Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jake Foxall a prisoner at HMYOI Glen Parva on 12 November 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Jake Foxall was found hanged in his cell at HMYOI Glen Parva on 7 November 2015 and died in hospital on 12 November. He was 19 years old. I offer my condolences to Mr Foxall's family and friends.

This was Mr Foxall's first time in prison and he was evidently very anxious. He had been remanded to HMP Bullingdon in June and had been transferred to Glen Parva just three weeks before he hanged himself. He had self-harmed at Bullingdon a number of times. No one considered he was at risk of suicide or self-harm when he first arrived at Glen Parva, but staff began monitoring procedures two days later and monitoring continued for the rest of his time at the prison.

I am satisfied that Mr Foxall received good mental health support at Glen Parva. I am pleased that case reviews always included mental health nurses and there was good continuity of care. However, not all aspects of the monitoring procedures were good and there was too little attention to care plans to ensure that all relevant staff took practical action to help reduce his risk. Although Mr Foxall had reported being bullied, this was not adequately investigated and there was little evidence that staff considered or recognised the links between bullying and vulnerability.

These issues have been identified in previous investigations into deaths at Glen Parva and the circumstances reflect many of the themes in a Learning Lessons Bulletin I published in July 2014 about the self-inflicted deaths of young adult prisoners. I have seen for myself the efforts that the prison makes to try to keep its prisoners safe, but there is a need to ensure that the lessons from my investigations are embedded in safer custody strategy and practice.

Although Mr Foxall had often self-harmed, his acts of self-harm were mostly minor and there was little to indicate he was at high and imminent risk of suicide at the time he died. I consider it would have been very difficult for staff at Glen Parva to have prevented his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2016**

Contents

Summary

The Investigation Process

Background Information

Key Events

Findings

Summary

Events

1. On 13 June 2015, Mr Jake Foxall was remanded to HMP Bullingdon. It was his first time in prison. He was 19 and had a history of ADHD. He had recently self-harmed and arrived with a suicide and self-harm warning form. Mr Foxall told staff that he was scared about being in prison and had thoughts of harming himself. Staff immediately began Prison Service suicide and self-harm prevention procedures, known as ACCT.

2. Mr Foxall self-harmed by cutting his arms on 22 June, 10 July, 24 August and 21 September. Mental health staff supported him and he continued to be monitored until 4 October, by which time he appeared settled and said that he had no thoughts of suicide or self-harm.

3. On 16 October, Mr Foxall was transferred to HMYOI Glen Parva. Although Mr Foxall said that he feared for his safety, reception staff recorded that his risk of suicide and self-harm was low. He was due to give evidence at court against his co-defendant, who he believed had friends at Glen Parva who would harm him. A reception officer asked someone from the prison's safer custody team to speak to Mr Foxall about this, but no one did.

4. On 18 October, Mr Foxall said he had swallowed a razor blade and staff began ACCT procedures. His cellmate said he had prevented him from swallowing the blade and a nurse found no evidence that he had swallowed one. Mr Foxall said he was unhappy that he had been transferred to Glen Parva, as it was far from his family and he said he feared for his safety.

5. On the night of 24 October, Mr Foxall told staff that he had drunk bleach to poison himself. A nurse examined him but did not think he needed treatment. No one reviewed his risk at the time.

6. On 3 November, Mr Foxall told staff that two prisoners on a different landing were bullying him and named them. He was moved to a cell close to the staff office on the ground floor but no one investigated the possible bullying or challenged the alleged perpetrators.

7. On the evening of 7 November, a night patrol officer found Mr Foxall hanged in his cell. She radioed an emergency medical code and staff quickly began cardiopulmonary resuscitation. Paramedics arrived and took Mr Foxall to hospital. Mr Foxall did not recover and died on 12 November.

Findings

8. Some aspects of Mr Foxall's care at Glen Parva were good. There was mostly consistent case management at ACCT reviews by a manager who knew Mr Foxall and mental health nurses attended each case review. He received appropriate mental health support. However, the investigation found some deficiencies in ACCT procedures. Staff did not review Mr Foxall's risk after he had self-harmed, did not update the caremap in line with his identified risks,

and did not consider whether being bullied had increased his risk of suicide and self-harm.

9. Although two prisoners had allegedly bullied Mr Foxall four days before he hanged himself, staff did not investigate this adequately and did not follow the relevant local procedures. We have previously identified similar failures to respond effectively to bullying at Glen Parva.

10. While Mr Foxall had self-harmed in prison a number of times, most of his self-harm was minor and he had never expressed any suicidal intent. We consider it would have been very difficult to identify that he was at high and imminent risk of suicide shortly before he hanged himself and staff could not have prevented his actions. We are satisfied that Mr Foxall received a reasonable standard of mental health care at Glen Parva and there was an appropriate emergency response.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular:
    - All relevant staff should be trained in ACCT procedures.
    - ACCT caremaps should have specific, meaningful actions aimed at reducing prisoners' risks to themselves, progress should be considered at each review and the caremaps updated if additional needs are identified.
    - Staff should review risk of suicide and self-harm whenever an event occurs which indicates an increase in risk.
    - ACCT reviews should fully consider and record the impact of bullying on the risk of suicide and initiate appropriate action.
    - ACCT reviews should consider and record all known risk factors when determining the level of risk of suicide and self-harm.

- The Governor should ensure that allegations of violence, bullying, or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected.

