PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man whilst in the custody of HMP Glen Parva in December 2010

Report by the Prisons and Probation Ombudsman for England and Wales

March 2013

This is the report of an investigation into the circumstances surrounding the death of a man, who died at HMYOI Glen Parva. The man was found during a check of prisoners at around 6.00am, hanging from the window of his cell, in December 2010. He had been dead for some hours and resuscitation was not attempted. I offer my condolences to his family and friends.

The investigation was led by one of my investigators. A clinical reviewer provided a clinical review of the healthcare offered to the man in Glen Parva. I am grateful to the clinical reviewer and to the Governor and staff of Glen Parva for their full cooperation in this investigation. I am sorry that the report has been delayed.

The man had been recalled to custody in October 2010, following a breach of his licence conditions. Although he had been placed under suicide prevention and self-harm monitoring provisions for a short time just after he returned to Glen Parva, he had given staff little cause to consider applying those measures in the period leading up to his death. The man's relationship with his girlfriend had ended, just before the Christmas period but he had not confided in staff about this, nor how he was feeling, and no additional support was offered to help him throughout this difficult period. As a result, the investigation concludes that staff could not reasonably have foreseen that the man would decide to take his own life.

However, the investigation makes clear that there is scope for learning from the man's tragic case and six recommendations for improvement are made. Two are about the need for staff to comply fully with the suicide and self-harm monitoring guidance, one calls for Glen Parva to clarify the procedures for checking prisoners during the night and another insists on the need for staff to immediately treat every apparent hanging incident as an emergency from the outset. There is also scope for learning from the clinical review and the investigation endorses recommendations about ensuring the transfer of medical information when prisoners move establishments and the need for automated defibrillator machines on the units at Glen Parva. In view of the circumstances which gave rise to the recommendation about medical information, a copy of this report will be sent to the Governor of HMYOI Brinsford.

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 **March 2013**

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SUMMARY

1. The man was released on licence on 16 August 2010, from HMYOI Glen Parva. He had served part of a sentence of 30 months. During his custodial sentence, he had committed several offences against prison rules, including fighting with other prisoners. He did not seem to have much hope for his future and said he felt his convictions would get in the way of his long-term goals of employment and accommodation.

2. On 21 October 2010, the man's licence was revoked because he missed a number of appointments with his probation officer and failed to inform her that he had started a new relationship. Both were specific conditions of his prison licence. The police arrested him and he was taken to Glen Parva on 23 October. The man said he had been taking drugs and drinking quite heavily so an alcohol detoxification programme was started. He was assessed as being unsuitable to share a cell mainly because of his history of fighting with other prisoners.

3. The man was concerned about contacting his girlfriend. After failing to get through on the telephone on the morning of 24 October, he refused to go back to his cell and was eventually restrained by staff. Later that day, staff placed the man under the suicide prevention and self-harm management procedures because he was found with a lump on his forehead. The man said he had 'blacked out' (he did have some history of collapsing) but there were concerns that he had harmed himself deliberately.

4. The suicide prevention paperwork completed that day and the following morning showed that the man's main concern was to contact his girlfriend and his daughter. He did speak to his girlfriend in the afternoon and an officer noted this had "really lifted his spirits." The next review meeting was brought forward to 26 October and a decision made to stop the monitoring. Although this was very soon after it had started, it did appear that he had calmed down after his recall and that positive contact with his girlfriend had made him feel much better.

5. At the Sentence Planning Board on 4 November, the man was told that he was likely to have to stay in prison until his sentence expiry date of 19 September 2011. The man had originally thought he was only being recalled for 28 days. The suicide prevention post-closure review the next day failed to make reference to this meeting or what it meant for the man. We make a recommendation about this and the need for relevant staff to contribute to such reviews.

6. The man's offender supervisor noted on 7 December, that the man seemed "very smitten" with his girlfriend and that he smiled a lot when talking about her. During conversations with his girlfriend on the

telephone on 11, 12 and 13 December the couple referred to a visit that Thursday (16 December) and how they were looking forward to it.

7. The man tried to call his girlfriend on 24 December at 9.20am but the answer machine went on – he did not leave a message. The officer on the unit that day and early evening said the prisoners were locked in their cells from about 4.30pm. She went off duty at 8.30pm and the Operational Support Grade (OSG) took over as the night patrol on Unit 8. The OSG said the atmosphere was quite excitable because it was Christmas Eve. He said a lot of the prisoners were playing loud music, televisions were on and there was 'banter' between the prisoners. The unit did not settle down until the early hours.

8. Whilst doing his final roll check of his shift, shortly before 6.00am on Christmas Day, the OSG looked through the observation panel of the man's cell and saw that he appeared to be sitting at his desk underneath the window, looking out. His arm was raised and the OSG saw that there was some green sheeting around his neck. He tried to get a response from him. The OSG said he wasn't sure if the man was "messing around". There was no response and so he used his radio to summon emergency help. He then used his cell key (kept sealed for emergencies) to open the door and go in. Other staff arrived, including two nurses. The man had sadly been dead for some time. Rigor mortis had set in and no resuscitation was attempted. Paramedics arrived shortly afterwards. Two recommendations are made about night checks of prisoners and immediately treating every apparent hanging as an emergency.

9. The man did not confide in any staff about his relationship ending, nor how he was feeling. When we looked at the other deaths at Glen Parva since 2004, we found that two other cases were similar, in that the young men had taken their lives soon after their relationship with a girlfriend had broken down. We have asked the Governor to put together a working group to look at ways in which prisoners might be encouraged to talk to, or seek help from others in the prison at times of acute crisis such as this.

10. The clinical reviewer made two recommendations which we endorse. One was about the accurate transfer of information between prisons and the other to consider the provision of automated defibrillator machines (although these would not have made a difference in the man's case).

THE INVESTIGATION PROCESS

11. This office was notified of the man's death on 29 December 2010. Notices were issued to staff and prisoners at Glen Parva telling them that an investigation would be taking place and inviting those who wished to see the investigator to make themselves known. The investigator did not receive any response to these notices. Another investigator in this office visited Glen Parva on 5 January 2011, to open the investigation.

12. A clinical review of the man's medical care was commissioned. A clinical reviewer was appointed to carry out the review. His report appears at annex one. Unfortunately, this review was delivered very late. This combined with workload pressure at this office has lead to the delayed production of this report.

