortly afterwards, the man spoke to an officer and asked to end his association period. The officer told the investigator that he did not act in a way that caused concern. He thought that it was not unusual for prisoners, including the man, to request an early end to the association period. The officer asked another officer to lock him in his cell. The officer did not specifically recall doing so during interview, but he was locked in his cell.

113. Shortly before 11.00am, the SO left his office to find the man so that he and the nurses could talk to him. Staff on the unit informed the SO that he had asked to end his association period, and the SO went to collect him from his cell.

114. When the SO opened the cell door he saw that the man was in a standing but stooped position by the cell's window. He was alone in the cell as his cellmate was out on association. He was facing the SO but his head was on his chest. He had tied a torn bed sheet around his neck. The other end of the bed sheet was attached to the window handles.

The emergency response

115. The SO used his radio to inform the control room of a 'code blue' situation. This emergency code communicates that a prisoner is not breathing. The SO also specified the location, and made clear that it was a medical emergency and that an ambulance would be required. He then went into the cell.

116. An officer was in an office on the same unit when he heard the radio message. When he left the office, he saw the SO entering the cell and followed him in. Another officer also ran to the cell after hearing the radio

message. The SO used a specially designed tool to cut through the bed sheet, and he and the first officer lowered the man to the floor of the cell. As there were already two officers in the cell, the other officer left to lock other prisoners on the unit in their cells.

117. The nurses who were in the SO's office when they heard him shout and relay the message over the radio. They immediately made their way to the cell, arriving just after the second officer. The SO was cutting through the bed sheet as they arrived. When the man was laid on the floor, both nurses began to check for signs of life. Because they had been in a nearby office for a different reason, neither of them had emergency medical equipment to hand. When the nurses began their checks, the first officer left the cell and helped his colleagues to lock prisoners away in their cells. Both nurses did not find any signs of life. The man did not appear to be breathing and did not have a pulse.

118. Two other nurses were on Unit 15, adjacent to Unit 14, when the alarm was raised. Nurse A ran directly to Unit 14, and told the investigator that she arrived less than a minute after the initial radio message. The nurses then began cardio-pulmonary resuscitation (CPR), with Nurse A performing rescue breaths and another nurse administering chest compressions.

119. Instead of going straight to Unit 14, one nurse went to get emergency medical equipment. An officer carried it to the cell and the nurse arrived shortly afterwards. A nurse helped to set up the equipment. A tube was inserted into the man's mouth and connected to an oxygen supply. A defibrillator (a piece of medical equipment which assesses electrical activity in the heart and delivers an electric shock if appropriate) was attached.

120. Nurse B was in the outpatients unit when she heard the radio message. She made her way to Unit 14 with a trolley containing emergency medical equipment. During interview, she estimated that it took her three minutes to arrive. When she reached the cell, she saw that the emergency equipment was attached, chest compressions were being administered, and oxygen was being delivered. The nurses continued with the resuscitation effort, performing chest compressions in rotation so that they did not become too tired.

121. The defibrillator initially showed no sign of heart activity. However, after a few minutes, it detected a normal heart rhythm. Nurse B was then able to find a strong pulse. Almost immediately afterwards, at about 11.10am, the paramedics arrived in the cell.

122. The nurses stopped performing chest compressions because the man's heart was beating on its own. The paramedics asked the nurses to continue the delivery of oxygen. They then inserted a different tube to secure his airway more effectively. He was then moved to a spinal board and stretcher. The paramedics and the first officer carried the stretcher to the waiting ambulance. Nurse A continued to administer oxygen during this time. While being carried

to the ambulance, the members of staff heard him trying to take a breath. He was taken by ambulance to hospital.

Events at Glen Parva after the emergency response

123. The SO explained to the investigator that after the man was taken to hospital, staff reviewed all prisoners subject to ACCT monitoring to offer additional support. A meeting known as a hot debrief also took place on the same day. This was attended by the members of staff who had been involved in the emergency response. The purpose of the meeting was to discuss the incident and to offer support to those who might need it. The chairman recognised that the members of staff involved had managed to resuscitate the man.

Events at hospital

124. The man remained in hospital. He was initially placed in a medically induced coma to stabilise him and give him the best chance of recovery. Although his condition seemed to improve slightly over the next few days, there was a strong possibility that he had suffered a brain injury due to being deprived of oxygen while hanging. A decision was made by a doctor at the hospital that no further resuscitation would be carried out if he stopped breathing.