The Investigation Process

11. The investigator issued notices to staff and prisoners at Glen Parva informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator visited Glen Parva on 17 November 2015 and obtained copies of relevant extracts from Mr Foxall's prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Foxall's clinical care at the prison.

14. The investigator interviewed twenty-two members of staff and five prisoners at Glen Parva between December 2015 and February 2016. The clinical reviewer joined him for interviews with healthcare staff in January.

15. We informed HM Coroner for Leicester City and South Leicestershire of the investigation. We have sent the coroner a copy of this report.

16. One of our family liaison officers contacted Mr Foxall's mother to explain the investigation and to ask if she had any matters she wanted the investigation to take into account. Mr Foxall's mother did not have any immediate questions.

17. Mr Foxall's mother received a copy of the initial report. The solicitor representing the family wrote to us pointing out one factual inaccuracy. The report has been amended accordingly. They also raised 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.

Background Information

HM Young Offenders Institution Glen Parva

18. HMYOI Glen Parva holds up to 800 convicted and remanded young adult 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

19. The report of the most recent inspection of Glen Parva in November 2015 has yet to be published. In initial feedback to us, the inspectorate found the number of ACCT documents and self-harm incidents had increased since the last inspection. The quality of many ACCT documents lacked adequate detail. At the previous inspection in April 2014, inspectors reported that Glen Parva was not safe. Assaults on prisoners and staff had risen by a quarter in a year. Efforts to tackle perpetrators and protect victims from bullying were largely ineffective. Inspectors noted a direct link between the high levels of bullying and levels of self-harm but the prison had no strategy to address this. The prison had not implemented some recommendations made by the Prisons and Probation Ombudsman after previous deaths. Inspectors recommended improvements to ACCT procedures. They noted that some staff did not adequately challenge poor behaviour.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest published annual report for the year to December 2014, the IMB reported that, despite the disappointing inspection report, there was a relentless focus on raising standards, but there was still considerable work to do to improve. The IMB noted that Glen Parva had introduced a new safer custody strategy in October 2014 to address the inspectors' findings and Ombudsman's recommendations.

Previous deaths at HMYOI Glen Parva

21. We have investigated nine apparently self-inflicted deaths of young men at Glen Parva since 2010. These investigations identified some similar themes to this investigation and included:

- The lack of a clear and coordinated strategy to protect vulnerable young men and address the underlying issues distressing them.
- Staff failing to recognise factors which raised the risk of suicide and relying too heavily on outward appearances.
- ACCT case managers underestimating the level of risk at case reviews.
- The ACCT process failing to address bullying and debt issues.
- Incidents of bullying not being properly investigated or the perpetrators appropriately challenged.

Assessment, Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

23. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

24. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

Bullingdon

25. On 13 June 2015, Mr Jake Foxall was remanded to HMP Bullingdon, charged with robbery. He was 19 years old and it was his first time in prison. Mr Foxall's escort record, which accompanied him to prison, recorded that he had Attention Deficit Hyperactivity Disorder (ADHD), asthma and was at risk of cutting his wrists. It included a suicide and self-harm warning form, which said that Mr Foxall had self-harmed in the last six months and had current thoughts of self-harm.

26. At an initial health screen, a nurse recorded that Mr Foxall had a history of anxiety and ADHD (for which he had been prescribed ritalin throughout his childhood) and had current thoughts of self-harm. He considered that Mr Foxall was at risk of suicide and self-harm and began ACCT procedures. He noted that Mr Foxall had last self-harmed two weeks earlier and felt low and abandoned. Mr Foxall said that he felt that his friends and family hated him for what he had done and that they would turn against him for being in prison. He said he was scared about being in prison and had only started to cut himself a few weeks earlier since 'getting into trouble'. He said that he had no suicidal thoughts but it was a 'spur of the moment thing that occasionally [popped] into his head'.

27. On 18 June, staff moved Mr Foxall to the 'support and mentoring unit' at Bullingdon, where prisoners who are identified as likely to find it difficult to cope or fit in are supported by another prisoner mentor to help them develop confidence and integrate. Staff recorded that Mr Foxall had settled well, but on 22 June and 10 July, Mr Foxall self-harmed by cutting to his arm. On 22 June, a nurse referred him to the mental health team.

28. On 14 July, a mental health nurse assessed Mr Foxall, who said that he constantly worried that someone would come into his cell and attack him. They discussed ways to help relieve his anxiety and avoid self-harming.

29. Mr Foxall had seven ACCT case reviews between 14 June and 23 July. On 23 July, Mr Foxall said he had a prison job and no longer wanted help from the mental health team. The nurse noted he had discharged himself from their care. That afternoon, staff at a case review decided to end ACCT monitoring. The case manager recorded that Mr Foxall was in a 'happier place', had no thoughts of suicide and self-harm and had support mechanisms.

30. On 19 August, Mr Foxall told staff that his grandmother had cancer and the news had led to thoughts of self-harm. Staff immediately began ACCT procedures again. On 24 August, Mr Foxall self-harmed by cutting his wrist. On 8 September, staff ended ACCT monitoring, as he had not harmed himself again. On 21 September, they re-opened ACCT procedures because Mr Foxall had cut his arms. At his request, staff referred Mr Foxall to the mental health team.

31. On 4 October, staff at an ACCT case review decided to end ACCT monitoring. The case review noted that Mr Foxall was in a 'good way'. No one from the

mental health team saw Mr Foxall until 7 October when he told a nurse that he was happy, had a job as a library orderly, attended the gym regularly and mixed with other prisoners. The nurse arranged to see him two weeks later.

