

**Investigation into the circumstances surrounding the
death of a man at HMP Littlehey
in April 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

February 2009

This is a report into the death of a man. The man was a 48 years old who apparently took his own life at Littlehey prison on 29 April 2008. The man had been in prison since 2002 (apart from some time he spent in an Approved Premise in 2007) and had transferred to Littlehey in June 2007.

I would like to offer my sincere condolences to the man's family for their loss.

The investigation was undertaken by my colleague. I would like to take this opportunity to apologise for the delay in issuing this report, which I am sure must have caused the man's family additional anxiety. We would both like to thank Littlehey's Governor, the prison's liaison officer and staff for their participation and assistance in the investigation. A clinical reviewer was identified by Cambridgeshire Primary Care Trust to carry out a review of the man's clinical care. I would like to thank him for his helpful review.

In what are very sad circumstances, I was heartened to learn of the professional and caring attitude of staff at Littlehey, who appeared to genuinely care about the man's well being and tried to help him as much as they could. I believe they should be commended for this.

The man suffered from depression and a personality disorder. I know his family are concerned that he was not receiving medication for this when he died, however he was assessed by medical staff at Littlehey and they decided that medication would not be effective. From the information provided by this investigation, I am satisfied that the man was given the best care available, by both prison and healthcare staff, who spent time counselling him and reviewing his progress, via the Assessment, Care in Custody and Teamwork (ACCT) process especially.

I make five recommendations, two of which are to formally commend staff. The clinical reviewer also highlights an area of good practice in regard to medical record keeping.

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SUMMARY

The man was discovered in his cell at HMP Littlehey on the evening of 29 April 2008. He had made the ligature from a bedsheet which he had tied to the bars of the cell window. He was 48 years old and had been at Littlehey for less than a year.

The man had been sentenced to eight years imprisonment and was due for release in September 2009. He had been released on licence in January 2007 and resided at an Approved Premises in Surrey. However, he did not comply with the terms of his licence and was recalled to prison in April. He transferred to Littlehey in June of that year.

During his time in custody, the man was treated and assessed for depression and a personality disorder. The man was frequently assessed by clinical staff at Littlehey and it was decided that prescribing medication (in particular anti-depressants) would not be an effective way to treat him. It was noted that on previous occasions he had stopped taking prescribed medication of his own accord and was reluctant to take any again. It was observed that his problems were behavioural and that counselling from the Mental Health In-Reach Team was appropriate.

The man harmed himself on many occasions and spent a great deal of time being monitored and assessed by staff via the ACCT process. The last ACCT was closed on 23 April, six days before he died. At the last ACCT review he had presented well and staff thought that he seemed to be engaging with staff and was more positive.

The day the man died had been a prison training day and all prisoners had spent much of the day in their cells. During evening association a senior officer noticed that the man seemed angry. They spoke for about 20 minutes and he appeared to clam down. He returned to his cell for a cup of coffee and a cigarette. About half an hour later the senior officer went to check on him in his cell and saw that he was hanging from a ligature.

I believe that staff tried valiantly to resuscitate him until the paramedics arrived. Sadly the efforts of staff and the paramedics were unsuccessful and the man was pronounced dead at 8.36pm.

THE INVESTIGATION PROCESS

1. I appointed a colleague to conduct the investigation on my behalf. Notices were issued both to prisoners and staff inviting anyone who had information relating to the man's death to make themselves known to my investigator. Two prisoners asked to speak informally about the man, but one changed his mind when she visited the prison.
2. The man's prison records, including his medical records were made available to my investigator during her initial visit to the prison on 2 May. A full set of documents were given to my investigator, already filed in a ring binder, with clearly ordered and relevant documents, which she found extremely helpful. Additional documents were forwarded to her a week later.
3. My investigator visited Littlehey to carry out taped interviews with staff on 19 and 20 June and 17 July 2008. Two members of staff also spoke to my investigator informally.
4. One of my Family Liaison Officers (FLOs) contacted the man's family to explain the role of the Prisons and Probation Ombudsman and to offer them the opportunity to participate in the investigation process. The man's sister said she was concerned because she did not think that the man was on any medication for depression when he died. She said the man had a long history of depression and needed medication to control this. My family liaison officer agreed to pass this concern on to my investigator who will look at this as part of the investigation.
5. The man's sister wrote to my family liaison officer after she received the draft report and asked us to reflect her views here. She said that she felt her brother was bullied in prison but that he would have kept this to himself to avoid repercussions from the bully or bullies and to save her from worrying about him. Additionally, having read the statements from prison staff she believes they all tried to help the man the best they could. She asked us to pass on her particular thanks to a nurse who had especially tried to help the man and who offered such kind words to her in a letter following his death.
6. A thorough and helpful clinical review was carried out by a clinical reviewer from Cambridgeshire Primary Care Trust (PCT). A copy of this review is annexed to this report.