13. The family liaison officer contacted the man's grandmother, to offer a visit and ask whether the family had any questions or concerns that they wanted to raise. The man's grandmother said she thought the man's girlfriend had written to end their relationship shortly before he died. She also thought the man may have been told he had longer to stay in prison than he first thought. In March 2011, another family liaison officer took over the role of family liaison officer. The man's family and foster family responded to the draft report. His family said that they felt the prison had let him down and that he was not looked after or checked properly.

14. The investigator visited Glen Parva to carry out interviews with staff on 28 February, 1 and 2 March 2011. On the latter date, the investigator and the clinical reviewer did two joint interviews. Investigator B carried out interviews on 28 March and she was assisted by another investigator who assisted with preparing the investigation report.

15. The investigator did not have access to the letters left by the man, relating to his actions. They had been passed to the Coroner, who refused our requests for copies of them as she did not wish to release them prior to the inquest.

THE MAN

16. Medical records show that from an early age and throughout his childhood, the man had severe behavioural problems.

17. As a child, the man spent some time living with foster parents and in the care of the local authority. A doctor who assessed the man gave an opinion was that there was a clear history suggestive of attention deficit hyperactivity disorder (ADHD) dating from early in the man's life.

18. The man was prescribed methylphenidate, a drug used in the treatment of behaviour disorders, by the doctor who diagnosed him. (This medication is also known under the brand name Ritalin.) A letter about a follow up appointment indicates that there were still concerns about his behaviour. His foster parents said the man was unable to occupy himself positively at all, unless he was supervised. His medication was changed to a slow release version of Ritalin to reduce the effects of the drug running out during the day. Melatonin was introduced to try to help regulate his sleep patterns.

19. The doctor continued to be involved in the man's care. In March 2002, it was noted that the foster family were feeling a great strain. There had been serious incidents of violence at school and the man was excluded. Risperidone (an atypical anti psychotic drug) was added to the Ritalin. During a review in October 2002, it was noted that the man's Ritalin prescription had been changed to Concerta XL (another brand of methylphenidate).

20. In August 2007, whilst in HMP and YOI Ashfield, the man was reviewed by the visiting child and adolescent psychiatrist. She wrote to the man's GP to inform him that he had requested some behavioural therapy to help him deal with his impulsivity. He was still being prescribed Concerta XL and risperidone. The man was due to be released at the end of September. His GP records show that, after his release, his doctor continued to prescribe Concerta XL and risperidone, but this appeared to have stopped in October 2007.

21. The man's former partner had a daughter whilst he was serving the first part of his sentence, before his release on licence and subsequent recall.

HMYOI GLEN PARVA

22. Glen Parva was originally built as a borstal in the early 1970s and became a youth custody centre when borstal training was abolished. (A borstal was a type of youth prison abolished in 1982). It later changed designation to a young offender institution (YOI) and now holds both unconvicted and convicted male prisoners aged between 18 and 21. It has an operating capacity of around 800 prisoners.

23. The Leicestershire County and Rutland Primary Care Trust (PCT) is responsible for commissioning healthcare in the prison. Among other services provided are nurse triage, mental health clinics, GP surgeries and well man checks with access to the dentist, optician and physiotherapist. The Bush End Surgery in Wigston is contracted to provide ten sessions of clinical cover on weekdays at Glen Parva. The doctors undertake nine booked surgeries, two to three hours each, and a doctor is present part of each morning and each afternoon Monday to Friday. They also visit prisoners in the segregation unit and see anyone who has an urgent need for a GP.

Her Majesty's Inspectorate of Prisons

24. Her Majesty's Inspectorate of Prisons (HMIP) last inspected the prison 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.
>
> "Young prisoners spent a reasonable amount of time out of cell, but both the quantity and quality of purposeful activity were insufficient… Substance misuse services were reasonable but staff vacancies limited the range and quality of what could be delivered. We welcomed the much needed provision for young men with alcohol problems."

Independent Monitoring Board

25. Every prison has an Independent Monitoring Board (IMB) made up of local independent volunteers, appointed by the Secretary of State, who monitor standards to make sure prisoners are being treated fairly and humanely. Each IMB is required to report every year on their findings. In the last report on the period between December 2009 and November 2010, the following observation was made, "The Board

considers that Glen Parva continues to be a safe and respectful environment."

> Against a background of continuing concern about the physical condition of some of the older residential units, the IMB was pleased to note that the prison had been upgraded to Level 4 in the most recent HM Prison Service Audit. This is the highest level of performance possible.

Assessment, Care in Custody and Teamwork

26. Assessment, Care in Custody and Teamwork (ACCT) is a care planning tool used in prisons to help monitor and support prisoners identified as being at risk of self-harm or suicide. Any member of staff can "open" an ACCT by filling in certain documents detailing 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 diffusing circumstances where suicide or self-harm can take place.

Previous deaths at HMYOI Glen Parva

27. Since 2004, when the Ombudsman's office was given responsibility for investigating all deaths in prison custody, there have been 12 deaths at Glen Parva. Eight of these occurred before the death of the man. Previous findings and similarities between this and other deaths are discussed in the issues section of this report.

KEY EVENTS

28. On 15 October 2008, the man appeared at South Worcester Magistrates' Court, charged with several offences committed whilst on bail, including a violent offence. He was remanded into custody at HMYOI Brinsford. He underwent the standard first reception health screening process. The man said he had been taking Concerta XL and risperidone but could not give details of his GP so that this could be verified. A Mental Health Assessment referral was made in order to review the need for the medication. The man said he drank only occasionally and that he had not taken any illicit drugs for a month.

29. The man again appeared before Worcester Magistrates' Court, on 29 October and was taken to HMYOI Glen Parva afterwards. It was recorded in the reception health screen, "states he was diagnosed with ADHD at the age of 9 years and was on Ritalin until the age of 17 years". He told the nurse he had last smoked cannabis about four weeks earlier. The staff nurse who did the assessment did not consider that his medication needed to be reviewed. The follow-up health appointment the next day noted that a non-urgent referral to the GP was needed because of a family history of epilepsy.

30. The GP reviewed the man on 10 November 2008 and they discussed his history of collapse which had occurred over the past three to four years. An electro encephalogram (EEG) was planned to assess the possibility of epilepsy as a cause for the collapses. (An EEG measures and records the electrical activity in the brain.)

31. On 20 November, the man had a medical examination at Brinsford after returning there. The record states, "No change to mental/physical health since assessment 15/10/08" and in subsequent notes, no mention is made of the collapses or planned EEG.