32. On Friday 16 October, a nurse assessed Mr Foxall as fit for a transfer to Glen Parva that day. Mr Foxall said that he was concerned about moving to Glen Parva and believed other prisoners there would harm him. The nurse advised him to raise his concerns with prison staff, but there is no record that he did this before he moved. Mr Foxall's escort record for his move noted that Bullingdon had monitored him as at risk of self-harm and suicide until 4 October.

Glen Parva

33. When Mr Foxall arrived at Glen Parva on 16 October, he told Officer A that he was worried about being there. He said he had to give evidence against his co-defendant, who was at another prison, but he believed his co-defendant had friends at Glen Parva who would hurt him. Mr Foxall did not know who they were. The officer told Mr Foxall that she would ask the safer prisons team to speak to him, and told him to raise any concerns with unit staff. Mr Foxall said that he had no current thoughts of suicide or self-harm.

34. Mr Foxall told Officer B in reception that he had no suicidal thoughts. The officer assessed him as suitable to share a cell. He noted his ACCT history at Bullingdon and his concern about his safety at Glen Parva. Mr Foxall shared a cell in the prison's induction unit with prisoner, A, who had also been moved from Bullingdon.

35. At an initial health screen, Nurse A noted that Mr Foxall was on remand, had transferred from another prison and that this was his first time in prison. Mr Foxall said he had a history of self-harm, had previously been managed under ACCT procedures, but had no current thoughts of suicide or self-harm. The nurse noted Mr Foxall was pleasant, quietly spoken and looked well. She referred him for a mental health assessment due to his ADHD history. The nurse and the officers who saw Mr Foxall in reception did not consider he was at risk of suicide or self-harm.

36. That afternoon, Officer A emailed the safer prisons team to ask someone to speak to Mr Foxall about his safety concerns. There is no evidence that anyone from the safer prisons team took any action in response to the email.

37. The next day, 17 October, Nurse B saw Mr Foxall for a second health screen and mental health assessment. He said he had no current ADHD symptoms and had not received any treatment for ADHD for over a year. Mr Foxall said he had suffered from anxiety in the past. The nurse noted that Mr Foxall's speech was normal, he had no abnormal thoughts or perceptions and he displayed no signs of emotional or mental distress. Mr Foxall said he had cut his arms at Bullingdon three to four weeks earlier because being in prison was affecting him and he had been monitored under ACCT procedures. Although he said he was nervous about his transfer to Glen Parva, he said he felt okay and intended to apply to go back to Bullingdon. He said he had no current thoughts of suicide or self-harm. The nurse assessed his risk as low and told him about available support services.

38. A member of the chaplaincy team saw Mr Foxall as part of the routine induction process. Mr Foxall registered as a Christian but said he did not want to join the prison chapel activities. He said his main concern was for his grandmother, who had cancer.

39. At 8.40pm on 18 October, Mr Foxall's cellmate, prisoner, A , rang the cell bell and told Officer C that Mr Foxall had swallowed a razor blade and had been acting strangely. (He told the investigator that he had told the officer that Mr Foxall had tried to swallow the razor blade and he had taken it from him and handed it to the officer.) The officer said that Mr Foxall told him that he had swallowed a razor blade because he did not want to be at Glen Parva and he began ACCT procedures.

40. Officer C radioed the night manager and asked a member of healthcare staff to attend. Nurse C examined Mr Foxall who was sitting up and did not appear distressed. He told the nurse that he had swallowed a razor blade because he could not cope and "hoped it would all be finished". Mr Foxall said he was in pain. The nurse examined Mr Foxall but found no sign of trauma to his throat from the razor blade. He noted that Mr Foxall did not look in pain and told him to drink fluids to flush the blade through his system. He asked Mr Foxall to book an appointment to see the prison doctor the next day and told staff to contact the healthcare team if Mr Foxall's condition deteriorated.

41. Afterwards, the night manager spoke to Mr Foxall who said he did not want to be at Glen Parva and believed his co-defendant's friends at the prison would harm him. The night manager recorded on the ACCT document that Mr Foxall should stay in his current cell and staff should observe him twice an hour at irregular intervals and have three conversations with him daily. Staff should refer Mr Foxall to the healthcare team, remind him of the Listeners' service (prisoners trained by Samaritans to offer support) and a safer prisons officer should interview Mr Foxall about his concerns. There is no evidence that anyone from the safer prisons team went to see him.

42. At 10.00pm, Nurse C checked Mr Foxall who was lying on his bed watching television. He said he still had stomach pain. The nurse said he did not appear distressed. He noted that nurses would review Mr Foxall the next morning and referred him to the mental health team.

43. On 19 October, Officer D assessed Mr Foxall as part of ACCT procedures. Mr Foxall said that he felt at threat from his co-defendant's friends at Glen Parva. His next court hearing was on 9 December. He said his family lived in Oxford and the distance to the prison affected the support they could offer him.

44. Officer D noted that Mr Foxall's mood was low. Mr Foxall said that he had declined the chaplaincy's offer to find out information about his grandmother's illness but was glad staff were aware of his concerns and could help him. He said he felt restless at night and believed he was suffering from anxiety. He said he had no current thoughts of suicide and self-harm and had not wanted to kill himself when he swallowed the razor blade. He told the officer that he had self-harmed at Bullingdon because he had felt depressed. He wanted to transfer from Glen Parva and needed something to do to occupy his time, as he

could not cope with being locked up. He said he was happy with his current cellmate.