125. Prison escort staff remained at the hospital with him, though no restraints were used. He did not regain consciousness. A few days later it was confirmed that he had suffered a brain injury. Hospital staff decided that he would receive basic nursing care, but would not be proactively treated or resuscitated.

126. At 3.35pm, the prison's family liaison officer telephoned the man's friend to tell him about the seriousness of his condition and the end of life care that was being implemented. The friend already knew that he was in hospital and asked to be kept informed of any developments.

127. The officers at the hospital were informed at 4.15pm that the man had died.

Events after the man's death

128. The next morning, the family liaison officer was informed of the death. He telephoned the man's friend at 9.39am to break the news to him.

129. Notices to staff and prisoners were issued, informing them of the man's death. A memorial service took place at the prison.

130. The family liaison officer maintained contact with the man's friend to provide information and offer support. The man's friend arranged his funeral, and the prison made a contribution to the cost in line with national guidance. The funeral took place on 16 June. The man's friend found the family liaison officer to be very helpful and supportive.

131. The family liaison officer made numerous telephone calls and sent emails to the Nigerian Embassy and the Congolese Consulate in attempts to find members of the man's family. However, these attempts proved fruitless.

ISSUES

Identifying the man's risk of self-harm

132. An ACCT self harm monitoring document was opened for the man while he was at Woodhill. It was opened on 14 January and closed on 25 January 2011. Details about this ACCT process are scant because the document is missing. It is therefore impossible to say exactly why staff began ACCT monitoring, what steps were taken to help him, or why they closed the ACCT document.

133. There is evidence that he posed a risk of harm to himself during the same period. On 15 January, the day after the ACCT document was opened, he set a fire inside his cell and then tried to hang himself immediately afterwards. It is not clear what action was taken afterwards to try and keep him safe. On the day that the ACCT document was closed, he became very upset and angry, and had to be restrained by staff, after he encountered Officer A and his fixation with her resurfaced.

134. The fact that the ACCT document is missing not only makes it impossible to make a judgement about its quality and appropriateness, but also raises the question of how much information staff at Glen Parva had about his risk to himself. When he transferred on 14 April, Woodhill staff recorded on the person escort record (PER) that an ACCT document had been closed on 25 January, but there was no further information given about the attempted hanging, and there was no indication that the ACCT document was included in the transfer paperwork.

135. In attempting to locate the ACCT document, the investigator contacted the safer custody managers at both Woodhill and Glen Parva, and asked them to check whether the document was in their possession. The safer custody manager at Woodhill was sure that the document had accompanied the man to Glen Parva, but the safer custody manager at Glen Parva said such a document had never been received. There was no copy of the ACCT document in the records provided to the investigator, who also checked with the Leicester Coroner's office that it was not included in the documents seized from Glen Parva.

136. Members of staff at Glen Parva were not initially aware that the man had previously tried to hang himself at Woodhill. On the PER, the section to indicate an attached ACCT document was not completed. Although it is impossible to be completely certain, it seems likely that the ACCT document was never sent to Glen Parva, but neither was it stored safely at Woodhill. We make the following recommendations:

The Governor of HMP Woodhill should ensure that closed ACCT documents are stored properly and can be accessed when required.

The Governor of HMP Woodhill should ensure that copies of closed ACCT documents are sent with prisoners on transfer to other establishments.

137. Regardless of whether or not the ACCT document was transferred with the man to Glen Parva, some information about him harming himself was available. Details about the attempted hanging and the fire setting were included in the clinical record and available to members of staff at Glen Parva throughout his time there, though they were only sought on the day of his death.

138. Similarly, the incidents were detailed on the electronic prison record available to prison officers. However, this record by default only shows the last three months of entries unless otherwise specified. Therefore, the man's act of self-harm on 15 January would only have been displayed to discipline staff very briefly when he arrived at Glen Parva in April.