HMP Littlehey

7. HMP Littlehey is a category C prison with an operational capacity of 706 adult male offenders, but typically holds around 690. It first opened in 1988 with eight residential wings. Two additional units were added to the prison in 1997 and 2003. It integrates sex offenders (74% of the current population at Littlehey) into the normal regime of the prison.
8. Approximately ten per cent of the prisoners at Littlehey are serving life sentences. A small proportion are category D which enables them to work in the community. The prison offers a sex offender treatment programme as well work and education opportunities.
9. Provision of healthcare within the prison is the responsibility of Cambridgeshire Primary Care Trust (PCT), with a general practitioner (GP) service being provided by a local National Health Service practice.

Anti-ligature knives (fish knives)

10. Anti-ligature knives, also known as 'fish knives' (because of the shape of the knife) or 'cut down tools' are specially designed to cut ligatures.

Assessment, Care in Custody and Teamwork (ACCT)

11. ACCT requires any member of staff who identifies concerns about a prisoner they believe to be at risk of suicide or harming themselves to take action and to record these actions. The ACCT document should be available to all staff where the prisoner is located, including workshops and visits. Within 24 hours of an ACCT being opened, the prisoner is seen by an assessor and has a case review meeting. ACCT reviews are held at appropriate intervals and are attended by the prisoner and a case manager, together with other members of staff.

B Wing

12. B wing is a general residential wing which houses convicted prisoners, many of whom are lifers. It has an integrated regime which means it houses vulnerable prisoners with those who are not considered to be so. There is no dedicated vulnerable prisoner unit at Littlehey.

Care and Separation Unit (CSU)

13. The purpose of the Care and Separation Unit (CSU) is to maintain safety, order and discipline and the respect for human dignity. Segregation of prisoners is sometimes necessary to help them address negative aspects of their behaviour and return to normal location as soon as possible. However, a prisoner may be segregated for many reasons. For example, if a prisoner has been found guilty of breaking discipline rules or if a prisoner's behaviour is so disruptive that keeping them in their normal location may be unsafe. A

prisoner can also be held in the CSU if it is for their own safety, or if they are under threat from other prisoners. This is only considered as a last resort.

Cell Sharing Risk Assessment (CSRA)

14. All prisoners are subject to a Cell Sharing Risk Assessment (CSRA) on reception. The CSRA process is designed to assess the risks posed by the individual, and this includes taking into account the situational context of any previous violence. As assessment takes place before a prisoner spends their first night in custody (with the exception of open prisons) and triggers a risk minimisation plan for those identified as high or medium risk in addition to a review process.

Her Majesty's Chief Inspector of Prisons (HMCIP)

15. The prison was most recently inspected by HM Chief Inspector of Prisons on an announced visit in July 2007. In her report, the Chief Inspector said:

“This full announced inspection confirmed that Littlehey remained an impressively safe prison, with mutually respectful staff-prisoner relationships, a reasonable amount of purposeful activity and an appropriate focus on resettlement. Littlehey remains an impressive and improving prison, able to work effectively with some very high risk prisoners. It provides a fundamentally safe and respectful environment, in which prisoners are generally occupied purposefully.

16. Suicide and self harm arrangements were generally well managed by the full time safer custody coordinator and the approach to those on an open assessment, care in custody and teamwork (ACCT) document was proactive and multidisciplinary. The quality of the ACCT documents was good, and the prison was taking active steps to improve standards further. Some excellent examples of work with very vulnerable prisoners were evident, and staff fully engaged in supporting those deemed at risk.

17. Health services were adequate, although some waiting lists were long. Mental health services were well integrated, with management care plans shared with wing staff so that prisoners could be consistently supported.