32. The man appeared at Worcester Crown Court on 5 January 2009 and was held on Judge's Remand (which means that he was convicted but not yet sentenced by the judge). He was taken to Glen Parva. On 9 February, he was sentenced to 36 months in custody. His First Reception Health Screen (completed because of a change in his status from convicted to sentenced) noted the need for the EEG referral. The original referral from the GP does not seem to have led to an appointment. A further letter on 16 February resulted in the offer of an appointment on 1 April with the neurology clinic at Leicester General Hospital. Unfortunately, this appointment letter was sent directly to the man, so it had to be rearranged for 6 May. (Prisoners are not allowed to know of booked hospital appointments because of the increased risk of a planned escape attempt.) The appointment with the consultant neurologist led to a view that the collapses were "syncope" (medical term for fainting) and not epilepsy.

33. A Cell Sharing Risk Assessment (CSRA) at Glen Parva assessed the man to be 'high risk' (this means a high risk to other prisoners' safety if he were to share a cell with them). A decision was made to put him in a single cell.

34. During his sentence at Glen Parva, the man committed several offences against prison rules, including fighting with other prisoners. The offences resulted in punishments such as additional days added to his sentence, loss of earnings, being confined to his cell and loss of association (free time spent on the wing with other prisoners).

35. In June 2009, the man began an offending behaviour course – Enhanced Thinking Skills (ETS). A note in his offender supervisor contact sheet says:

> …The man states that he does not see the point with ETS as he will end up back in prison and therefore what's the point. Have spoken about the possible consequences of refusing however did not appear concerned. Have spoken to unit staff about sudden U-turn in motivation…".

The man dropped out of ETS and in July and became a cleaner on his unit instead. He did agree to do some education-based work in his cell.

36. An entry in the NOMIS case notes In January 2010, states that the man's CSRA was now rated as 'low'. (This meant he would be able to share a cell). He then shared a cell for a period of time but unfortunately in April, he and his cell mate caused extensive damage to their cell and barricaded themselves in. The man subsequently had 18 days added to his sentence by the Independent Adjudicator who held the disciplinary hearing. His CSRA was changed to 'high'. In May, he spent time in the segregation unit after assaulting another prisoner. He spent a further period there at the end of May after refusing to return to his cell.

37. During July and August, plans were discussed for the man's release. During his pre-release board on 5 August, he expressed the view that he could see himself being recalled to prison if his licence conditions were very strict. He was told that the conditions would be. He said his long-term goals were employment and accommodation but he was very negative as he believed that his convictions would get in the way of this. Staff told him that at the end of the day, it was up to him and the choice was his. He was conditionally released from Glen Parva on 16 August 2010.

38. A Multi-Agency Public Protection Arrangements (MAPPA) meeting was held on 23 August at Worcester Probation Office. (The MAPPA process assesses and manages the most serious offenders, through a multi-agency approach.) The MAPPA panel noted that the man had

refused to undertake any work to address his offending behaviour in custody. They also noted his adjudications for violence and aggression towards staff and other prisoners. They said of the man, "continues to maintain a stance that violence is an acceptable behaviour and that it is part of who he is". There were concerns about whether he would fulfil the conditions attached to his period on licence.

39. On 21 October, the man's licence was revoked. He was arrested by police who used CS gas (a spray used to control violent behaviour) during the arrest. The police doctor examined him at the police station shortly after midnight on 23 October and confirmed that he was fit to be detained, interviewed, charged or transferred.

40. The man was taken to Glen Parva later that day. The First Reception Health Screen was carried out by Staff Nurse A. It was noted that the man was low in mood because he was missing his girlfriend, but had no suicidal thoughts. He admitted the use of cannabis (daily habit) and crack cocaine (daily habit). He said he used heroin, benzodiazepines (a sedative) and amphetamines (a stimulant) occasionally. He reported drinking 15 units of alcohol a day. The man had some injuries from smashing a police cell door. The GP saw the man and started him on a detoxification programme. He prescribed chlordiazepoxide (a drug used to manage the effects of alcohol withdrawal) and thiamine (a vitamin) to prevent some of the longer-term effects of alcohol abuse. The need for medication for the man's ADHD was also reviewed, but it was decided that it was not appropriate to prescribe this because the man had not taken the medication for many months.

41. The man was assessed as 'high risk' in terms of sharing a cell because of his history of fighting, assaults and setting fire to his cell during his previous period in custody. It was also noted that he was previously high risk. The man was put into a single cell on unit 15.

42. The next day, 24 October, around lunchtime, the man was allowed a phone call to his girlfriend because he had been unable to get through the night before. He asked to make another phone call and became unhappy when this was refused by staff. The man said he would not return to his cell. Senior Officer A and Officer A spoke to him in order to try to diffuse the situation. During interview, the SO said:

> "He indicated that despite having a couple of calls to his girlfriend that morning he needed to speak to her further and he offered concerns about the state of his relationship with his girlfriend. Both myself and Officer A assured him and reassured him that he would get out later that afternoon to make further phone calls."

43. The man initially seemed to have accepted things and began to walk back to his cell. However, as he walked away, he lashed out at the two officers and said he was not going to return to his cell until he had made the phone call. Officers restrained the man was restrained using

Control & Restraint (C&R) techniques and escorted back to his cell. (C&R is the only approved method for staff to restrain violent prisoners by force.) Staff Nurse, B saw the man at 1.00pm and noted that he had not received any injuries during the restraint. The man was subsequently charged with not obeying a lawful order. He pleaded guilty at the adjudication (on 26 October) and was given a suspended punishment of stoppage of earnings (prisoners can earn money by taking jobs in prison workshops), canteen (the process for prisoners to buy personal items) and association (a time of the day when prisoners are allowed to socialise with each other).

44. Soon after, at 1.05pm, a healthcare support worker from the substance misuse team had a meeting with the man. She made a record of the level of his drug and alcohol misuse. He told her that he drank seven pints of beer a day. She noted that he presented as quiet and lethargic, that his hands shook and he was sweating. She wrote in his medical record that he should be monitored for alcohol withdrawal symptoms, such as vomiting, appetite, sleep pattern and orientation. She also wrote that his mood should be monitored in case of any deterioration.

45. The healthcare support worker made a further entry at 3.42pm:

> "[The man] presents as very angry, states is requesting to make a phone call – has had to be restrained earlier today and put behind his door by unit staff. The man states he is not eating and is not sleeping. Documentation [by member of staff] states that he appeared to be asleep all night."