139. On balance, we think that members of staff cannot reasonably be expected to have looked for entries made three months earlier if there was no clear reason to do so. However, this only strengthens the argument for detailed information to accompany prisoners being transferred. The PER risk indicator form specifically asks about the risk of suicide and self-harm. It is not sufficient to record that an ACCT was closed on a particular date, without including any further information about the actual risk posed and the nature of any previous self-harm. There was also no mention of the fact that the man had set a fire in his cell, something which would almost certainly have affected his cell sharing risk assessment at Glen Parva. We consider that better quality information on the PER might have prompted the reception staff to look more closely at some of his risk factors. We make the following recommendation:

The Governor of HMP Woodhill should ensure that person escort records (PERs) list all significant known risks.

140. Although the PER lacked detailed information, there were occasions on which members of staff at Glen Parva could have checked the man's records to identify possible risk factors. On 26 April, two nurses saw him at the request of unit staff. He was clearly in crisis and was described as almost inconsolable, and crying so much that he struggled to speak. Yet, there is no evidence to suggest that the nurses examined his clinical record, when they would have discovered that he had attempted to hang himself three months earlier.

141. On 7 May, staff opened an ACCT document after he made a cut to his neck using a razor blade. Again, there is no evidence that at this point or on the following morning, unit staff checked his electronic prison record for any previous entries about self-harm and suicide. The information came to light on the morning of 8 May, only shortly before his death, because he mentioned it to a member of staff and also because two nurses checked the clinical

record to obtain some background information before going to see him. We make the following recommendation:

The Governor of HMYOI Glen Parva and the Head of Healthcare should ensure that staff check the records of prisoners subject to ACCT monitoring, or about whom they have concerns, for information about previous risk factors.

142. The ACCT procedures for the document open on 7 May were satisfactory. A risk was identified, a plan for keeping the man safe in the short-term was made and he was moved back to his old cell temporarily. The ACCT assessment interview and first case review took place the next morning. Although the review was not multi-disciplinary, arrangements were made for him to see mental health nurses later that day. Sadly, he used a bedsheet to hang himself before this happened.

143. We have examined the decisions which were taken on the morning of 8 May about the risk that he presented to himself. The SO was clear during his interview with the investigator that he wanted to relocate him to a safer cell. He told the SO that he had previously tried to hang himself and this increased his concern. Furthermore, the officer who completed the ACCT assessment interview thought that he presented a serious risk to himself. When the SO telephoned the duty governor to request a move to a safer cell, he was advised to verify the information with Woodhill.

144. The duty governor explained his reasoning to the investigator, arguing that safer cells reduce the risk of hanging but do not prevent other types of self-harm. He pointed out that, the previous evening, the man had made a cut to his neck rather than trying to hang himself. He went on to say that if a prisoner expressed thoughts of harming himself by hanging, or made a noose and showed it to a member of staff, he would have no hesitation in moving him to a safer cell. Furthermore, he told the investigator that he had not refused to move him, but had wanted some additional verification first.

145. When the two nurses arrived on Unit 14, they told the SO that they had discovered information in his clinical record that the man had tried to hang himself at Woodhill in January. The SO again spoke to the duty governor, but was once more advised to telephone Woodhill and verify the information.

146. The duty governor's initial intention was to try and corroborate a claim made by the man. It is less easy to understand his rationale in persisting with this course of action after information from the clinical record was uncovered. The clinical record is a reliable source of information with entries made only by members of staff. It is difficult to understand why further verification of such information was required before moving him to a safer cell.

147. If required, it would have been very easy to find a second source for the information had members of staff properly interrogated the prison's electronic record system. The previous incident in January had been recorded, and a search using the date in question – which was known from the clinical record

– would have displayed the relevant entries. Nevertheless, it seems strange that the clinical record itself was not considered by the duty governor to be a satisfactory source of information.

148. The conversations between the SO and the duty governor took place very shortly before the man was found hanging. Even if a safer cell had been approved, there is no guarantee that the move would have happened before he had the opportunity to hang himself.

149. The SO had ensured that the man could participate in association when this would not ordinarily have been permitted. He observed him on the unit around 10.25am. Shortly afterwards, however, the man told an officer that he wanted to end his association period and return to his cell.

150. A number of officers told the investigator that it was not unusual for the man or other prisoners to end their association period early, and that this request was not in itself a cause for concern. Although the officer who ultimately locked him in his cell did not remember doing so, the other officer told the investigator that he had no reason to be concerned about his demeanour.

