



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
in June 2014 at HMYOI Glen Parva**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man who was found hanged in his cell at HMYOI Glen Parva in June 2014. He was 18 years old. I offer my condolences to the man's family and friends.

One of my senior investigators had conduct of this case. A clinical reviewer reviewed the man's clinical care at the prison. Glen Parva cooperated fully with the investigation.

The man had two periods of time at Glen Parva in 2014 and had attempted suicide two weeks before he first arrived there on 10 March 2014. Despite this, he was not identified as a risk of suicide and self-harm. He was released on 9 May, but a month later, on 9 June, he was remanded back to Glen Parva, charged with a new offence. He said that he did not have any thoughts of suicide or self-harm. On a day in June 2014, shortly before 6.00am, an officer found him hanged in his cell.

I have previously identified shortcomings at Glen Parva in the identification of prisoners at risk of self-harm or suicide. In this case, the man had tried to kill himself only two weeks before arriving in prison for the first time. Court staff had identified this and warned prison staff. I am concerned that poor procedures in Glen Parva's reception meant that this information was not appropriately managed or considered. Nevertheless, even without the information, reception staff ought to have identified and acted on his risk factors.

The man appeared to settle after that, and when he was sent to Glen Parva a second time, no one identified him as a risk. While this decision was more understandable than the first, several of his risk factors remained. This man's death is a stark reminder of the importance of correctly identifying the risks and supporting vulnerable young prisoners when they come into custody.

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

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SUMMARY

1. On 10 March 2014, the man was convicted of affray. He was sentenced to four months in prison and sent to HMYOI Glen Parva. This was his first time in prison. He was 18 years old, had a history of alcohol and drug abuse and had attempted suicide, by hanging, two weeks before his conviction. Court custody staff recorded his recent suicide attempt on a suicide and self-harm warning form. Despite his evident risk factors, when he arrived at Glen Parva, staff did not open an ACCT (Assessment, Care in Custody and Teamwork, the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm).
2. The man refused to engage with the mental health team and said he had no thoughts of suicide or self-harm. Prison doctors examined him and prescribed medication for a skin condition. On 9 May, he was released from Glen Parva.
3. One month later, on 9 June, the man was remanded into custody at Glen Parva charged with a further offence. He again said he had no thoughts of suicide or self-harm and no one assessed him as at risk. That evening he had called his mother. He was upset with her and blamed her partner for him being in prison. On 10 June, a number of staff saw him as part of his induction process. No one had any concerns about him.
4. At 5.40am on a day in June, an officer found the man hanged in his cell and called for emergency medical help. Healthcare staff performed cardiopulmonary resuscitation (CPR) until paramedics arrived. At 6.05am, the paramedics confirmed that he had died.
5. We are concerned that staff at Glen Parva did not identify the man as at risk of suicide and self-harm when he first arrived at Glen Parva in March 2014. This was despite a recent suicide attempt and several other factors that increased his risk. As he had seemed to cope with his first period at Glen Parva, this in turn led staff to underestimate his risk when he returned in June. We are concerned that staff placed too much reliance on the man's presentation, rather than his evident risk factors. Important information from court, about the man's risk when he first arrived, was mishandled because of poor reception processes. When he was found hanged, officers did not follow the required procedures for notifying a medical emergency and there was a delay in calling an ambulance. We make three recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at Glen Parva, informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
7. The investigator visited Glen Parva on 19 June and obtained copies of the man's prison and healthcare records. NHS England appointed a clinical reviewer to review the man's clinical care. The investigator interviewed 18 members of staff and one prisoner at Glen Parva. On 23 July, he gave the Governor initial feedback about the preliminary findings of the investigation.
8. The investigator informed HM Coroner of the investigation who sent us a copy of the post-mortem report. We have sent the Coroner a copy of this investigation report.
9. One of the Ombudsman's family liaison officers and the investigator met the man's family and their legal representative on 11 July. His family were upset that the Prison Service had given them misleading information after his death, which caused them additional distress.
10. The man's family wanted to know:
 - What information was noted when he arrived at the prison, what risk factors were considered, what clothing and footwear did he have and what happened in March 2014 when he was in prison?
 - Why was he in a double cell on his own and what was the outcome of his cell sharing risk assessment?
 - Was he being bullied?