45. Officer D noted as actions to help reduce Mr Foxall's risk that he could contact his mother and either get a job in the prison or find something to occupy his time to avoid him self-harming. The officer recorded Mr Foxall's triggers for self-harm as his court hearing on 9 December, his loss of family contact, and feeling vulnerable and isolated, which could result in him being bullied.

46. That afternoon, Supervising Officer (SO) A held Mr Foxall's first ACCT case review with Officer D and mental health nurses, Nurse D and Nurse E. Mr Foxall said he wanted to contact his mother. He said that he had felt settled and had a job at Bullingdon and this had helped to reduce his feelings of wanting to self-harm. He felt that he had taken a step backwards since moving to Glen Parva. The SO said he would need time to settle in and that he would move to another unit after his induction. He said Mr Foxall should engage in education or get a job. Mr Foxall said that he had self-harmed in the past when he was depressed. He agreed to talk to staff if he had thoughts of self-harm.

47. Nurse E told the investigator that Mr Foxall said he did not want to be at Glen Parva and hated being so far from home. He was worried about his court hearing but expected to be bailed. He said he would contact his mother the next day. The nurse said she had encouraged him to talk to prison and healthcare staff when he felt like self-harming. The nurse noted that Mr Foxall should have a mental health assessment and would benefit from coping mechanisms until his court hearing date. Mr Foxall said he felt better after talking to staff and said he would continue to do this if he needed support.

48. The ACCT review assessed Mr Foxall's risk of suicide and self-harm as raised and decided that staff should observe him hourly and record three conversations with him daily. Identified actions for the ACCT caremap were that Mr Foxall should talk to healthcare staff about his depression, engage with prison officers and write to his mother to ease his emotional issues. All were for Mr Foxall to take forward. There was no action about a referral for a mental health assessment or to deal with Mr Foxall's anxieties about the possibility of being threatened by other prisoners. SO A set the next case review for 22 October.

49. On 20 October, Dr A, a prison GP, examined Mr Foxall to see if there had been any physical effects after apparently swallowing the razor blade. Mr Foxall said his stomach pain had improved but he had back pain. The doctor said that Mr Foxall had seemed well and said he had no thoughts of self-harm. The doctor noted that the healthcare team should monitor Mr Foxall for stomach pain and referred him for physiotherapy for his back pain. She told us she had not been trained in ACCT procedures and was not aware of Mr Foxall's history of self-harm. She did not recall seeing the ACCT document at the consultation.

50. On 22 October, SO A and Nurse F, a mental health nurse, held the second ACCT case review. Mr Foxall said he was happy that he was moving to another unit that day and that he phoned his mother daily. He was waiting for a mental health assessment and to get a job. The SO noted that Mr Foxall's mood was settled. Mr Foxall said that he often had thoughts of self-harm but

watched television to distract himself. He agreed that the period before his court case would be stressful, as he had to give evidence. The nurse told him the mental health team would support him and that he should also speak to unit officers but he said he did not know them well enough. He declined any additional support from the chaplaincy. The review assessed his risk of suicide and self-harm as low and reduced the level of observations to hourly when Mr Foxall was in his cell. The SO noted that he had reviewed the caremap, made no changes and that the ACCT plan would remain open until all the issues had been resolved and Mr Foxall was settled in his new unit. He set the next case review for 28 October.

51. After the ACCT review, Nurse F assessed Mr Foxall's mental health and diagnosed mild depression. They discussed coping strategies to manage his thoughts of self-harm and devised a care plan. (She later gave him a copy of his care plan and a workbook on distraction techniques.) She told Mr Foxall to speak to unit staff when his mood was low and that he should maintain his contact with his family.

52. That day, Mr Foxall moved to a single cell in Unit 14 on an upper floor. The prison chaplain saw Mr Foxall who said he was annoyed that he had been moved from Bullingdon, but hoped to get a good job at Glen Parva. Mr Foxall said he had no negative thoughts, had started to adjust to life at Glen Parva and was in contact with his mother.

53. That day, Mr Foxall applied for a transfer to Bullingdon or another prison. He said he believed that a lot of people at Glen Parva were after him. That evening, staff moved Mr Foxall to a ground floor cell, which he shared with Prison A.

54. On 23 October, a custodial manager made a routine check of Mr Foxall's ACCT document. She noted that all the caremap actions were for Mr Foxall with no evidence that staff had offered to help him. She informed the staff on duty of her concerns about this.

55. On the evening of 24 October, prisoner A rang the cell bell and told Officer E that Mr Foxall had drunk some bleach. Mr Foxall told Nurse G that he had accidentally swallowed it. The nurse removed a bottle of liquid from his cell, but could not confirm it was bleach. The nurse noted that Mr Foxall had no problems breathing or with his speech and said the healthcare team should review him the next day.

56. On 25 October, Nurse H contacted the National Poisons Information Service who said that the dose of bleach Mr Foxall claimed to have taken would not have detrimental health effects. Mr Foxall said he had had stomach pain in the night. The nurse noted that he looked well and his throat showed no signs of skin damage. She told him to drink milk. No one reviewed Mr Foxall's risk of suicide or self-harm as a result of this incident.