151. While the man was locked in his cell, the SO was discussing with the two nurses whether he would be better located in a safer cell. He did not know that he had asked to end his association period and was locked in a standard cell on his own. Although an ACCT document had been opened the previous night and two mental health nurses were due to check him, officers on the unit locked him in a cell by himself.

152. In fairness to the officers, their decision did not contravene the frequency of observations set out in the ACCT document. There was no requirement to observe the man continuously, and the officers did not know about the previous hanging attempt at Woodhill. Nevertheless, it might have been prudent for someone to inform the SO that he had asked to return to his cell.

Mental health support

153. On 14 January, when the man was at Woodhill, he saw a mental health nurse. After a discussion about his problems - unresolved grief, an infatuation with Officer A, feelings of loneliness and concerns about deportation - he was added to the nurse's caseload. She saw him on 18 and 21 January, 1, 8 and 22 February, and 1, 11 and 25 March.

154. Although his problems remained much the same throughout this period, he was at least seeing a nurse regularly and an overview of his mental health was recorded. Unfortunately, some of his problems were not easily resolved: he could not seem to control his feelings for Officer A, and his immigration case was in the hands of UKBA. Although he was referred for bereavement counselling, this did not happen.

155. When he was transferred to Glen Parva, the nurse wrote to the mental health in-reach team to inform them that he had been part of her caseload at

Woodhill. The clinical record shows that this information was received at Glen Parva on 19 April. However, no assessment of his suitability for the in-reach team appears to have taken place. Indeed, he was seen by nurses only during periods of crisis on 26 and 27 April and 7 May.

156. Although the man was not at Glen Parva for long, 18 days should have been sufficient to arrange a mental health assessment for someone who had already been working with an in-reach team and was accustomed to regular appointments with a mental health nurse. There was little continuity of care, which is unfortunate because his issues had not been resolved. Although he did start some one-to-one work with the chaplaincy, this was not the same as professional input from a mental health nurse. We are disappointed that he was not formally assessed by a mental health nurse. We make the following recommendation:

The Head of Healthcare at HMYOI Glen Parva should ensure continuity of mental health provision for those prisoners transferred from another establishment.

157. The clinical reviewer reviewed the man's clinical care. He comments:

> "His mood was extremely variable. At times he was pleasant and polite and he was popular among fellow prisoners and, indeed, members of staff because of his particular talents at football, card tricks and guitar playing. At other times he could be highly emotional, expressing despair at his inability to form meaningful relationships and at what he saw as his hopeless future. Recurring themes were his unresolved grief over the death of his mother, his feelings of social and emotional isolation and his fear of being deported to a country that he did not know and where he did not know anybody. His inappropriate feelings of attachment to a female member of staff at Woodhill loomed large in the final months of his life and could trigger changes from normal mood to extreme distress within minutes. When he was extremely distressed he could, on occasion, require control and restraint. There is evidence that he was self-centred and that he had a tendency to behave very impulsively."

158. He goes on to say:

> "Because of his social and emotional isolation, together with his fear of being deported to an unknown environment, it could be argued that for him death was as logical an option as continuing to live, and that this is not an indication of any form of mental illness. This would indicate that his risk of suicide was always high. The fact that he had good insight into his problems meant that he was aware that change was unlikely. He had very few factors to prevent him taking his own life, other than the short term solutions of football, card tricks and music. The one-to-one support that he was given may well have provided short term protection against suicide at times when he was distressed but there is no evidence that it was likely to produce long term change in his understanding of his circumstances or of his perception of his future. He demonstrated impulsivity and his self-

strangulation attempt on 15 January 2011 seems to have been entirely impulsive, given that the circumstances were such that he was bound to be found almost immediately."

159. The clinical reviewer concludes that, because of the factors listed above, the risk of the man harming himself was always high and the timing of such incidents was unpredictable. He does not make any recommendations about the quality of the clinical care that he received. We are, however, concerned about the continuity of mental health provision following his transfer to Glen Parva. Although he was seen by mental health nurses, this was in response to crisis situations rather than as a result of the referral that was made by the mental health nurse at Woodhill.

Immigration issues

160. Following the man's remand in January 2010, conviction in March and sentencing in May, his release date was calculated as 8 October the same year. However, because he was a Nigerian national, he was instead considered for deportation by UKBA.