The man's family received a copy of the draft report. The solicitor representing the family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMYOI GLEN PARVA

11. HMYOI Glen Parva holds up to 800 convicted and remanded young men aged between 18 and 21. There are ten residential units each holding up to 80 prisoners. Leicestershire Partnership Trust delivers primary mental health services and Northamptonshire Primary Care Trust provides in-reach (acute) mental health services.

HM Inspectorate of Prisons

12. HM Inspectorate of Prisons' most recent inspection of Glen Parva was in April 2014. Inspectors found that outcomes for young men at Glen Parva were unacceptable in many areas and that Glen Parva was not safe. Induction arrangements were disorganised and the early days processes needed improvement. The number of assaults on prisoners and staff had increased significantly in the previous 12 months. There were problems with the use of new psychoactive substances, known as legal highs, which also led to debt and bullying.
13. Inspectors found that the prison had implemented Prison and Probation Ombudsman's recommendations from previous investigations into deaths at Glen Parva, but the actions had not been sustained in practice. There were weaknesses in ACCT procedures and young men identified as at risk of suicide and self-harm did not receive the support they needed. The personal officer scheme was ineffective. There was appropriate health screening. Prisoners were able to see a nurse every day for advice and triage and doctors held daily clinics.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent report, for the year ending November 2013, the IMB at Glen Parva noted that there had been a marked increase in the numbers of prisoners monitored under suicide and self-harm prevention procedures. The IMB considered there was a good range of services to promote the physical and mental health of prisoners. Those with mental health problems had access to professional care and counselling and support services were generally available, often provided by the chaplaincy.

Assessment Care in Custody and Teamwork (ACCT)

15. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap about how they will be met. Regular multi-disciplinary reviews should be held. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Previous deaths at Glen Parva

16. Since 2011, there have been five self-inflicted deaths at Glen Parva, three in 2011 and two in 2013. We have previously made recommendations about the operation of ACCT and emergency response procedures.

KEY EVENTS

17. On 10 March 2014, the man was convicted of affray, sentenced to four months in prison, and sent to HMYOI Glen Parva. This was his first time in prison.
18. At court, a custody officer received information from the Probation Trust that the man had attempted suicide by hanging two weeks before. He noted in the Person Escort Record (PER) form that a clinical psychologist at outside hospital had assessed him afterwards. He thought that the man had not made a serious attempt to end his life and his actions were more likely to have been attention-seeking behaviour. The man said he had obsessive compulsive disorder, depression and psychotic episodes. The clinical psychologist had found no evidence of any of these conditions, but recommended a further assessment.
19. The custody officer also completed a suicide and self-harm warning form. The man told him that he would not try to hang himself again because it hurt. He said he had no thoughts of suicide and self-harm but was anxious about going to prison. The custody officer recorded on the warning form that he had telephoned Glen Parva and had spoken to an officer. Escort records and suicide and self-harm warning forms are used to alert all criminal justice agency staff about prisoners' risks. The forms accompanied the man to Glen Parva.
20. When the man arrived at Glen Parva, at approximately 6.25pm, an officer met him and signed the PER to record that he had read it. He did not sign the suicide and self-harm warning form, and it is not clear if he read the form, as he should have done in line with the mandatory instruction in section 2.18 of Prison Service Instruction (PSI) 74/2011. (This says that the PER and any other available documentation, including suicide and self-harm warning forms, must be examined, and the prisoner interviewed in Reception, to assess the risk of self-harm or harm to others by the prisoner.)
21. The officer told the investigator that he was aware of what had been written on the escort record but, as he had not signed the suicide and self-harm warning form, he must not have seen it. He and his colleague completed the basic reception procedures. He knew that any member of staff should open an ACCT if they had concerns about his prisoner, but he did not consider whether the man was a risk of suicide and self-harm, which he considered was the responsibility of the nurse at his initial health screen.
22. The man then moved to the Induction Unit where staff completed a cell sharing risk assessment. He was assessed as suitable to share a cell with others.
23. A nurse saw the man for an initial health screen. She said she did not see the man's escort record or suicide and self-harm warning form. He told her that he had tried to hang himself two weeks earlier, and had previously taken an overdose of diazepam when he had felt depressed. He said that someone had hit him in the face with a kettle two days earlier. The nurse recorded that the man said that he smoked and did not want to give up, and he drank alcohol. He used drugs, but had never injected them. The nurse noted that he had a

mark on the right side of his neck, but otherwise appeared fit and well. She also noted the details of his community GP and that he was not on any prescribed medication.