18. There was an effective personal officer scheme. Prisoners knew who their personal officer was, and extensive entries in wing files indicated a great deal of knowledge about prisoners. Staff encouraged participation in offending behaviour programmes.”

Independent Monitoring Board (IMB)

19. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are wholly independent of the Prison Service and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and flagging up areas of concern.

20. Littlehey's latest IMB report covers the period February 2007 to January 2008. The Board considered that Littlehey continued to be a well run prison providing a safe and respectful environment for prisoners. However, the Board were concerned at the number of prisoners with mental health problems and personality disorders who make disproportionate demands on the time of staff and regimes. However, the Board recognised the excellent work of the In-Reach Team with few resources.

21. The Board were pleased to report that Littlehey is a safe prison with 30 assaults and 12 fights recorded in the year, although they remained concerned at the high number of self harm incidents. 117 incidents were recorded in the reporting year, many of these were multiple self harmers. 159 ACCT documents were opened and the Board were impressed with the way in which reviews were conducted, especially when a member of the mental health In-Reach Team were present.

22. The number of bullying incidents remained low. Under the prison's anti-bullying strategy 16 perpetrator packs and five victim packs were opened in the reporting year.

Licence Recall

23. Once released, prisoners can be recalled to prison by the Secretary of State, if they breach the conditions of their licence.

Suicide and Self Harm Prevention strategy

24. The Governor published a Suicide and Self Harm Prevention document in January 2006. The strategy aims to identify and provide special care for prisoners in distress and reduce the risk of suicide and self harm by creating a safe environment and helping prisoners cope with custody. Also, it identifies and supports prisoners in crisis and treats them with respect and dignity. The prison also involves the whole of the prison community in the prevention of self harm and suicide.

KEY FINDINGS

25. The man transferred to Littlehey from Swaleside prison on 6 June 2007. In the Cell Sharing Risk Assessment (CSRA) carried out on that day, it was noted that the man had previously threatened to kill himself, had blades in his possession at the time of his arrest, had previously stated that he would harm himself and had attempted to hang himself whilst at Maidstone prison (he was at Maidstone prison in 2004 and again in 2005). It also noted that the man had been on an Assessment, Care in Custody and Teamwork (ACCT) document on 20 November 2006, as he had cuts to his wrist. The man refused the offer to make a telephone call on his arrival at Littlehey.
26. During his first reception health screening that same day, the man told the reception nurse that he had no mental health issues but had suffered from depression and panic attacks. During this interview it was noted that he presented as “stable”.
27. The man wrote to his sister on 7 June. In the letter he told her he had transferred to Littlehey and that he intended to apply for a transfer to Maidstone prison and continue his appeal against the revocation of his licence. The man mentions that he felt uneasy at Littlehey, as they have no unit specifically for vulnerable prisoners. The man signed off the letter by saying he is “ok” and that his sister should not worry too much.
28. On 12 June the man was prescribed 40mg Atorvastatin and on 14 June he was prescribed 5g sachets of Colestid medication, both were for managing his high cholesterol level. (The man continued to have this medication prescribed for him throughout his time at Littlehey.) He had taken this medication before at previous prisons.
29. When the man initially arrived at Littlehey he had previously been under the care of a community mental health team and because of this he was referred to the prison’s Mental Health In-Reach Team. On 3 July the man was assessed by a clinical nurse lead for mental health. During this meeting the mental health nurse noted that the man “presented well”, but preferred to keep himself to himself. It was also noted that the man had been treated for depression previously, but was currently not receiving any medication. The man had previously been prescribed Paroxetine in 2002 and Citralpram in 2006, although he stopped taking this medication of his own accord. They discussed his history of harming himself and his high cholesterol levels. The mental health nurse referred the man to the Counselling, Assessment, Referral, Advice and Throughcare Service (CARATS, a service specialising in the treatment of substance abuse) because of his history of alcohol and drug use.
30. The man’s time at Littlehey began without incident until he was located in the Care and Separation Unit (CSU) and placed on constant observations on 12 July. There had been an incident on E wing where the man told staff he ‘disintegrated’. The man became very anxious and agitated whilst speaking to staff. He began shaking uncontrollably and became very incoherent. An ACCT

was opened and a meeting held with him at 11.45am that day. At this meeting the man told staff that he wanted to kill himself and appeared to be glancing around the office almost looking for something to harm himself with. He then began to punch himself and staff intervened.