46. That evening, whilst giving him his evening meal in his cell, the man was found with a head injury. He had a lump on his forehead and there was blood on the floor. At 4.45pm, SO A (who was in charge of Unit 15 at that time) placed the man under the suicide prevention and self-harm monitoring provisions and opened an ACCT document to record the actions. The initial section of the document, 'Concern and Keep Safe Form,' completed by the SO said that the man's mood was low due to separation from his family and girlfriend and that he was detoxifying from drugs and alcohol. The SO also completed the 'Immediate Action Plan' (usually completed by the unit manager). He decided that the man needed to stay in a single cell as his CSRA was rated as 'high'. He said the man was aware of both the availability of Listeners (prisoners trained by the Samaritans to offer support to others) and the Samaritans dedicated phone, but did not wish to use either. The SO also wrote that the man was detoxifying from drugs and alcohol.

47. Later that evening, Nurse C assessed the man, at the request of SO A, as he had been banging his head on the cell wall. The man told the nurse he had banged his head on the floor because he blacked out. He could not explain why the blood was spread over such a large area

and he had dried blood on his fingers. He admitted to banging his head on the cell door whilst in police custody and said he did this because he was angry. He was given his medication at 6.45pm. Regular checks were made of the man during the night. In the morning, he had a raised pulse and was given an appointment to see the GP that afternoon.

48. The substance misuse team saw the man just before 10.00am on 25 October and, soon after, Officer B talked to him as part of the ACCT process. The officer carried out an assessment interview with him. He made detailed notes of what they discussed. Under the heading, 'Individual's perception of the problems related to current distress', he noted:

> "The man is annoyed as he has not spoken to his girlfriend since coming into custody on Friday. He is worried about his three year old daughter and partner, only wish is to contact them…"

49. Officer B said the man was adamant he did not purposely hurt himself and that he must have 'blacked out'. It is recorded under the heading about previous acts of self-harm, "the man has never self-harmed or attempted suicide previously. He states he can cope with prison fine and has no issues on the outside". When talking about how he was feeling now, Officer B made this note about the man:

> "The man is frustrated but will be okay once he speaks to his girlfriend. He does not feel depressed but is a little stressed… he has no thoughts of self harm or suicide and claims he never will…"

50. Under the heading, 'Reasons for living and coping resources' is written:

> "Girlfriend and 3 year old daughter. The man has another child on the way, girlfriend is 7 months pregnant. Has support of his nan. Only 28 days to serve, keen to get out. He is looking to address his drinking and drug issues before release".

51. The man then had his first ACCT review with Officer B and Senior Officer B at 10.40am. He was adamant that he had banged his head because he had passed out in his cell. He reiterated that he had not injured himself on purpose. It was felt that the man would be happy once he had spoken to his girlfriend. The SO said in both the police interview and PPO interview that he thought he allowed the man to make a phone call from the office (but his ACCT document indicates that he spoke to his girlfriend later that afternoon). The record of the meeting showed that they believed it might be possible to close the ACCT if the man maintained his stability and consistency from then on. The next meeting was arranged for 29 October.

52. The GP reviewed the man given his elevated pulse and decided to extend the detoxification period, with propranalol (a drug to reduce the rapid heart rate) added to his medication. A member of the Counselling Assessment Referral Advice and Throughcare services (CARATs) team (who work with prisoners who have substance misuse problems), made an entry in the ACCT ongoing record on 25 October at 3.20pm. It was recorded that the man thought his alcohol use was more of a problem than his drug use. He said that he was feeling agitated because he had not spoken to his girlfriend but that he would be fine once he had. The next entry at 4.05pm, by Officer C, noted that the man had now received his pin number (allowing him to telephone people who had been approved) and that he had spoken to his girlfriend. The officer said it had "really lifted his spirits".

53. A decision was made to bring the ACCT review meeting forward to 26 October. SO B was present, as was Officer D. It was noted that the man's major problem (which was contact with his girlfriend) had been "resolved" and that he had no thoughts of self-harm. The ACCT monitoring was stopped and the post-closure review set for 2 November.

54. On 28 October, the man moved to Unit 8 and met his Offender Supervisor. (Offender Supervisors work in prisons to ensure that the objectives in an offenders sentence plan are implemented.) The man knew he had been recalled because he failed to tell probation that he was in a new relationship (which was one of his licence conditions) and that he had missed or arrived late for appointments. The man seemed to think that he would be recalled for 28 days.

55. A Sentence Planning Board took place on 4 November. Those present were the man, his offender supervisor and Offender Manager (via telephone conference). The man was told during this meeting that he had been given a standard, not 28 day recall. He was therefore likely to stay in custody until his Sentence Expiry Date of 19 September 2011. The man's offender supervisor noted in his history sheet that the man was not happy about this. She told our investigator that the only way in which the man might be released earlier was if he could show the Parole Board that he had addressed his offending behaviour. The Board set some targets of engaging with CARATs about drink and drug misuse and obtaining a Construction Skills Certification Scheme (CSCS) card (this allows the person to obtain a job in the construction industry).

56. The ACCT post-closure review took place on 5 November with the man, SO C and Officer E present. It noted that the man had settled well onto Unit 8 and that he appeared to be mixing well with his peers. He did not mention any other concerns he had at this time. The review did not discuss the implications of the meeting the day before or that the man was likely to have to stay in custody for much longer than he first thought.

57. The man's personal officer noted in his history sheet on 6 November, that he was settled on the wing and kept himself to himself. The man's personal officer said during interview that "…he was quiet. He didn't really come to the attention of staff. He was talkative when he wanted to be, on association he played pool and chatted to staff and chatted to his peers…" He also said that the man never talked to him about his relationship with his girlfriend. The man's detoxification medication ended on 6 November. He did not subsequently come to the attention of the healthcare team for any mental health issues.

58. On 3 December, the man rang his girlfriend. The next day he spoke with his grandmother at around 10.00am. He told her that he could not get hold of his girlfriend that morning and was getting frustrated because of this. His grandmother asked if he would be out of prison before Christmas. The man said he did not know and that his probation officer had told him he would get out when he had completed a drug course. He added, "…I probably will be, yeah".