24. The nurse screened the man using a standard template designed to establish the state of a prisoner's physical and mental health and to identify any substance misuse and self-harm issues. She told the investigator that she did not remember the man. She recorded on the template that he seemed very calm and relaxed and not tearful or anxious, although he was depressed at being in prison. She told the investigator that she had not thought she needed to open an ACCT document. She said that she had opened ACCTs before, but had not received any formal training.
25. On 11 March, a member of the mental health team (a nurse) saw the man as part of the routine reception process. He told her that he had tried to hang himself two weeks earlier. He said that he had been worried about his court appearance and had got into debt with his drug dealers. He declined support from the mental health team as he saw it as a sign of weakness. He signed a disclaimer which stated "I contrary to medical advice refuse further mental health input. I have been informed of the possible consequences of my action and assume responsibility for my own health. I have been advised of my rights to access healthcare at any time in the future".
26. The man agreed that the nurse could contact his mother. His mother said that her son had been assessed after his attempted suicide and that he had been referred for a further assessment. The nurse told the man's mother that he had refused the support of the mental health team. The nurse recorded that the mental health team would try to get him to engage with them over the next few days and that he was aware that he could request to see them at any time.
27. The nurse told the investigator that she had seen the man for a standard mental health triage assessment for all new prisoners. She had received ACCT training at her previous prison and at Glen Parva. She had not considered it necessary to open an ACCT, as he did not appear depressed or distraught about being in prison.
28. The same day, a healthcare assistant assessed the man for drug and alcohol issues. He said that he occasionally used drugs at the weekends and spent about £20 - £30 a week on drugs. He said that he only sniffed or smoked drugs and he had last used MCAT (a slang name for methadone – a synthetic amphetamine) a week before he arrived at Glen Parva. He told the healthcare assistant that he had no craving for drugs and had eaten and slept well overnight.
29. The healthcare assistant asked the man about the mark on his neck. He said that he had "gone off my head for a bit", as he had started to drink more. He was adamant that he had no current thoughts of suicide and self-harm and he had a job as a plasterer to go to when his sentence ended. The healthcare assistant recorded that she had spoken to the nurse and was aware that the

man did not want any input from the mental health team. She referred him to the drug and alcohol team because of his recent drug and alcohol use.

30. On 13 March, a member of the mental health team (a nurse), reviewed the man, who said that he was fine and repeated that he did not want any further help from the mental health team. He said that he had tried to hang himself because of the stress of the court case, which had led him to use alcohol and drugs in excess. As a result, he was in a lot of debt, but he denied being anxious or in a low mood and said he had no thoughts of suicide or self-harm.
31. On 14 March, a nurse reviewed the man again. He reiterated that he did not want to engage with the mental health team and he knew how to get help if he needed it. He repeated that he had no thoughts of suicide or self-harm.
32. On 18 March, a member of the therapeutic drug and alcohol service (TDAS), saw the man as a result of the healthcare assistant's referral. He said that he had used cannabis since he was 13 and his use had increased over the subsequent years. He drank excessively and had used MCAT after he committed his offence as he realised that he would receive a custodial sentence. He said that he owed £600 to his drug dealer, which he had arranged to pay back when he was released. He said he did not want any support from the drug and alcohol service as he had the resolve to live without substances.
33. On 26 March, a nurse examined the man who had a rash on his face which he thought was impetigo (a bacterial infection of the skin). The nurse referred him to a prison doctor, who confirmed that he had impetigo and prescribed a week's course of antibiotics.
34. On 2 April, a senior officer spoke to the man after he told an officer that he and his cellmate had been bullied. He did not name the perpetrators. The man's cellmate named the prisoners responsible and staff began to monitor them under Glen Parva's tackling anti-social behaviour (TAB) scheme. Staff supported the man and his cellmate as part of the TAB scheme.
35. A senior officer told the investigator that the man had paid off some of another prisoner's debts. As a result, other prisoners saw him as a soft target, and he had also come under pressure, because he shared a cell with the man who named the perpetrators. On 3 April, staff moved the man and his cellmate to another unit, and the bullying apparently stopped. There is no record of the man mentioning any other concerns about bullying while he was at Glen Parva.
36. His cellmate told the investigator that he and the man had shared a cell for six weeks. He said that they instantly became friends and got on very well. Once they moved to the new residential unit, they were no longer bullied.
37. On 3 April, the man saw a doctor and asked to be prescribed antidepressants. He told the doctor that this was his first time in prison and he and his cellmate had been bullied but had now moved cells. He said that he was depressed because of his offence, about which he felt ashamed. This had led him to drink