31. At 12.00pm an immediate action plan was put in place. It said that the man was to be re-located in the CSU in the constant observation cell and was to be observed until a further assessment and review had taken place. The man was given the opportunity to make a telephone call, but he said he did not want his sister involved in his ACCT management. The duty doctor attended this meeting and it was agreed that the man should be on daily medication. It does not say what this medication was.
32. An assessment interview was carried out from 2.15pm until 3.55pm. At the interview the man told staff that he understood his problems, but did not want to discuss them at that time. He said he just 'disintegrated' and wanted to kill himself by throwing himself off the three's landing on E wing, but said that he could not bring himself to do it. He thought that by making officers restrain him from throwing himself, this amounted to harming himself. The man described this as 'cowardice' and was disappointed that he could not find the courage to commit suicide. He then began punching himself and was again restrained by staff. The man said he did not like being monitored by ACCT as he did not like the attention, but accepted that because of his actions he needed to be closely monitored. An urgent referral was made for the man to see the mental health nurse.
33. The second review was held the next day at 10.20am, attended by the mental health nurse amongst others. The mental health nurse opened the review by saying that she had seen the man about three weeks earlier (when he had been referred by CARATS because of his alcohol dependency) and he had seemed fine then. She asked what had changed. The man said he did not want to discuss it, but agreed to speak to the mental health nurse and another nurse (who was also in attendance) if the other staff left the meeting. They had a confidential chat and it was decided that to try and relieve the man's paranoia by taking him off of constant observations. The man thanked the nurses for allowing him this and enabling him to move forward. The ACCT panel decided to reduce the level of observations to three times an hour.
34. The third case review was held the next day, 14 July at 10.00am. The man told the review panel that he felt better. He said he had had these episodes before, but was unable to explain why they happened or what brought them on. They discussed the man's move back to normal location, but he was unwilling to talk about any issues on E wing. He said that he was paranoid and did not know what was real and what was unreal. The man said he no longer felt that way and it was agreed to reduce his observations to half hourly to be reviewed again the next day.
35. The fourth case review was held on 15 July. The second nurse was again in attendance with three other members of staff, including the Deputy Governor. It was noted that the man appeared settled and calm and he said he felt a bit

better than yesterday. His return to E wing was discussed again and he agreed to give it a try. They also spoke about the support available to the man, the staff, Mental Health In-Reach Team and his cell mate, who was very supportive. The man said that he liked to keep himself to himself but that he did like his cell mate and they got on well. It was agreed that the man would return to the safer cell in E wing and be observed hourly. A further review and mental health assessment was arranged for the next day.

36. On 16 July, the fifth review was held. The man said he felt 'ok' and was settling back into the wing routine. The man told a senior officer (SO) who was conducting the review that it was his first time in prison, was not sure if he had ever been assessed by a mental health team and said he did not use drugs or alcohol. Another senior officer and a mental health nurse then joined the meeting. The man began to get upset and agitated. He said he felt negative about his life but did want to be released from prison and carry on with his life. The man said he was scared and did not know how he would move forward. It was agreed that he should take small steps, beginning with his move to normal location on E wing. The ACCT was to remain open with the next review to be held on 23 July 2007.
37. An entry made in the man's Inmate Medical Record (IMR) on 17 July shows that he was discussed by members of the Cambridgeshire Mental Health Team. They queried whether he should be referred for a Korsakoff's syndrome assessment. This is a brain disorder usually associated with heavy drinking over a long period of time. The symptoms include short term memory loss, apathy and repetitive behaviour. There is no entry in the IMR to indicate whether this assessment took place.
38. The sixth case review was held on 23 July, and attended by the man, two senior officers and two nurses (one of which was the mental health nurse). At this review it was noted that the man's level of risk was raised as he had appeared very evasive. The man was breathing erratically, sighing and seemed emotional. The man said he just wanted to be left alone and did not want to interact with others. He said he felt that he had been 'stitched up' but could not explain what he meant by that. However, it was agreed that the observations on the man should be reduced. The next review was due on 1 August.
39. On 26 July, the man had an appointment to see the mental health nurse and a psychiatrist. The psychiatrist diagnosed the man with a borderline/avoidant personality disorder, difficulties with interpersonal skills and relationships and a history of alcohol dependency. He thought that the man was prone to panic attacks and had a Type C personality that manifests through anxiety and dependency in relationships. It was agreed that medication was not an appropriate way to treat somebody with this personality disorder, as it was a behavioural, rather than a medical condition.
40. On 27 July the man was again seen by the Cambridgeshire Mental Health Team. It was agreed that they would carry on their assessment of him. Two days later on 29 July 2007 the man was on E wing, when he told staff he was