161. He was kept informed of UKBA's decision making process. He had the opportunity to consult a member of staff in the prison about the matter, and employed a solicitor to appeal against the decision to deport him. Ultimately, he exhausted his avenues of appeal and at the time of his death he was awaiting deportation to Nigeria.

162. The decision making and appeal processes continued for six months after his calculated release date. During this period, he was not serving any custodial sentence but was held under immigration powers waiting for a final decision about whether he would be deported. He was transferred from Woodhill to Glen Parva because of his infatuation with an officer, though he still remained in the prison system rather than at an immigration removal centre. It is undesirable for people to remain in prison beyond their normal release date while awaiting removal from the country.

163. It is not within this office's remit to comment on deportation decisions. The rationale behind the decision to deport him to Nigeria was fully stated in the document sent to him. It is clear, though, from his interactions with prison staff, that he was very upset about the prospect of going to an unfamiliar country where he had no family or friends, no connection or attachment, and of which he had few memories.

164. The prospect of deportation was clearly a difficult issue for the man, and so it is surprising that members of staff working on Unit 14 at Glen Parva did not know that he was being held there for this reason alone. Certain officers were unaware that he was not simply serving a sentence or on remand. Nurse A, after seeing him on 26 April, did not know that he was awaiting deportation. It is surprising that an issue discussed regularly at Woodhill, which caused him distress and worry, was not even known to members of staff working closely with him at Glen Parva.

165. This is, of course, not to say that nobody knew about the man's immigration status. His cellmate was aware, as were Officer B and the two chaplains..

The Governor of HMYOI Glen Parva should ensure that staff working with immigration detainees are aware of their status, its implications and the needs that this may present.

The emergency response

166. When the SO raised the alarm just before 11.00am on 8 May, the response was quick. Two nurses arrived at the cell almost immediately, and two more followed very shortly afterwards. Staff performed CPR in a swift, coordinated and effective fashion. Emergency medical equipment was used appropriately. A fifth nurse arrived with further equipment and assisted with the CPR effort. Even before the arrival of the paramedics, the resuscitation effort had resulted in his heart beating on its own, even though he was unresponsive when he was found.

Although he did not survive, this should not detract from the commendable effort made by the nurses during the emergency response. The clinical reviewer agrees and states that CPR was carried out in an exemplary fashion

Supervision of the man

167. When speaking to the Ombudsman's family liaison officer (FLO), the man's friend was under the impression that he had been left alone when he was supposed to be observed continuously. He wondered whether this was in fact the case and if it had provided him with the opportunity to hang himself.

168. We have examined the three incidents of self-harm already mentioned. When the man was at Woodhill, an ACCT document was opened on 14 January. This was not prompted by an act of self-harm but rather by concerns about his mental health. Because the ACCT document is missing, it is impossible to know the required level of observations. However, we think it very unlikely that he would have been left alone in a standard cell over the lunch period on 15 January if constant supervision was required. Constant supervision involves a member of staff remaining outside the cell and watching the prisoner continuously. It is not used often and is most unlikely to have been used for a prisoner who had not harmed himself.

169. We therefore think it unlikely that, when he set fire to his waste paper bin and subsequently attempted to hang himself, he was subject to constant supervision. There is a reference in the paperwork to him being placed on constant supervision *after* he attempted to hang himself, but it is impossible to be sure how long this was in place because of the missing ACCT document,

170. At Glen Parva, he harmed himself by making a cut to his neck on the evening of 7 May. At this time he was not subject to ACCT monitoring and so was not being checked any more frequently than other prisoners. An ACCT document

was then opened and he was observed once an hour. This level of monitoring continued on 8 May. He was not subject to constant supervision but was checked at least every hour. He had been back in his cell for around half an hour when the SO discovered him with the bed sheet around his neck.

171. We have found no evidence to suggest that he was subject to constant supervision on the occasions that he harmed himself or that expected supervision at the time of his ACCT did not take place.

CONCLUSION

172. The man was a young man with a number of different emotional problems. He clearly worried about the prospect of being deported to Nigeria, and indeed was detained in prison custody beyond his normal release date so that this could be arranged. In addition, though, he had strong feelings of unresolved grief about the death of his mother some years earlier. He also became infatuated with an officer at HMP Woodhill. As the clinical reviewer comments in his clinical review, he presented a high risk to himself because of his emotional issues and the threat of deportation. He was deeply troubled and his problems were entrenched.