57. On 28 October, SO A held the third ACCT case review with Nurse F. Mr Foxall said that drinking the bleach had not helped or poisoned him. The SO and the nurse explained the seriousness of drinking bleach and said he should ask staff for support when he felt like harming himself. Again, he said he did not know

the officers on his unit well, but agreed he would do this. The SO said he would ask staff to talk to Mr Foxall. Mr Foxall said he had no thoughts of suicide or self-harm. He said he got on with his current cellmate but asked for a new one. He said he phoned his mother and had written to her but did not have enough credit to phone his girlfriend. The review assessed that Mr Foxall's risk of suicide and self-harm had increased to 'raised' but kept observations at hourly when he was in his cell. Staff were still required to record three conversations each day with him. The SO noted that he had reviewed the caremap and made no changes.

58. The next day Mr Foxall's request for a transfer was turned down. The reply said he could not go back to Bullingdon, as it had to keep spaces for new prisoners.

59. On 31 October, at a mental health review, Mr Foxall told Nurse B that he was feeling more stressed as his court hearing date got nearer. He was nervous about giving evidence against his co-defendant, who was once a close friend. He said he had no thoughts of self-harm at the time but had thought about harming himself the previous night. He said his family supported him. The nurse noted that Mr Foxall's mood was low and that his depression had deteriorated to a moderate level. She arranged a GP appointment for 5 November to consider antidepressant treatment. Mr Foxall said he was not getting on with his cellmate and asked to be moved. The nurse spoke to Officer F about this.

60. Shortly afterwards, Mr Foxall told Officer F that he wanted to move because his cellmate was too loud. That afternoon, Mr Foxall moved to a shared cell on the first floor. On 2 November, Mr Foxall said he wanted to move to a different unit because he felt unsettled. The officer suggested he talked about this at his next ACCT case review.

61. On the afternoon of 3 November, Mr Foxall told a healthcare assistant from the mental health team that he wanted to move to another cell because he was being bullied and feared for his safety. He said he had thoughts of self-harm and could not guarantee that he would not act on them. The healthcare assistant noted that Mr Foxall appeared anxious and did not want to come out of his cell. She said she told unit staff including the ACCT case manager, SO A, about this and recorded her contact in the unit observation book. She noted that the SO said he would tell staff to look into any bullying issues. She told Nurse I, from the mental health team, who was due to see Mr Foxall that day.

62. Shortly afterwards, Officer G recorded in Mr Foxall's ACCT document and the unit observation book that Mr Foxall had named two prisoners he said were bullying him and had discussed this with SO A. The SO decided that they should move him to a cell opposite the staff office on the ground floor. He told the investigator that he could not remember if staff took any further action against the prisoners who Mr Foxall had said had bullied him.

63. Nurse G saw Mr Foxall later that afternoon to review his mental health and told him that staff were investigating the bullying. Mr Foxall said he had no current thoughts of self-harm and the nurse said that someone from the mental health team would review him in a week.

64. That day, Mr Foxall moved to a ground floor cell on his own opposite the staff office. Prisoner A was in the neighbouring cell, which he shared with prisoner B. Officer G recorded in the ACCT record that Mr Foxall's mood was good. Mr Foxall collected his evening meal and staff recorded no concerns about him.

65. On the morning of 4 November, at an appointment with Dr B, Mr Foxall said that he was stressed about being in prison. Although he had no current thoughts of suicide he was worried that he might self-harm to relieve his stress. The doctor noted that Mr Foxall was depressed and they discussed stress management techniques. He prescribed citalopram, an antidepressant, but told him that it might take two to three weeks to start having a positive effect. He encouraged Mr Foxall to exercise and to use the chaplaincy support services. The doctor told the investigator that Mr Foxall was concerned about giving evidence against his co-defendant but was positive about his prospects of being released from prison after his court appearance in December.

66. Shortly afterwards, Mr Foxall phoned his mother briefly and said he had received her letter and money, and had written to her. He said he would not be able to call her again until 9 November (the date of his court hearing) but hoped to be released that day. He was disappointed that his solicitor had not contacted his mother and asked her to contact them. They each said they loved the other.

67. SO B and Nurse T held the fourth ACCT case review on 4 November. (SO A, the case manager was on leave.) SO B had not met Mr Foxall before and noted that it was his first time in prison. Mr Foxall said that another prisoner had bullied him but he felt safer in his new cell and was glad to be next to his previous cellmate, prisoner A. He said he was in regular contact with his mother and had no thoughts of suicide or self-harm. He said he had been prescribed antidepressant medication. SO B was happy with how Mr Foxall presented and the review assessed his risk of suicide and self-harm as low. Mr Foxall's level of observations remained the same. SO B noted that he had reviewed the caremap and the next case review was scheduled for 11 November.

68. On 5 November, Officer H recorded in the ACCT document that Mr Foxall had spent all day in his cell, lying on the bed watching television. He noted that Mr Foxall had not talked to staff, but had nodded when they asked if he was okay. Staff did not record any concerns about him when they saw him when he collected his medication and meals but had noted that he been reluctant to communicate that day. At around 9.00pm, prisoner A spoke to Mr Foxall through the gap where pipes went between their cells and had no concerns about him.

69. On 6 November, prisoner A appeared at court and went back to Bullingdon. Officer I recorded in the ACCT document that Mr Foxall appeared on edge. Mr Foxall told him that two prisoners had previously bullied him for his canteen (weekly order from the prison shop) and he was worried because it was canteen day and it might happen again.) The safer custody team told the investigator that Mr Foxall had ordered only £2 telephone credit that week.