excessively, use drugs and try to hang himself. He said he would never do that again or come back to prison. The doctor noted that he had possible symptoms of depression. He asked a nurse to tell the man's unit manager about the allegation of bullying and to ask the mental health team to review him. He did not prescribe antidepressants.

38. On 6 April, a nurse saw the man for a mental health review because of the doctor's referral. He said that other prisoners had threatened him about another prisoner's tobacco debts, but he had moved and this had stopped. He said he was due to be released in four weeks. The nurse recorded that he appeared in low mood, but said that he did not have any thoughts of suicide or self-harm. She referred him back to the doctor to consider further treatment.
39. The man did not attend appointments with a doctor on 7 and 9 April. On 12 April, a nurse saw him again, who said he was fine and did not want any mental health support. On 14 April, after he did not attend another GP appointment, the doctor contacted the man's wing. An officer told him that the man was aware of the appointment but had refused to attend.
40. On 17 April, an officer reviewed the man because of the previous bullying. He said that had no concerns about his safety and had not been bullied since he and his cellmate had moved to another unit.
41. On 28 April, the man's face rash had returned and he had sore eyes. A doctor examined him and diagnosed impetigo, conjunctivitis (eye infection), blepharitis (inflammation of the eyelid) and an ear infection. He prescribed antibiotics and creams. On 9 May, he was released from Glen Parva.
42. On Saturday 7 June, the man was arrested and charged with threatening behaviour with a knife. A police risk assessment noted that he had a history of depression, had previously attempted suicide and did not know how he currently felt. On Monday 9 June, the man appeared at Magistrates' Court and was remanded to Glen Parva to appear at Crown Court on 23 June. A custody officer noted on the man's escort record that he had self-harmed in March 2014 but said he had no current thoughts of self-harm or suicide. There was no suicide and self-harm warning form.
43. The man arrived at Glen Parva at 3.25pm. An officer saw him in reception and signed the escort record. He told that investigator that he was aware from the record that he had self-harmed three months earlier but had said that he had no current thoughts of self-harm. He saw no need to open an ACCT. He was given prison clothing and signed his property record to confirm what clothing he had handed in. He kept his Lacoste trainers.
44. A nurse saw the man for an initial health screen. He told her that he had previously attempted to hang himself because of family issues, but had no current thoughts of suicide or self-harm. He said that he had an infection around his ear and she referred him to a doctor. She recorded his community GP details and that he was not prescribed any medication. She assessed that he was not a risk to others for sharing a cell.

45. An officer completed the cell sharing risk assessment and noted that he was a standard risk and suitable to share a cell. The officer said that he was aware that there was a historical self-harm marker on the man's computer record, but he gave him no indication that he had any such thoughts. The man's only concern was a rash on his face.
46. At 5.50pm, the man rang his mother. All calls (except legally privileged calls) are recorded and a transcript of the call showed it lasted just over five minutes. He told his mother that he had been remanded, and was due back in court in two weeks. His solicitor had told him to expect a 12 to 18 month sentence. He blamed his mother's partner for him being in custody and said "you kick me out all the time". He ended the call saying that he only rang her because he knew her telephone number and he did not want to talk to her anymore. He did not make any further telephone calls. He was allocated to cell 9 on landing three, a double cell on his own. On 9 and 10 June, there were 44 prisoners in the induction unit, which has capacity for 88 prisoners. No one shared a cell in the induction unit on those dates.
47. An operational support grade was the night patrol officer on the induction unit from 9 June. She told the investigator that the man did not raise any concerns that night.
48. On 10 June, a nurse saw the man for a mental health triage assessment. He said that he had no thoughts of suicide or self-harm and knew how to get support if he needed it. A doctor prescribed him antibiotics for impetigo. The nurse told the investigator that on the two occasions that she had seen the man, she had had no concerns that he was at risk of suicide or self-harm.
49. An officer completed first day induction documents and procedures with the man. She said that he chose not to go to the library that afternoon and preferred to remain in his cell. She said that she had not had any concerns about anything he said or how he appeared. .
50. A prison chaplain saw the man as part of the induction process. He told the investigator that he had spent ten minutes with the man talking to him about the role of the chaplaincy team, and about what to expect during his induction. He said that the man was relaxed and jovial and at ease with the other prisoners on the unit.
51. The operational support grade came back on duty on the evening of 10 June. There were 44 prisoners on the induction unit and no one mentioned any concerns about the man during the handover from the staff going off duty. She completed a roll check when she came on duty to check that all prisoners were present in their cells, and further checks at 12.00am and 3.00am. She saw nothing to suggest any concerns about the man.
52. The operational support grade was doing the last check of her shift when she came to the man's cell at 5.40am. He had covered the door observation panel with a poster, but there was a small gap at the bottom. She saw that the man