59. Two days later, on 5 December, the man spoke to his girlfriend on the phone for a few minutes. The conversation was upbeat to start with but when the conversation turned to when she was going to visit him next (she told him in a couple of weeks), the man's attitude and tone changed. He said he had already not seen her for a couple of weeks. He added "do what you want". His girlfriend then agreed to try and book a visit sooner.

60. The man's offender supervisor made an entry in the man's contact sheet on 7 December, noting that he appeared to be reasonably happy, that he had had some visits from his girlfriend and that he was waiting to go on a Prisons Addressing Substance Related Offending (PASRO) group course, run by the substance misuse team. She noted that the man seemed "very smitten" with his girlfriend and that she had never seen him smile as much as when he was talking about her. Dr A was the last member of healthcare staff to see the man. He had a consultation with him on 7 December, about his acne and decided to continue the treatment his existing treatment.

61. The man's Cell Sharing Risk Assessment was due for review on 9 December. The review concluded that he should remain 'high risk' and therefore unsuitable for sharing a cell with another person. The man's personal officer made another entry in the man's history sheet on 9 December that he was polite towards other staff and his peer group.

62. The man spoke to his girlfriend on 11 December. He was upset and angry that he had not had letters from her. He used the terms "mad" and "vexed". His girlfriend said she had sent a letter but he replied that he had not had one for over a week. He told her, "I'm trying to hold it down man, you don't understand, it's f***ing hard man". His girlfriend replied that if he loved her, he would just keep things together and get

through it. The man said he did love her and that was why he was trying to be different on this sentence. He asked for a postal order to be sent in so that he would have money to buy cigarettes. The two also mentioned a visit and she said that she had booked one for Thursday.

63. The next day, the man and his girlfriend spoke for eight minutes on the telephone. He said he had cut his ear open the previous night and that it had been a bit of "home surgery". They discussed his brother and he asked if she was visiting on Thursday, to which she replied yes. The investigator has looked into whether the man was treated for an ear injury at this time. There are no records in the medical or wing file to show that he had harmed himself.

64. On 13 December, the man spoke to his girlfriend on the phone for a few minutes. He appeared to be upbeat and when she asked him how he was, replied "all good". He was laughing and joking at times. They both referred to seeing each other on Thursday (16 December) and that they were looking forward to this. In fact, no visit was booked for this date and no visit took place.

65. The man's personal officer's last working day on the unit before Christmas was on 22 December. He said the man had seemed "okay really, no red flags flying at all, he seemed quite settled".

66. The man tried to call his girlfriend on 24 December at 9.20am but there was no answer. The answer phone activated and, at this point, he ended the call without leaving a message. Officer F was on duty on Unit 8 from 1.30pm to 8.50pm. She said the prisoners had their tea meal around 4.00pm and that everyone was back in their cells by about 4.20pm. All of the other staff then left the unit and the officer was patrolling from 4.30pm until the member of staff on night duty arrived to relieve her. She carried out a final roll count at 7.30pm. The officer described the man as "a quiet person, he kept himself to himself".

67. Senior Officer D started his night shift at around 8.30pm on Friday 24 December. He was the night orderly officer, which means he was the person in charge of the prison during the evening and night. (Other, more senior managers would have been contactable by telephone and able to go into the prison if necessary). Officer Support Grade (OSG) A was on Unit 8 that night. There were 71 prisoners on the unit. No prisoners were being monitored under the ACCT process. After doing a count and check of all the prisoners, the OSG read through the Observations Book (a book used by staff to record day to day events worthy of note on the unit). There was nothing in the book about the man that day.

68. OSG A carried out regular patrols around the unit. He recalled in interview with the police that "there was a little bit of banter going on as it was Christmas Eve but it was generally in good spirit". He told the

investigator during interview that “a lot of lads were quite excitable… lot of banter, radios up, televisions playing; nothing untoward”.

69. During routine patrols cell lights are not switched on nor door flaps opened. OSG A told the police that in addition to the headcount when he first comes on duty at 8.30pm, there is one at midnight, 3.00am and 6.00am. He said that lights are left off at the midnight and 3.00am counts (so as not to disturb those sleeping) but switched on for the first and last checks.

Events on 25 December

70. The unit settled down around 2.30am. OSG A recalled during interview with the investigator that he would have been on the 2’s (second floor) landing around 2.30am doing the roll check (count of prisoners) because he remembered one of the prisoners shouting out, asking him what time it was. OSG A said afterwards he wondered if this had been the man. (The man’s cell was in fact on the third floor).

71. At around 5.50am, OSG A started his final check, switching on cell lights as necessary. When he reached cell 8 on the 3’s landing he looked through the observation panel on the door and saw the man “sitting by the window”. A metal desk and chair are fixed to the floor, directly below the window. The man appeared to have his left hand raised. It was in the metal mesh grill on front of the window. OSG A saw that the man had some green sheeting around his neck that was attached to the window. He kicked the door to try to get a response from the man because he said he was not sure if the man was messing around. A prisoner in the cell next door, number 9 asked, “What’s he doing boss?”. The OSG went to his door and said “I think he’s pissing about. Has he said anything to you during the night?” The prisoner said no and the OSG went back to cell 8. He kicked the door again and called out to the man. When there was no response, the OSG contacted SO D using his radio. The radio net was on “talk through” at that time, meaning that all those carrying a radio could hear all the transmissions.

72. The Governor of Glen Parva arrived at the prison early, at about 5.50am. He had gone to the prison in order to pay his compliments to the staff who were working during the Christmas period. After speaking to the Governor in the gate area, SO D went to the part of the prison where the morning roll count is collated and checked. The assistant night orderly officer, was also here. At about 5.57am, a call came over the radio net from OSG A. He said that there was a “prisoner suspended”. SO D asked Officer G to go to the healthcare centre in order to escort the nursing team to Unit 8 and asked the gate to call the paramedics. The OSG lock then used the radio to tell staff which cell he was at.

73. Officer H was one of the assistant night orderly officers and was about to go into Unit 9 when he heard OSG A's radio message. He went into Unit 9 in order to get Officer I so that they could both go to Unit 8.

74. Nurse A was in healthcare when he heard OSG A's radio message. The nurse heard that there was someone with a ligature on Unit 8. He said it was difficult to understand exactly what was happening but he and his colleague, Nurse D got their emergency equipment ready. Officer G arrived at healthcare in order to collect the nurses (healthcare staff do not carry keys at night). The three of them ran to Unit 8, the officer opening the doors on the way. Nurse A estimated that the time between hearing the radio message and arriving at the cell was five to ten minutes. Nurse D thought it to be ten minutes. SO D said during interview that it was approximately five minutes.