70. The member from the chaplaincy team saw Mr Foxall that morning as part of the process to support prisoners assessed as at risk of suicide and self-harm. Mr Foxall raised no concerns and said that staff were dealing with the bullying. He told him he had no thoughts of suicide or self-harm and hoped to be bailed when he appeared in court on 9 November. Officer J also saw Mr Foxall that morning and noted he appeared in a good mood. He had put some of his belongings in a bag and told the officer that he was going to paint his cell.

71. At 11.45am, Mr Foxall called his mother who said that she had spoken to his solicitor who was preparing a bail application. Mr Foxall told his mother that he was okay and had been painting his cell. He said he no longer shared a cell and staff were keeping an eye on him because he had depression. His mother said she had received his letter and asked if he would be okay in prison. Mr Foxall said he was fine and was going to collect his medication.

72. Officer G gave Mr Foxall and prisoner C, more paint to do some painting on the unit. Prisoner C told the investigator that he got on well with Mr Foxall, who told him that he had inherited a debt from another prisoner who had been released from prison. (When a prisoner is released, prisoners sometimes force their cellmate or the person who takes their place in the cell to take on any debts they might have.) He said he had previously seen some other prisoners talking to Mr Foxall at his door and suspected they had been enforcing a debt.

73. Later that afternoon, custodial manager, B, gave Mr Foxall a smoker's pack because he did not have enough money. (A smoker's pack is an advance supply of tobacco and cigarette papers, usually given to prisoners when they first arrive. Payment is deducted from subsequent prison pay.) Prisoner C said that Mr Foxall's mood was much better when he had tobacco. He said Mr Foxall gave a small amount of tobacco to another prisoner, which he believed was in part payment of the debt.

74. Nurse F saw Mr Foxall on the evening of 6 November and noted that his mood was good, he appeared settled and showed no signs of distress. Mr Foxall said he had no thoughts of self-harm. He said he had felt down earlier after he had phoned his mother but felt happy at the time.

75. Prisoner C who was in the cell next to Mr Foxall and had shared with prisoner A before he was moved to Bullingdon that day. He told the investigator that he and Mr Foxall were both quiet but they talked to each other a lot. He knew Mr Foxall was unhappy about being at Glen Parva but he had never talked about his history of self-harm, although he had referred to swallowing a battery before. Another prisoner had assaulted him about a week earlier and he said that Mr Foxall was worried that he would be the next victim. Mr Foxall told him that prison A had got into debt with other prisoners for tobacco, and he was being threatened to pay it back.

Saturday 7 November 2015

76. On 7 November, Mr Foxall spent most of the morning painting in the unit with prisoner C. Officers recorded in the ACCT document that Mr Foxall had spent time with other prisoners that morning and had collected his medication as usual.

77. Prisoner C said Mr Foxall had told him that he had a few problems with other prisoners who he said were annoying. He said he did not know if Mr Foxall was being bullied but he had seen another prisoner pressurising him for tobacco. He said he had overheard a brief conversation between Mr Foxall and another prisoner, when the other prisoner told Mr Foxall that he did not believe he would be released on bail.

78. After he collected his lunch, Mr Foxall stayed locked in his cell watching television. Prisoner C spent the afternoon painting the unit. He said he saw at least one prisoner open and shut the observation panel on Mr Foxall's cell door and turn his cell light on and off when walking past his cell, which prisoners sometimes did to annoy the person inside.

79. That afternoon, Mr Foxall asked Officer K, who was doing an ACCT check, if he could move to another unit, where he had a friend. The officer said he told Mr Foxall that it was too late to deal with his request that day, but staff would look into it the next day. He noted in the ACCT record that Mr Foxall had asked to move to another unit.

80. Prisoner C said he saw Mr Foxall again at around 5.00pm when they collected their evening meals. They talked briefly about what was on television.

81. The night patrol officers for the unit came on duty at 8.30pm. At 8.30pm and 9.30pm they noted in the ACCT record that Mr Foxall was lying in bed.

82. Prisoner C said he spoke to Mr Foxall through the gap in the pipes at around 9.50pm. Mr Foxall had asked him if he was okay and he said he was. He said he had been surprised at the way Mr Foxall had asked him this. They were both watching the same film on television and agreed to speak during the next commercial break.

83. At 10.03pm, night officer A looked through the door observation panel to check Mr Foxall and saw him standing, facing the wall, with his eyes closed. At first, he thought Mr Foxall was leaning against the bed. He called his name several times but got no response and started to shake the door handle. He shone his torch into the cell, then turned the night light on and saw what he thought was some green cloth near Mr Foxall's ear. He ran to the staff office (immediately opposite the cell) and told night officer B that something was wrong. Within 20 seconds, night officer B came to the cell with night officer A but they could not get a response from Mr Foxall. Night officer B saw the green material near Mr Foxall's ear and realised he was hanging from a bed sheet tied around his neck. She said Mr Foxall looked pale but she thought he was alive.

84. Night officer B radioed an emergency code blue (logged at 10.05pm), said that a prisoner had hanged himself and asked for help. A paramedic team was already in the prison because of an incident in another unit and agreed to go to Mr Foxall's cell. The Governor was in the prison and also responded to the emergency code.

85. For security reasons, staff working in residential units do not carry standard prison keys at night, but have a cell key in a sealed pouch for use in an emergency. Night officer B began to break the seal on his key pouch. Night officer A took the key and was putting it in the cell door when other staff arrived in the unit.