was hanging from the window with a ligature around his neck made from bedding. She immediately radioed a code blue emergency (to indicate circumstances such as when a prisoner is unconscious, not breathing or hanging and that an emergency ambulance and immediate medical assistance are required).

53. A nurse and the healthcare assistant were already on the induction unit and went immediately to the man's cell, taking emergency equipment with them. The nurse said that she told the operational support grade to open the cell door using a key in sealed pouch which night patrol staff carry for emergencies. The healthcare assistant then went in and removed the ligature while the nurse lowered him to the floor. The nurses began cardiopulmonary resuscitation. They attached an automated external defibrillator (which monitors the heart rhythm and administers electrical shocks to restore the normal rhythm when necessary). The defibrillator did not detect a shockable rhythm. Ambulance service records show that the 999 call was received at 5.44am. Paramedics arrived at 5.51am and took over the man's care. At 6.05am, they confirmed that he had died.
54. The paramedics handed an envelope they had found in the man's cell, addressed to his mother and family, to officers. A custodial manager said that he received the envelope, did not open it, put it in a sealed transit envelope and handed it to the police when they arrived. We have not seen the letter, but the coroner's officer told the investigator that it was a suicide letter in which the man gave his reasons for killing himself.

Contact with the man's family

55. The deputy governor and a prison chaplain visited the man's mother at approximately 9.30am to break the news of his death and to offer condolences and support. Glen Parva maintained contact with the man's family for ongoing support and offered financial assistance towards the funeral expenses, in line with national guidance.

Support for staff and prisoners

56. A manager held a debrief on the morning of the man's death for the staff involved in the emergency response to discuss what had happened and to offer the services of the prison's care team. Officers and members of the chaplaincy team supported prisoners affected by the man's death. Staff reviewed prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by his death.

Post-mortem

57. A post-mortem examination found that the cause of the man's death was hanging. A toxicology report did not show any traces of any drugs or alcohol.

ISSUES

Assessment of risk

58. Prison Service Instruction (PSI) 64/2011, covering safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include early days in custody, previous self-harm, first time in custody, being charged with a violent offence and a history of mental health problems. New prisoners must be interviewed in reception so that staff can assess their risk of suicide or self-harm. All staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and act appropriately to address any concerns, including opening an ACCT if necessary.
59. PSI 64/2011 specifically sets out the following mandatory action:

“Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT...”
60. When the man arrived at Glen Parva on 10 March, reception staff did not appropriately assess his risk of suicide and self-harm and took no action based on the suicide and self-harm warning form or his person escort record. He had several known risk factors for suicide and self-harm; this was his first time in prison, he was young, had very recently attempted suicide, had been charged with a violent offence and said that he had a history of mental health problems.
61. It is not clear whether reception staff saw the suicide and self-harm warning form but some saw the escort record which should have alerted them to his risk. (The handling of the information is dealt with below.) Irrespective of the external documents, the information the man gave the officers and nurse at Glen Parva should have prompted them to open an ACCT as he was clearly at an increased risk of suicide and self-harm.
62. In a Learning Lessons Bulletin published in April 2014, about risk factors in self-inflicted deaths, we listed seven risk factors which increased the risk of suicide and self-harm. This man had at least three of these risk factors – he had previous self-harmed, was newly-received into custody and misused substances. It is also possible that he had mental health problems that had not yet been assessed. In another Learning Lessons Bulletin of July 2014, in which we looked at issues arising from the self-inflicted deaths of 18 to 24 year old prisoners, we noted that risk assessments too often relied too heavily on a prisoner’s presentation and their own assurances that they had no thoughts of harming themselves. The staff appeared to have been too easily reassured by what he told them.
63. Had staff opened an ACCT when the man first arrived at Glen Parva in March, it is likely that this would have led staff to pay closer attention to his risk when he returned in June. However, we accept that in June, his risks were less pronounced. He had been at Glen Parva very recently and had seemed to cope well and he had not harmed himself since his previous suicide attempt