75. OSG A looked back into cell 8 after contacting SO D. He said in his police statement, "I looked back into the cell and could see that the male's bottom was about an inch off the metal seat". He decided to enter the cell. He broke his sealed pouch (which holds a cell key for use in emergency situations), unlocked the cell and went in. The OSG put his arm around the man. He described him as "very stiff". He tried to hold the man's weight in order to get the ligature off his neck but said that it was too tight. He pulled the other end of the ligature out of the window grill and attempted to place. The man in the recovery position on the floor of the cell. He said the man's arm and legs stayed in the same position they were in when he was at the window (a seated position) and that the man's body felt "very hard". The OSG then stepped back out of the cell and saw SO D and Officer J arriving.

76. SO D and Officer J went to Unit 8 and onto landing 3. The SO said the OSG A had already unlocked cell 8 and had got the man down from the window grill. The man was lying on his right hand side on the floor. Officer J used his cut-down tool to cut the ligature from the man's neck. The ligature was made of green cotton material, from either a pillow case or bed sheet. Rigor mortis had set in. The SO and Officer J moved the man onto his back and checked for signs of a pulse or breathing. Officer I and Officer H arrived at this point, as did Officer G and the healthcare staff. Nurse A said the man's arm was raised (as it had been at the window grill) and his legs were not together. Nurse A checked for a carotid pulse, radial pulse and any signs of breathing. His pupils were fixed and his nails and toes blue. He described the man's body as cold and very stiff. The nurse felt that there was nothing that could be done. He did not therefore use the defibrillator or perform any form of resuscitation technique. (A defibrillator measures electrical activity in the body and advises on action to be taken. Action can include a brief electric shock to the heart to enable the natural pacemaker to regain control and establish a normal heart rhythm.) The SO asked the gate officer to call the police.

77. The paramedics arrived and were escorted to Unit 8 by Officer H, arriving at about 6.15am. They went into the cell and were briefed by Nurse A. They applied their defibrillator, which gave a flat line reading (this indicated he was clinically dead). Officer H went to the man's cell and SO D described what had happened.

78. At 6.22am, SO D left the landing and rang the Duty Governor (who was at home) to tell him of the man's death. He told the SO that he would make his way to the prison. The cell was sealed and the police arrived soon after and took staff statements.

After the man's death

79. Staff involved with the man were offered support and the opportunity to reflect on events in both a hot and cold debrief. Support to staff was also provided by the Care Team within Glen Parva. The investigator was assured that prisoners were notified about the man's death and those regarded as particularly affected or vulnerable prisoners were checked by staff and offered support.

80. The deputy family liaison officer went with Governor A to the home of the man's grandmother to break the news of his death. There were many people at the home because it was Christmas Day.

81. The funeral took place on 17 January 2011. In accordance with Prison Service policy, Glen Parva contributed towards the cost of the funeral. The family liaison officer attended the funeral on behalf of the prison.

82. The post mortem showed that the man died as a result of hanging. Toxicology tests indicated that the man had not taken drugs or drunk alcohol prior to his death.

83. Several members of the family visited the prison and Unit 8 on 2 February 2011. They met with Governor B and the family liaison officer, as well as the senior officer on the unit.

Information received from the family after the man's death.

84. The man's nan told our family liaison officer that the family liaison officer had told her that the man had been in good spirits on Christmas Eve. She doubted this, as she was aware that the man had received a letter from his girlfriend ending their relationship. She said that, although they had not known each other long, the man had "really fallen for her". However, she could not be specific as to when he received the letter – which was not available to the investigator as it had been retained by the coroner - and the investigation produced no evidence that staff were aware of this letter and its potentially serious impact on the man's state of mind.

ISSUES CONSIDERED

Clinical care offered to the man

85. The clinical reviewer concluded that the man was treated in a way that was at least equitable with what would have been expected in the general population and, when he was obviously distressed in October, that appropriate steps were taken to ensure his safety. He considered there were no obvious signs the man was feeling suicidal on 24 December and that therefore it would have been impossible to prevent. The clinical reviewer said the decision not to resuscitate him was appropriate. He concluded, "I am happy that all possible steps were taken to safeguard the man by both healthcare and wing staff at HMYOI Glen Parva".

86. The clinical reviewer pointed out areas of good practice. HMYOI Brinsford had obtained previous prison medical records for the man which was appropriate given his longer term problems. He also felt that the suicide prevention and self-harm monitoring process was used appropriately when there were concerns about the man when he was first recalled into custody.

87. The only issue of concern raised by the clinical reviewer was the handling of the collapses the man suffered. The need for an EEG identified at Glen Parva was not noted when he transferred to Brinsford. The clinical reviewer went on to say that, in the man's case, the situation was not as serious as it might have been because he returned to Glen Parva in a relatively short time and the EEG issue was picked up again. In view of the lapse of time since this oversight and the consequent unavailability of evidence regarding the reasons why staff at Brinsford did not take appropriate action, we have not made a recommendation to the Governor of Brinsford. However, a copy of the report will be sent to him, so that he is aware of the failing identified and can give attention to any action that might be required. We endorse and slightly recast the clinical reviewer's recommendation:

The Governor and Head of Healthcare at HMYOI Glen Parva should ensure that potentially important health information is transferred with prisoners when they move establishments.

88. The clinical reviewer added that although in this case it would not have been effective, he wanted consideration to be given to providing automated defibrillators (which may be used by untrained staff). He said:

> "There is increasing evidence that early defibrillation is the most likely resuscitation action to ensure life is preserved and some young, fit men are at risk of sudden dangerous changes to their heart rhythm as well as the usefulness of this intervention in cases

of attempted suicide or deliberate self harm. The rapid availability on the units could be decisive in other cases".

The Governor and Head of Healthcare should ensure the availability of automated defibrillators on the residential units.

Management of risk of self-harm and the suicide prevention process

89. The investigator examined the ACCT process and reviewed the documents completed in respect of the man. The ACCT document was opened appropriately on 24 October, when it appeared that the man had deliberately injured his head. He was adamant the injury had occurred as a result of passing out. The ACCT meant that the man was interviewed in some depth by Officer B on 25 October. We thought the write up of this interview was very good and comprehensive. It helped the staff team identify that the man was upset because he had not been able to make contact with his girlfriend or daughter. Efforts were then made to find out the correct phone numbers and to have them cleared for use on the telephone system in the prison. He was able to speak to his girlfriend later on that same day and staff noted on the form that he felt much better as a result.