going to throw himself down the stairs on the wing. He attempted to do so and had to be restrained by staff. The man was taken to the Care and Separation Unit (CSU) for his own safety and was located in a safer cell. An ACCT review was held and the man told staff that other prisoners were talking about him. He said he felt suicidal and did not want to talk. It was decided that the man should be on five observations and hour.

41. The eighth case review was held the next day. Six staff attended this meeting including the mental health nurse and another mental health nurse, and the Deputy Governor. The man was unable to say why he had acted as he did and said he was looking to the mental health nurse for help. The mental health nurse explained that they were trying to establish why the man acted as he did. She explained that she needed to assess him but that he needed to take responsibility for any items identified.
42. A further review was held the next day, 31 July. The mental health nurse and the Deputy Governor, amongst others, attended the meeting. It was noted that the man's level of risk was raised as he appeared very negative and uncommunicative. He agreed to a move back to E wing and the mental health nurse reminded the man about the support available to him through the Mental Health In-Reach Team.
43. The tenth review was held on 1 August. The man had made a deep cut to his left wrist earlier in the day, he was treated at the local hospital and prescribed Flucloxacillin tablets. At the review, the man appeared negative and uncommunicative and mumbled that he was a 'dead man'. He said that he was told to plead guilty to something he hadn't done and stood up as if to leave the room until the mental health nurse spoke to him. It was agreed that the man should remain on two observations and conversations an hour.
44. A further review was held the following day. The man said he would like to return to E wing, although he still could not explain why he acted the way he did. The man's level of risk remained raised and it was agreed that he would be on two observations an hour.
45. On 3 August the twelfth review was held. The man was uncommunicative and just stared ahead. A Mental Health In-Reach Team manager tried to encourage the man to speak, but was unsuccessful. Another review was arranged for 6 August. Again, the man was uncommunicative at his review on 6 August. He said he did not want to speak and just wanted to be left alone. However, the man did say that he wanted to go back into his own cell with his cell mate. It was agreed that the man would be observed hourly during the day and half hourly during the night. Also on 6 August a mental health review was carried out by a third nurse. The nurse noted that the man was "a depressed man, lacking in motivation and overwhelmed by his thoughts".
46. Another review was held on 8 August. The man did not want to attend this review and asked for the ACCT to be closed. It was explained to him that this would not be possible at that time, due to his lack of motivation, lack of

cleanliness and his level of interactions. It was agreed that the man would remain on the same level of observations until his next review.