86. Officer L, Officer M, Officer N and Officer K responded to the emergency and reached Mr Foxall's cell within 50 seconds. Night officer A had unlocked the cell door as the officers approached. Officer L went into the cell followed by the other officers and cut the ligature. Officer M and Officer K helped place Mr Foxall on the floor. Officer N checked Mr Foxall for signs of life and said he was breathing and had a faint pulse that appeared to be fading. She told the investigator that they intended to place Mr Foxall on his back to start cardiopulmonary resuscitation (CPR), when healthcare staff arrived.

87. Nurse G and Nurse J responded to the emergency and arrived with a medical emergency response bag within three minutes. When they checked Mr Foxall, they found no signs of life. They placed Mr Foxall on his back and Nurse J started CPR by chest compressions. Nurse G attached a defibrillator, which found no shockable heart rhythm, and they continued chest compressions while applying oxygen through a facial mask.

88. The paramedics arrived from dealing with the other emergency at 10.11pm, six minutes after the medical emergency code, and took over emergency treatment. Officer L helped them bring Mr Foxall onto the landing because of the limited space in the cell. The paramedics administered adrenalin and shortly afterwards detected a pulse. At 10.26pm, they took Mr Foxall to the intensive care unit of Leicester Royal Infirmary.

89. Mr Foxall had left a note in his cell in which he said that he loved his family. He said he was hearing voices in his head, telling him he would receive a life sentence and he could not spend that time in prison. He said he cried himself to sleep at night.

90. Shortly before 11.00pm, the governor telephoned Mr Foxall's mother, explained what had happened and arranged to meet her at the hospital. The governor and the prison's family liaison officer went to the hospital. Mr Foxall's mother and other family members arrived at around 2.00am. The governor and the family liaison officer stayed with Mr Foxall's family until around 4.00am and offered support.

Support for prisoners and staff

91. Before going to the hospital, the governor debriefed the staff involved in the emergency response and offered her support and that of the staff care team. Many of the staff we interviewed said they had received very good support from

prison managers. The next day, staff reviewed prisoners assessed as at risk of suicide and self-harm, in case they had been affected by Mr Foxall's actions.

Events after Mr Foxall's admission to hospital

92. On 9 November, the family liaison officer visited the hospital and offered Mr Foxall's mother continued support.

93. Mr Foxall never regained consciousness. On 12 November, doctors advised Mr Foxall's family that he was unlikely to recover. The governor and the family liaison officer were present to support Mr Foxall's mother when doctors switched off the life support machine. In line with Prison Service policy, the prison contributed to the costs of Mr Foxall's funeral. On 19 November, the prison chaplain led a memorial service at Glen Parva, which Mr Foxall's mother attended.

Cause of death

94. A hospital consultant who specialised in critical care confirmed Mr Foxall's cause of death as brain damage caused by a lack of oxygen resulting from hanging. The coroner was satisfied that there was no need for a post-mortem examination. As Mr Foxall had been in hospital for five days before his death, the coroner did not order toxicology tests.

Findings

Assessment of Mr Foxall's risk of suicide

95. Mr Foxall had a number of risk factors for suicide and self-harm. He was a young man, on remand and this was his first time in prison. He had recently moved to a new prison, which meant he had lost some social support and family contact and he had been diagnosed with depression. In our Learning Lessons Bulletin published in July 2014, about self-inflicted deaths of 18-24 year olds, we identified a number of themes which increased risk for young adults. Some applied in Mr Foxall's case. These included bullying, separation from family and the disruptive impact of a move to a prison away from external support.

96. Although the full extent of Mr Foxall's vulnerability might not have been recognised at Glen Parva, he was being managed under ACCT procedures after apparent acts or threats of self-harm. Until he hanged himself on 7 November, most of his previous self-harm had consisted of making minor cuts to his arms, which he said he had done to relieve tension. It is not clear that he actually harmed himself at Glen Parva by swallowing a razor blade or bleach and, if he did, his motivation appears to have been more about getting a move back to Bullingdon than to cause himself any serious harm.

97. Mr Foxall had a number of risk factors for suicide. However, none of his previous acts of self-harm were potentially lethal and he had repeatedly denied that he had any suicidal intention. He had never previously tied a ligature or harmed himself in a way that would have led to his death. While his self-harm indicated a risk of suicide, we do not consider that there was anything about Mr Foxall's behaviour or demeanour on 6 or 7 November which should have led staff to conclude that he was at high and imminent risk of suicide at the time. Although the investigation has identified some areas for improvement in ACCT procedures and in dealing with allegations of bullying, we do not consider that staff could have predicted or prevented his actions on 7 November.

Management of ACSCT procedures

98. There was good consistency and continuity of ACCT case management. SO A, the case manager, chaired the first three case reviews but was unable to chair the fourth as he was on leave at the time. There was also good multidisciplinary attendance, with a nurse from the mental health team present at each of the case reviews. Two nurses attended the first case review and Nurse F, who was Mr Foxall's mental health care coordinator at Glen Parva, attended the three reviews held afterwards. Prison Service Instruction (PSI) 64/2011, on safer custody, which outlines ACCT procedures, expects continuity of case management and multidisciplinary attendance of relevant people involved in the prisoner's care, but this is something we rarely find.

99. However, we did not consider that all aspects of ACCT procedures operated so effectively. PSI 64/2011 says that all staff in contact with prisoners must be ACCT trained. Dr A, who assessed Mr Foxall while he was subject to ACCT monitoring, had not been trained in ACCT procedures and did not record her contact with him in the ACCT record.