90. Prison Service Order (PSO) 2700 Suicide Prevention and Self Harm Management, Annex 8G says:

> "The First Case Review must be attended by the Unit Manager… wherever possible it should be attended by the Assessor… where it is clear that there are mental health or drug/ alcohol issues, an appropriate member of staff must be invited to make a contribution … in writing or by telephone if they are unable to attend at such short notice … The appropriate member of the Chaplaincy team must also be invited to attend."

91. The initial case review write up did not indicate that contributions or invitations to attend had been sought from the healthcare or chaplaincy departments. The man was going through an alcohol detoxification at that time and it would have been appropriate to have sought input from the healthcare team.

The Governor should ensure that unit managers seek contributions to ACCT reviews from all appropriate staff. A note of which contributions have been sought and received should be made on the case review sheet.

92. We consider that although the ACCT monitoring was stopped very quickly, this was a reasonable decision by the staff team at the time. The man had no prior history of self-harm and was adamant his forehead was injured because he had blacked out. His main worry was trying to get in touch with his girlfriend. This had been sorted out quickly and the man felt happier after speaking to her.

93. The part of the ACCT document that describes post-closure reviews states that they must discuss:

1. How the individual is feeling now.
2. How they are managing with the problems that led to their episode of distress.
3. Whether they are now in contact with friends, family or some other support.
4. Whether they have now got something in their lives that they feel positive about (eg. work, art, exercise, education, hobby, something they enjoy or gives them a sense of purpose).
5. Whether they can see alternative ways of dealing with a similar problem should it arise in the future.

94. The record of the post-closure review on 5 November did not make reference to the reasons why the man had been subject to ACCT monitoring. The most surprising issue was that it did not mention that the previous day, the man had found out he was staying in prison for many months, not 28 days as he had originally thought. The man's offender supervisor wrote in his history sheet on 4 November:

> "…The man was not happy because he was told by his OM that his recall is not a 28 day one and could serve until his SED (Sentence Expiry date) on 19/09/2011 – The man stated that he is not motivated to do anything and doesn't mind staying until his SED. Although towards the end he stated he is willing to engage with CARATs which he is doing so".

95. Even if the man chose not to raise this point in his post-closure review, we think a member of staff should have raised it to explore how he felt about it. The reading of a prisoner's history sheet should be done routinely before ACCT reviews/post-closure reviews. It may well have been the case that the man did not had a problem with the prospect of being in prison for longer than he first thought after his recall, but the issue should have been discussed at this review meeting and a note made. In our last but one report into a self-inflicted death at Glen Parva in June 2009, we recommended:

> "…the Governor should ensure that staff attending an ACCT post closure review consider all the evidence, including the wing history sheets, about the prisoner's wellbeing since the ACCT procedures were closed".

Glen Parva accepted this recommendation and said:

> "Senior Officers will be briefed at their morning meeting about the need to include all relevant sources of information about a prisoner

for post-closure reviews. A follow-up notice to staff will be issued and compliance will be checked by managers."

96. We repeat this recommendation, slightly extended and ask the Governor to assure himself that steps have been taken to address it:

The Governor should ensure that staff attending an ACCT post-closure review should consider all the evidence, including the wing history sheets, about the prisoner's wellbeing and possible triggers of self-harm since the ACCT procedures were closed.

Previous deaths at Glen Parva

97. Before the man died, there had been six self-inflicted deaths at Glen Parva since 2005. Two of those deaths are similar in some ways to the man's circumstances. The young men had gone through relationship problems or breakdown a short time before they took their lives. One had asked staff if he could have a Listener. The other young man had spoken to his mother about being unable to cope, but not to staff or his peers.

The roll checks carried out during the night

98. Glen Parva provided the following instruction about the roll checks carried out by the OSG staff at night:

> "Patrol the landings and report any unusual noise or activity to the NIGHT DUTY MANAGER. All prisoners must be observed once before midnight, once between midnight and 0300 hours, and once between 0300 and 0600 hours, if staff have difficulty observing into the cell because of poor light then the use of the night light is unavoidable (NB: these checks are in addition to checks made on 'taking over' and 'handing over' responsibility for each residential unit). Checks must be recorded on the F81."

99. When the investigator who assisted with writing the investigation report, spoke with prison liaison officer B, he said that his understanding of the purpose of these checks was "to make sure no one has escaped". It is primarily just a count of the prisoners to check they are all in their cells. The investigator asked whether he would expect a night patrol to speak to someone if they thought things were unusual (such as a prisoner not being in bed at 3.00am, but looking out the window instead). He said that in such a circumstance he would expect the night patrol to say something to check the prisoner was all right.

100. OSG A could not be expected to remember the details of his counts of all the cells in Unit 8 each night. He said that because it was Christmas Eve, the unit was quite noisy and the prisoners did not settle down until the early hours. He recalled doing a count between 2.30am and 3.00am. He said that when he was on the 2's landing at around 2.30am, somebody shouted out to ask him what time it was. The OSG said, "… I [do] wonder as to whether this may have been the man… checking as to what the time was and when I was likely to return back".

101. Rigor mortis[1] is the stiffening of the body after death because of a loss of Adenosine Triphosphate (ATP) from the body's muscles. ATP is the substance that allows energy to flow to the muscles and help them work, and without this the muscles become stiff and inflexible. Rigor

[1] Explore Forensics (UK) website

mortis begins throughout the body at the same time but the body's smaller muscles are affected first.

102. 'Knight's Forensic Pathology' by Saukko and Knight (2004) states:

> "The flaccid period immediately after death is variable, but commonly extends to between three and six hours before stiffening is first detected, depending on environmental temperature and other factors… The onset of rigor may be markedly accelerated or retarded by the factors mentioned below...
>
> "As a chemical process, the speed of onset and the duration of rigor is modified by temperature. The colder the environment the slower the process and vice versa. The other modifier of the speed of onset of rigor is physical activity shortly before death. Muscular exertion… hastens the onset of rigor.

103. 'Forensic Pathology' by DiMaio and DiMaio (2001) states:

> "Rigor mortis usually appears 2 – 4 hours after death. This can vary greatly… The classic presentation of rigor mortis in its order of appearance is jaw, upper extremities and lower extremities".