173. In January 2011, the man set a fire in his cell and then attempted to hang himself. The ACCT self harm monitoring process was used, but the documents are now missing and it seems that information was not passed on to HMYOI Glen Parva when he was transferred there in April.

174. After his transfer, the man continued to fixate on the officer from Woodhill. Although he was a well-liked prisoner, the same emotional issues continued to affect him. On the evening of 7 May, staff opened an ACCT document after he made a cut to his neck. The next morning, after associating with other prisoners on the unit, he returned to his cell and tied bedding around his neck and the window handles. He was found hanging shortly before 11.00am. A co-ordinated and sustained resuscitation effort resulted in a pulse, but he died several days later in hospital.

175. We have made a number of different recommendations. As with too many other investigations, we have drawn attention to deficiencies around the sharing of information between different prisons. The man had been assessed as a risk to himself while at Woodhill, but this was not effectively communicated to Glen Parva. Information that was recorded on his electronic record by staff at Woodhill was not checked by staff at Glen Parva, even though it was available. There was also little apparent awareness amongst staff at Glen Parva about his immigration status, despite this clearly playing on his mind, and there was limited continuity of mental health care for this troubled young man.

RECOMMENDATIONS

For HMP Woodhill:

1. The Governor of HMP Woodhill should ensure that closed ACCT documents are stored properly and can be accessed when required.

   The recommendation was accepted. Following completion of the post-closure stage of the ACCT, it is filed in the prisoner's core record by the case manager. This record is accessible by members of staff at any time if required.

   Monthly managerial checks will be undertaken on ACCTs closed during the previous month.

   A Notice to Staff will be issued reminding case managers of the proper process.

2. The Governor of HMP Woodhill should ensure that copies of closed ACCT documents are sent with prisoners during transfer to other establishments.

   The recommendation was accepted. Closed ACCT documents are sent to prisoners on transfer within the core record.

3. The Governor of HMP Woodhill should ensure that person escort records (PERs) contain sufficiently detailed information about known risks.

   The recommendation was accepted. All staff completing PERs are trained to cross-reference P-NOMIS information with information on the security file. Medical risk is completed by healthcare staff and taken from the electronic clinical record (SystmOne). This gives the extra assurance that any information regarding risk will be identified.

   Management checks of PERs will be introduced by the Safer Custody manager, for those with known risks.

   The discharge manager will check that PERs contain all relevant risk information from core records. A Notice to Staff will be issued to remind discharge managers of this responsibility.

For HMYOI Glen Parva:

4. The Governor of HMYOI Glen Parva and the Head of Healthcare should ensure that staff check the records of prisoners subject to ACCT monitoring, or about whom they have concerns, for information about previous risk factors.

   The recommendation was accepted. All prisoners are seen on the second morning following their arrival at Glen Parva. Members of the healthcare

team introduce themselves and identify any current or previous issues. As part of this process, staff will review the clinical records for risk factors.

5. The Head of Healthcare at HMYOI Glen Parva should ensure continuity of mental health provision for those prisoners transferred from another establishment.

The recommendation was accepted. Primary mental health processes are in place to ensure that all referral pathways are recorded, including the telephone referral sheet, functional email inbox and prisoner applications. Appointments are booked through the electronic clinical system (SystmOne) as soon as a referral is received. The current waiting time for this is four days.

Secondary mental health is commissioned separately. In-reach to in-reach referrals completed within this team. The head of healthcare will liaise with the secondary mental health services manager to highlight the recommendation and seek assurance that appropriate processes are in place.

6. The Governor of HMYOI Glen Parva should ensure that staffing working with immigration detainees are aware of their status and its implications.

The recommendation was accepted. Every foreign national offender is screened to see if they require support in terms of immigration. If prisoners have an enhanced support need, an alert is put on P-NOMIS, their details are added to the spreadsheet in the Safer Custody folder on the shared computer drive, and a support plan is put in place. An officer from the Safer Custody team will be notified of all prisoners that are issued with an IS91. They will see these prisoners on a weekly basis to see how they are coping. A summary entry of all contact will be entered on P-NOMIS and if any concerns are raised, an email will be sent to unit senior officers and the personal officer for that prisoner.