before he came into prison. Staff were aware of the suicide attempt as it was noted on his escort record but did not assess him as at risk. We are satisfied that this was not an unreasonable assessment on this occasion.

64. We note that the man made a telephone call to his mother shortly after he arrived, which an officer facilitated. It is clear from the transcript that this was a difficult conversation and he was upset about his position and blamed his mother's partner for him being in prison. It does not appear that anyone noticed any change in his mood after this call.
65. We are concerned that two members of staff had not been ACCT trained. While we do not consider that this was a factor in this man's death, it is important that all members of staff who come into contact with prisoners and who are responsible for assessing their level of risk are ACCT trained. In an investigation into a death at Glen Parva in September 2013, we also found that two nurses had not received any ACCT training. We made a recommendation about this and, in their response, Glen Parva told us that all staff who have contact with prisoners would either receive ACCT training when they start or would receive refresher training by the end of December 2014.
66. In our report into the death at Glen Parva in September 2013, issued in March 2014, we also made a recommendation about assessing risk and opening ACCT documents. We also noted that officers in reception did not properly consider the risk information on the suicide and self-harm warning form. (The report was issued after the man first arrived in prison, and we received the response in April 2014). The Prison Service said in their response that guidance had been produced and made available to appropriate staff. Training would be given to for first night, reception and healthcare staff.
67. We welcome the prison's intention to take steps to address these issues, but we consider that the failure to open an ACCT for the man when he first arrived on 10 March - when there were such clear signs that he was at risk of suicide and self-harm – is of such concern that we repeat our previous recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular, this should ensure that reception and first night staff:

- **Have a clear understanding of their responsibilities and the need to share all relevant information about risk;**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other sources;**
Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

Handling information in reception

68. We were concerned that no one in reception appeared able to explain what had happened to the suicide and self-harm warning form, completed at court on 10 March. The officer said that, as he had not signed it, he did not think that he had seen it. The nurse said that she was not sure if the form was one that was usually passed to healthcare staff, although she added that had she seen the form, she would have signed it as required. The nurse did not see the Person Escort Record which is an essential tool for assessing risk.
69. It is impossible to know what happened to the warning form. However, it is apparent that the information on it was not considered properly. Reception staff were not clear about who should see the form and what the process was to ensure that this happens. We are also concerned that relevant staff did not see the escort record.
70. PSI 74/2011, the instruction about reception, is clear that staff should examine all forms, including person escort records and suicide and self-harm warning forms, when they are received. It requires that all relevant information about the prisoners should be noted in the appropriate record and forwarded to other staff as necessary and any action taken recorded. Neither the officer nor the nurse recalled seeing the suicide and self-harm warning form which should have prompted them to explore further the man's risk of suicide and self-harm. The nurse did not see the escort record. There is no record of who saw these documents or what happened to them in reception. We are concerned that poor reception procedures at Glen Parva inhibit appropriate risk assessment. We make the following recommendation:

The Governor should ensure, in line with PSI 74/2011, that reception staff examine and record all relevant information about newly arrived prisoners, that all relevant staff see person escort records and suicide and self-harm warning forms and that there is a clear audit trail to demonstrate that this happens.

Clinical Care

71. The clinical reviewer was satisfied that when the man first arrived at Glen Parva, he had appropriate input from healthcare staff. He received lifestyle advice, regular health checks and vaccinations. He was correctly diagnosed with impetigo and given antibiotics to treat it. During his first period at Glen Parva, he did not attend a number of scheduled GP appointments, but the clinical reviewer noted that prisoners cannot be forced to attend appointments. When the GP followed up why he had not attended three appointments in a row, it was clear that this was his decision and there were no prison factors preventing him attending.
72. The clinical reviewer considered that although the man's behaviour in prison did not indicate that there was any imminent risk to life, there should have been more scrutiny of his history of self-harm which might have influenced how he was managed when he first arrived at Glen Parva. However, the clinical

reviewer judged that different nurses conducted mental health assessments consistently and they used the standard screening test correctly.