104. When the man was found hanging a few minutes before 6.00am, all the staff who were involved described him as cold and that his body was very stiff. In fact, it was noted that his arms and legs stayed fixed in the position he had been in at the window. Rigor mortis cannot be used as a reliable indicator of the exact time of death. Because it had clearly set in throughout his body, it is likely that he had been dead for some hours before he was found. Whether he took his life before or after the 2.30am/3.00am roll check cannot be determined.

105. We think the Governor should clarify the policy statement which covers night observations for wing staff. It should be made clear that if a night patrol OSG observes a prisoner during one of the early morning checks (around midnight or 3.00am) who is not behaving in the way they would expect (ie asleep/lying on their bed) then it would be good practice to switch the night light on and visually and verbally check the prisoner is okay.

The Governor should amend the policy on checking prisoners during the night. Direct advice should be given on what action an OSG should take if they observe a prisoner not in their bed at a time when it would be usual for prisoners to be asleep.

Emergency response

106. The alarm was raised appropriately by OSG A when he found the man just before 6.00am. We are pleased that the OSG decided to go into the man's cell. SO D took all appropriate steps to get staff, including

healthcare, to the cell quickly. He also ensured the paramedics were called straight away and that they were escorted to the man's cell without delay. We agree with the clinical reviewer that it would not have been appropriate for resuscitation to have been attempted, given that rigor mortis had clearly set in.

107. However, in both his police statement and the interview with our investigator, OSG A said that he initially thought the man had been 'messing around' or 'faking' things. He said in the interview with the investigator:

> "… I still expected him to basically back head butt me or turn around and laugh. Even though he'd got a ligature – many years of doing this – we get kids that will do it for a laugh, they'll put it round and then turn around and smile at you. Which is basically what I expected him to do, I literally thought he was messing around. …"

108. Occasionally, in previous cases investigated by this office at other prisons, staff have expressed concern about prisoners 'faking' self-harm as a ploy to entrap or deceive staff. We asked Glen Parva whether this sort of thing does happen in the prison. Family liaison officer B said that Safer Custody did not have any records of it happening over the last few years. He said, anecdotally, that around two and a half years ago they did have a prisoner who tried to put things around his neck in order to try to 'entice' staff into his cell and that this might be the origin of what OSG G was saying.

109. In his police statement, OSG G said, "I looked back into the cell and could see that the male's bottom was about an inch off the metal seat." He then used his sealed cell key to go into the cell.

The Governor should issue a written instruction to staff making clear that it is very unusual for prisoners to 'fake' hanging and that any discovery of apparent hanging should be treated as an emergency situation.

CONCLUSION

110. The man was a troubled young man who seems to have found it hard to see a positive future for himself. He appeared to have high hopes for his new relationship and was clearly concerned about contacting his girlfriend when he was first recalled into custody for breaching his licence conditions.

111. The day after the man arrived at Glen Parva, he was placed under the ACCT suicide prevention and self-harm monitoring procedures for a very short period, owing anxiety about his inability to contact his girlfriend and the belief by staff that he had deliberately harmed himself. However, things seemed to settle for a while and he had regular contact with her.

112. During early December, the man learnt that his recall was not for 28 days but more likely, until the following September. His girlfriend wrote to end their relationship shortly before Christmas. The man did not confide in his personal officer or another member of staff about the relationship ending, nor how he felt. Therefore staff at the prison did not invoke the additional support and monitoring offered under the ACCT process.

113. We do not think that the man's death could have been foreseen by staff at the prison. Nevertheless, there are several recommendations for improvements in the management of prisoners at Glen Parva.

RECOMMENDATIONS

1. The Governor and Head of Healthcare at HMYOI Glen Parva should ensure that potentially important health information is transferred with prisoners when they move establishments.

   The NOMS response to the recommendation was:

   "Accepted. All information is routinely transferred between prisons from Glen Parva and we recognise that this is essential to maintain the safety of prisoners. We acknowledge that there was some information relating to an EEG that was not included on this occasion and Staff will be reminded through clinical supervision and staff briefings of the importance that all information must be transferred."

2. The Governor and Head of Healthcare should ensure the availability of automated defibrillators on the residential units.

   The NOMS response to the recommendation was:

   "Not accepted. The issue of defibrillators on residential units has been discussed at length in the Health & Safety meeting. It is felt that as there are centrally placed defibrillators within Healthcare and also on Unit 15 which is the first night centre this is adequate.

   "We have also reflected on the response to medical incidents and have a rapid response time. We therefore feel that locating defibrillators on units in a young offender establishment would not be appropriate at this present time due to issues surrounding training for prison officers and maintenance / safeguarding of the equipment which in turn may lead to longer term problems if the equipment is not fit for purpose."

3. The Governor should ensure that unit managers seek contributions to ACCT reviews from all appropriate staff. A note of which contributions have been sought and received should be made on the case review sheet.

   The NOMS response to the recommendation was:

   "This is accepted however it already exists in our policies. Managers are mandated to invite stakeholders that can contribute to the care and support of an offender. I will ensure that this is cascaded through Senior Officer briefings and forms part of the weekly audit."

4. The Governor should ensure that staff attending an ACCT post-closure review should consider all the evidence, including the wing history sheets, about the prisoner's wellbeing and possible triggers of self-harm since the ACCT procedures were closed.

The NOMS response to the recommendation was:

"Accepted. Local training on certain key aspects of ACCT is to be delivered soon. The importance of considering all evidence when conducting post-closure reviews will be covered in this training. In addition a local ACCT support aid is being produced which will be issued to all Case Managers as a reference document".

5. The Governor should amend the policy on checking prisoners during through the night. Direct advice should be given on what action an OSG should take if they observe a prisoner not in their bed at a time when it would be usual for prisoners to be asleep.

   The NOMS response to the recommendation was:

   "Partially accepted. The Glen Parva Local Security Strategy (LSS) gives clear instructions that night patrol staff must report any unusual activity immediately to the night manager. Additionally there is a hard copy night protocol located on each unit reinforcing the LSS instructions. However a local policy will now be written and published in addition to the measures above specifically covering all night duties."

6. The Governor should issue a written instruction to staff making clear that it is very unusual for prisoners to 'fake' hanging and that any discovery of apparent hanging should be treated as an emergency situation.

   The NOMS response to the recommendation was:

   "Accepted. A notice to staff has been issued to remind staff that the discovery of any prisoners apparently hanging should be treated as an emergency."