47. Three further reviews were held on 10, 13 and 17 August. At the review on 17 August, the man appeared positive and reasonably cheerful. The man said he felt fine and was trying to ensure he ate a little more and improved his personal hygiene. The man had been re-located to a single cell and said he was happy with this. As the man seemed so positive and said he had no suicidal thoughts or intended to harm himself, the ACCT was closed with a post-closure review date of 27 August. The mental health nurse requested that the man be located in a single cell, on mental health grounds.
48. A post-closure interview was held on 27 August. It was noted that the man had ongoing issues, but was feeling that steps were being taken to address these. It was agreed that a further review would not be required.
49. The man wrote to his sister on 3 September. In his letter he told her he was still at Littlehey and that not much had changed (although he had not applied for a transfer to another prison). He mentioned that he had been through a "bad patch" a while ago, but that he did not feel too bad at the moment.
50. On 6 September it is noted in the IMR that the man had an appointment with a psychiatrist (although it does not say who). He did not attend this appointment, although it is unclear from documentation why that was.
51. The man was seen again by the psychiatrist on 20 September. He concluded that the man had personality difficulties with prominent interpersonal impairment and relationship difficulties, with a long history of alcohol dependence. The psychiatrist noted that the man became distressed when they discussed his emotional well being and so no further follow up appointment was planned.
52. On 29 September the psychiatrist discharged the man from the care of the Mental Health In-Reach Team to the lead nurse for the Primary Care Trust. Any discharges from the Mental Health In-Reach Team are either closed or referred to the Primary Mental Health Team, as in this case. The psychiatrist said that the man was not suffering with any mental health issues such as schizophrenia, but as he had the borderline/avoidant personality he should be seen regularly by the lead nurse for the PCT. Her role was to try and help the man deal with this avoidance and try to challenge his behaviour. The PCT nurse first met with the man on 11 October and it was agreed that she would see him every two weeks.
53. The PCT nurse said during her interview with my investigator, that it was normal for somebody with this disorder not to be on any medication. The anxiety that the man felt was worked on from a behavioural, rather than a medical approach. The PCT nurse said that the man's mood fluctuated, which is why she referred him to see a psychiatrist so she could be certain that she was attempting to help the man in the right way. The PCT nurse worked with the man on his self esteem issues, his isolation and his dependency. She also

referred him to Rehabilitation for Addictive Prisoners Trust (RAPT) within the prison for support with drugs and alcohol on 27 December 2007. The PCT nurse asked for the man to be considered for the course. She wrote that he had been making considerable progress with her and the course would prove invaluable to him.

54. The man wrote again to his sister on 19 November. In this letter he said that he was not “having a good time of it” and wishes he was out. The man added that he just wanted to get through Christmas and the New Year and hoped things would be better by then.
55. By now the man had been located on B wing (although it is not clear from prison documentation exactly when this move took place). On 16 January 2008, the man had a fight with another prisoner. He made a comment “I won’t be here in the morning”. Staff believed this to mean that the man intended to harm himself and another ACCT was opened.
56. An assessment interview was held the following day and the man denied making the comment (that he would not be here in the morning) said he did not feel suicidal and did not want to harm himself. The man said the altercation with the other prisoner had been fully resolved and that he felt fine. It was agreed that this ACCT should be closed.
57. The man met with the PCT nurse on 18 January for another mental health review, in which they discussed his altercation with the prisoner two days before. The PCT nurse noted in the IMR that the sessions were helping the man but he “still has issues about feeling inadequate”.
58. A further mental health review was carried out on 7 March. The PCT nurse noted that the man appeared low in mood. It was agreed that she would monitor the man in one week’s time.
59. A senior officer on B wing along with the PCT nurse arranged for the man to have a job in the gardens so he could get some fresh air and do some physical work, hoping it would help him sleep more easily at night. The PCT nurse wrote to the labour allocation department at the prison and said that the man would benefit from purposeful activity and that he had a keen interest in conservation and outdoor activity. Three days later the man started work in the gardens. The officer in charge of the gardens party and recalled that the man was a good worker who would never refuse to do a job, but was selective with who he spoke to and would have mood swings. The senior officer also used to take the man sudoku and crossword puzzles to do, as he knew the man was intelligent and would need something to challenge him. The senior officer also made time to try and talk to the man generally.
60. On 12 March the PCT nurse opened an ACCT for the man as she thought he still seemed low in mood. The man had gone to work in the gardens but had struggled and felt very paranoid. The PCT nurse thought he would benefit from some extra support through this time and notes in the ACCT that the opening of the document is a pro-active measure. The PCT nurse also booked the man

an appointment to see the psychiatrist. An action plan was put together for the man and it was decided that he should remain in his single cell as he felt safe there and he should be observed on an hourly basis.