73. The clinical reviewer considered that the clinical care that the man received at Glen Parva was equivalent to that of an NHS patient treated in the community.

Emergency Response

74. PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies. Glen Parva has a local protocol that meets the requirements of the national instructions.
75. The operational support grade correctly called a code blue emergency at 5.40am, when she found the man hanging. However, the call to request an emergency ambulance was not made until at 5.44am. There is no evidence to suggest that the short delay in calling an ambulance affected the outcome for the man and the clinical reviewer commented that, based on the account provided by the two healthcare staff who responded to the emergency, he was already dead before they had arrived.
76. However, control room staff did not immediately call an ambulance as they should have done when the emergency medical code was called. We raised this issue in the investigation report into the previous death at Glen Parva. In their action plan, the prison reviewed and updated the policy on medical emergencies and circulated it to all staff. This action was shown as having been completed by 30 May, but evidently was not effective. We make the following recommendation:

The Governor should ensure that control room staff call an ambulance as soon as a medical emergency code is called.

RECOMMENDATIONS

1. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular, this should ensure that reception and first night staff:
 - Have a clear understanding of their responsibilities and the need to share all relevant information about risk;
 - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other sources;
 - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.
2. The Governor should ensure, in line with PSI 74/2011, that reception staff examine and record all relevant information about newly arrived prisoners, that all relevant staff see person escort records and suicide and self-harm warning forms and that there is a clear audit trail to demonstrate that this happens.
3. The Governor should ensure that control room staff call an ambulance as soon as a medical emergency code is called.

ACTION PLAN: [man's name] at HMYOI & RC Glen Parva on 11.06.14

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them on arrival. In particular, this should ensure that reception and first night staff:</p> <ul style="list-style-type: none"> • Have a clear understanding of their responsibilities and the need to share all relevant information about risk; • Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other sources; • Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent. 	Accepted	<p>Local guidance for identifying prisoners at risk of suicide and self-harm has been produced.</p> <p>This has been included in the Safer Custody training package that is currently being delivered to all staff with prisoner contact.</p> <p>A new Safety Strategy has been introduced that has a section specific to early days in custody and is clear about the situations in which an ACCT should be opened.</p> <p>The launch of the strategy involved 4 weeks of awareness events, including a full staff training day. Notices were published to staff and information was circulated by e-mail.</p> <p>Adherence to the strategy will be monitored in the coming months. There are a range of compliance checks including daily, weekly and closure management checks of ACCTs. Outcomes of these management checks are monitored by the Safer Prisons Team.</p>	<p>Completed</p> <p>Head of Safer Prisons</p>	

2	The Governor should ensure, in line with PSI 74/2011, that reception staff examine and record all relevant information about newly arrived prisoners, that all relevant staff see person escort records and suicide and self-harm warning forms and that there is a clear audit trail to demonstrate that this happens.	Accepted	<p>A new safety strategy has been launched that introduced a new procedure for managing self-harm warning forms. This places specific emphasis on recording any decisions made in response to the risk information on the self-harm warning form.</p> <p>The new procedure has been reinforced through training and briefings with reception staff who have been informed that they must refer to all relevant information about newly arrived prisoners, including the person escort record.</p> <p>Healthcare staff are required to sign self-harm warning forms to confirm that they have received and reviewed them. Reception staff are required to make an entry on P-Nomis to evidence they have seen and reviewed them.</p>	Completed	Head of Safer Prisons
3	The Governor should ensure that control room staff call an ambulance as soon as a medical emergency code is called.	Accepted	<p>A code red and code blue protocol is in place and is described in the newly launched Safety Strategy. This makes clear that any member of staff can request an ambulance and that when a medical emergency code is called control room staff must immediately call an ambulance. A notice to staff was published and the protocol was promoted during the Safety Strategy launch.</p> <p>Adherence to the protocol is monitored through the Orderly Officer and Duty Governor who monitor radio transmissions to ensure that it is applied appropriately.</p>	Completed	Head of Safer Prisons