National Offender Management Service

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Equality, Rights and Decency Group
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Ms Lydia Brown
Assistant Coroner
Leicester City and Leicestershire South

19 June 2015

Dear Ms Brown

Inquest into the death of Mr Greg Revell on 11 June 2014 whilst in HMYOI Glen Parva

Thank you for your regulation 28 report of 28 April 2015 addressed to the Governor of HMYOI Glen Parva and the Chief Executive of Leicestershire Partnership Trust concerning the recent inquest into the death of Mr Revell. Your letter has been passed to Equality, Rights and Decency (ERD) Group, in the National Offender Management Service (NOMS), as are responsible for policy on suicide prevention and self-harm management and for sharing learning from deaths in custody.

This response is provided on behalf of the Governor of HMYOI Glen Parva. As you have requested, I will respond to your first six concerns in turn. I understand that the Chief Executive of Leicestershire Partnership Trust will be responding separately to your seventh concern.

(1) Greg had been in Glen Parva YOI earlier the same year, and on that occasion presented with a florid and undistinguishable ligature mark on his neck from an attempt at self-harm shortly before his imprisonment. Notwithstanding this, he was not placed on an ACCT.
It is accepted that Mr Revell should have been placed on an Assessment Care in Custody and Teamwork (ACCT) when he first came into HMYOI Glen Parva. Local policies and procedures have since been reinforced to ensure that an ACCT is opened on reception whenever there is evidence of a recent self-harm attempt.

A new Safer Prisons strategy was launched in October 2014. This includes a new procedure for recording decisions made in response to the risk information on the self-harm warning form. The new procedure has been disseminated through training and briefings with reception and health care staff, who have been informed that they must refer to all relevant information about newly arrived prisoners, including the Person Escort Record, and make an entry on C-Nomis to record what they have observed and decided. Healthcare staff have also be reminded to record this information on SystmOne (the electronic medical records system).

2) There was confusion amongst prison officers who gave evidence regarding when it was appropriate to open an ACCT.

In accordance with PSI64/2011 Safer Custody, the local Safer Prisons strategy gives clear guidance to staff on when it is appropriate to open an ACCT. All existing staff have been briefed on the strategy, and new staff will receive 'Introduction to Safer Custody' training to ensure that they are confident about this process. A new Safer Custody team is now in place to

provide ongoing help, advice and support to staff on these matters and to monitor adherence to the strategy.

3) There was suggestion that there would be 'too many ACCTS' and they would be ineffective if all prisoners with risks were placed on an ACCT.

All prisoners presenting with a risk of suicide or self-harm are placed on an ACCT, regardless of the number of ACCTs that are already open in the establishment. At times when there are particularly high numbers of ACCTs the Governor will ensure that resources are reallocated to ensure that they are managed appropriately.

4 & 5) There was over-reliance upon what the prison officers were told by Greg, and insufficient emphasis on previous recorded risk factors in documentation available to them

All staff have been reminded of the local policy which states that an ACCT must be opened whenever information is received to indicate that a prisoner is at risk, even if the prisoner himself does not present as being at risk. Case managers have also been reminded to take account of all the relevant information and to have regard to the dynamic and static risk factors for the individual when carrying out case reviews, and not simply to rely on their assessment of the prisoner's presentation. This ensures that the level of risk is assessed on the basis of comprehensive information.

6) There was a culture of over-reliance on 'others' being responsible for enquiring further into statements regarding depression and self-harm made by Greg, rather than any focus on individual responsibility.

All staff have been reminded that safer custody is everyone's responsibility, and that whenever they identify a prisoner as being at risk of suicide or self-harm they must open an ACCT.

I hope this provides assurance that the concerns that you have identified have been addressed.

Yours sincerely

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NOMS Equality, Rights and Decency Group