61. An assessment interview the next day, attended by the PCT nurse and another senior officer noted that the man said he had a series of panic attacks the day before which led him to feel low in mood and paranoid. The man said he had no suicidal feelings and did not want to harm himself. It was agreed to review the ACCT in a week's time.
62. On 17 March, the man had a panic attack when he was asked to go to work. The man was taken to healthcare where he began to hyperventilate. Staff managed to clam the man down and a review was planned for the next day.
63. The next day the man was seen by a second psychiatrist. A letter from the psychiatrist in the IMR said that the man had been treated for depression in the past with paroxetine and citalopram (anti-depressants) but that he had been erratically compliant with his medication. The psychiatrist said that "currently there is no role for medication, he appears to be functioning reasonably. The man is not keen on taking medication regularly". The psychiatrist wrote that the man had said he did not feel "that bad" and had no current thoughts of harming himself. The man acknowledged that it would be a good thing if he resumed work in the gardens, as it would distract him from his negative thoughts. The psychiatrist said she would not review the man again unless there was any deterioration in his mental health.
64. A further review was held on 20 March 2008. The man seemed quite talkative and said he was feeling better. He said he found the work in the gardens hard, but that he enjoyed being out in the fresh air. It was agreed that the ACCT would remain open and a review would take place the following week.
65. On 27 March another review was carried out. The man told the PCT nurse and a fourth senior officer that he felt he was coping better and that being in his own company was one of his coping mechanisms. The man said he had no intention of harming himself or attempting suicide. However, the man did become quiet during the interview, prompting the staff to agree that the ACCT should remain open and reviewed in a week's time.
66. A further case review was held on 3 April. The man appeared to be in a fairly positive mood and said he was coping on a day to day basis. He said that through the Mental Health In-Reach Team and working in the gardens he felt his mood had "levelled out". It was agreed that the ACCT would be closed, with a post closure interview to be held in a month's time.
67. However, on 6 April the man harmed himself, cutting his torso and arms, banging his head against the cell wall and smashing and barricading his cell. The ACCT was re-opened and a meeting held on 7 April. The man declined to attend the interview or talk about this incident. It was decided that the man should be moved to the safer cell in B wing for at least 24 hours. The next review was scheduled for 10 April. The man did speak to The PCT nurse about

what he had done (although the date they discussed this is unclear) and the man told her he was distressed about people talking about him. The man was also very remorseful about his original offence.

68. On 10 April another case review took place. The man attended this review, but would not talk about the incident four days before. He said he was “ok”, and was seeing the Mental Health In-Reach Team weekly. The man said he was still having difficulty discussing matters that was bothering him and it was agreed that the ACCT would remain open for a further review on 16 April.
69. However, on 15 April, the man was returned early from his job in the gardens because he had appeared in a difficult mood. He was unhappy about this and became agitated and abusive towards staff, and then began to make cuts to himself. The man was taken to healthcare where his scratches were treated and dressed, and he was returned to the safer custody cell on B wing. A review was carried out later that day. The man engaged very well with the conversation and they spoke about his belief that he was hearing voices. The man said he just wanted to get some sleep and that he felt safe when he is asleep. It was agreed that he would be observed every hour and that there should be three meaningful interactions with staff each day. The man was also given the opportunity to return to his own cell as it had been cleaned and tidied.
70. On 17 April the man attended another mental health review. It was noted that “he does not feel suicidal but feels that he is going mad”. It was agreed that the man’s care plan should be re-evaluated. The man also said he thought that people were talking about his sister, but agreed that this could not really be the case.
71. The man was seen again on 18 April. The B wing senior officer and the PCT nurse attended this meeting, with another officer. The man seemed confused and admitted he felt paranoid and down in mood. The man said he felt confused about why he was at the meeting and that he was “wearing a mask” and holding back his feelings. He agreed to continue working in the gardens and seeing The PCT nurse. The next ACCT review was scheduled for 23 April.
72. Although there are no further ACCT documents or reviews, the senior officer on B wing noted in the man’s Ongoing Record on 23 April that his ACCT had been reviewed and that a Post Closure Interview was scheduled for the end of May. The PCT nurse also attended this review and recalled it was a long session and that the man seemed to be engaging well with staff. The man had returned to work in the gardens and was attempting more positive interactions with staff.

Events on 29 April

73. There was a different regime on 29 April, as it was a staff training day. These are held monthly and many of the prison’s services are effectively closed down to allow for the training. This meant that the man would not have been required to attend work in the gardens that day and that all prisoners would have spent

the majority of the day in their cell, apart from collecting their lunch and evening association.