100. The Prison Service instruction also says that the caremap should reflect the prisoner's needs, level of risk, and their triggers for distress. There should be detailed time-bound actions aimed at reducing the risk posed by the prisoner and cover the issues identified in the ACCT assessment interview. The person(s) named against each of the 'actions required' in the caremap must complete their actions by the date given. Caremaps should be reviewed and update at each case review with new actions added if necessary.

101. The caremap did not cover two of the three trigger points identified during the first ACCT review. It did not include an action for a nurse to refer Mr Foxall for a mental health assessment and for staff to support Mr Foxall until his court hearing on 9 December as agreed at the review. Each caremap action was for Mr Foxall to complete (which the custodial manager identified as a concern on 23 October) and all were ongoing rather than with any date for completion. There was nothing about his concerns that he was likely to be threatened by other prisoners, that he wanted to a transfer from Glen Parva and an activity to keep him occupied. The caremap should have had clear, specific and detailed actions aimed at reducing Mr Foxall's risk and should have been fully discussed at each ACCT case review. There is little evidence that this happened.

102. In addition to planned case reviews, the Prison Service instruction (PSI 64/2011) requires staff to hold a case review as soon as possible if a trigger for suicide or self-harm is activated or they are concerned about the prisoner at risk. We are concerned that no one considered holding an ACCT case review after Mr Foxall allegedly swallowed bleach, which could have indicated a potentially serious increase in his risk. No one discussed the incident fully until Mr Foxall's next scheduled ACCT review, which was four days later.

103. On 4 November, SO B, accompanied by Nurse F, chaired the ACCT case review. This was the first time the SO had met Mr Foxall. The review assessed his risk of self-harm as low based on his presentation and because he said he had no thoughts of self-harm. Even though Mr Foxall had said he felt safer after moving cells, we consider that this indicates the review did not fully recognise the risk for a vulnerable young prisoner who had recently reported being bullied. Mr Foxall had significant outstanding risk factors, and staff should have identified his continuing and increased vulnerability at the ACCT review. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular:

- **All relevant staff should be trained in ACCT procedures.**
- **ACCT caremaps should have specific, meaningful actions aimed at reducing prisoners' risks to themselves, progress should be considered at each review and the caremaps updated if additional needs are identified.**
- **Staff should review risk of suicide and self-harm whenever an event occurs which indicates an increase in risk.**
- **ACCT reviews should fully consider and record the impact of bullying on the risk of suicide and initiate appropriate action.**
- **ACCT reviews should consider and record all known risk factors when determining the level of risk of suicide and self-harm.**

Bullying and intimidation

104. Glen Parva's local violence reduction strategy sets out measures to support victims of bullying, threats and intimidation and keep them safe. It says that reports and incidents of victimisation should be promptly and thoroughly investigated by unit staff and the safer custody team. It also highlights the many ways in which prisoners can find themselves in debt.

105. Mr Foxall reported that he feared for his safety when he first arrived at Glen Parva and again two days later when he allegedly swallowed a razor blade. He told staff many times that he feared other prisoners would harm him because he was due to give evidence against his co-defendant. However, there is little evidence that staff fully discussed this with him and no one from the safer prisons team spoke to him to help reassure him. Glen Parva's local violence reduction strategy notes that the safer custody team should investigate matters further in such circumstances. Yet, no one did, despite two requests for them to do so.

106. SO A, the unit manager, took swift action when Mr Foxall reported that he was being bullied on 3 November and moved him to a different landing. However, he did not investigate the matter or begin a 'safer prison's support plan', as the local policy requires. No one investigated the alleged bullying or challenged the alleged perpetrators' behaviour, even though Mr Foxall had named the other prisoners. As noted above, there was limited evidence that staff took any effective action about potential bullying or intimidation during the ACCT process, despite identifying bullying as a potential trigger for suicide or self-harm.

107. Bullying is a risk factor for all suicides but this is especially marked in younger people. Mr Foxall told staff he had concerns about being bullied the day before he hanged himself. Although he had also said he felt safer since moving cells, without an investigation or challenge to the alleged perpetrators staff cannot have known that the bullying had stopped. It appears that Mr Foxall might have been under pressure to pay tobacco debts apparently incurred by another prisoner. This is a particularly invidious form of extortion in some prisons and it is concerning that the lack of investigation meant that the staff did not know or tackle the underlying cause.

108. In our July 2014 Learning Lessons Bulletin about the self-inflicted deaths of young adult prisoners, we identified a number of lessons that resonate with Mr Foxall's circumstances, including his experience of bullying. We found that 20% of 18-24 year olds who killed themselves had experienced bullying in the previous month, compared to 13% of other prisoners. We identified the need to investigate and take action to address bullying and to consider the impact on a prisoner's risk of suicide and self-harm.

109. We note that at the 2014 inspection, HM Inspectorate of Prisons found that prisoners at Glen Parva were not safe and that efforts to tackle bullying were largely ineffective. We understand that Glen Parva redesigned the Safer Prisons Support Plan and Early Intervention schemes after a previous death at

the prison in March 2015, but it appears that staff were not familiar with the requirements and did not operate the procedures effectively. We make the following recommendation:

The Governor should ensure that allegations of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected.

Clinical care

110. The clinical reviewer concluded that the general standard of health care Mr Foxall received at Glen Parva was comparable to the care he would have received in the community. While he was subject to ACCT monitoring, a member of the mental health team saw him each week to help reduce his risk of self -harm. She noted that he was appropriately prescribed antidepressant medication.

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