74. The B wing senior officer recalled at interview that when the training had finished for the day and prisoners were out of their cells on association, he began dealing with prisoner's correspondence on B wing. At about 7.00pm the man came onto the landing where the senior officer was working and seemed very angry. The man's fists and jaw were clenched and he did not speak to anybody, but was just staring. The man saw the senior officer, so turned round and began to walk away. The senior officer followed the man and asked him to come for a chat in the landing office. The man closed the office door behind him and the men stood about three feet apart. The senior officer asked the man what was wrong and the man said that people were talking about him again and that the senior officer had just witnessed this. The senior officer assured the man that this had not happened and his demeanour immediately changed.
75. The senior officer and the man spoke for another 20 minutes, in which time the senior officer said he would arrange for the man to see the PCT nurse the next morning, which the man agreed to do. They also spoke about the man's work in the gardens and whether he was eating his meals. The senior officer also offered the man some sudoku puzzles he had copied for him and the man immediately seemed happier and more willing to talk. The man appeared to have completely calmed down by the end of their conversation and said he was going back to his cell for a coffee and a cigarette. This was approximately 7.20pm. The senior officer said during his interview with my investigator that as the man had calmed down so quickly he did not think it was appropriate to open an ACCT.
76. The senior officer said that he continued working on prisoner's correspondence and needed to speak to a prisoner who was located three or four doors away from the man's cell. When the senior officer finished speaking to the prisoner he decided to look in on the man and see how he was because of their earlier conversation.
77. When the senior officer arrived at the man's cell, at approximately 7.50pm, the door was closed. It was not unusual for the man to close his door. The senior officer opened the observation panel and the cell light was not on. Again, this was not unusual. The senior officer could make out the silhouette of the man against the window, from the lights outside. He turned the cell's nightlight on, which is located outside the cell door, and immediately saw that the man was suspended by a ligature. The senior officer tried to radio for assistance but his radio would not work as it appeared to have a flat battery. He ran to the end of the corridor and shouted to staff for urgent assistance and then ran back to the cell. The senior officer opened the cell door, locking back the bolts of the door so he could not be locked in, and immediately lifted the man to take pressure off the ligature. The senior officer could see that the man had made the ligature from a bed sheet which he had suspended from the cell window.

78. Within a few seconds the senior officer was joined in the cell by two officers who were both working on the wing and had heard the shout for assistance. The senior officer instructed the first officer to cut the ligature and the second officer helped the senior officer support the man's weight. The first officer could not cut the ligature from around the man's neck as it was so tight she could not get the fish knife in, so the senior officer told her to cut the ligature to release it from the window, to allow them to lower the man onto the floor. The first officer then attempted to cut the ligature from around the man's neck, but it was still too tight. The senior officer then tried and managed to cut the ligature. The senior officer checked the man for signs of life, but could not find a pulse. He noticed a trickle of blood coming from his throat, where his ligature had been so tight. The senior officer then left the cell to locate the prison's Orderly Officer (the senior manager in charge of handling emergencies in the prison) and trained first aiders. The senior officer went to the landing office to use the telephone (as his radio was not working) and put out the emergency call via the Communications Room. An ambulance was called at 7.55pm by a member of staff in there.
79. The two officers had lifted the man onto the bed in the cell (as there was so little room on the floor) and after the second officer (a trained first aider) re-checked for any signs of life. The second officer recalled that the man did not appear to be breathing and that his jaw had begun to stiffen, meaning that it was difficult to open it. The man's face looked grey and he had a very red mark where the ligature had been. As the second officer could not detect any breathing or a pulse, he and the first officer began to administer CPR.
80. The second officer began to try and get some breaths into the man, which proved difficult because of the man's stiffened jaw. The first officer began chest compressions. The first officer did these for a few minutes until she was joined by a third officer (another trained first aider who heard an emergency call over the radio and attended from E wing). The third officer was unaware when he responded that the man had attempted to hang himself and it wasn't until he saw the ligature mark on the man's neck that he realised this. This came as a shock to him.
81. The senior officer had also returned to the cell by this time with a principal officer and two other senior officers. The principal officer was in the Communications Room with one of the senior officers when he was alerted that assistance was required on the three's landing on B wing, although he could not remember if this was via the radio or telephone, (although he was aware that a message was sent over the radio and all staff carrying a radio would have received it). The other senior officer was on call as an emergency first aider and heard the emergency call over the radio. (As there is not a 24 healthcare at Littlehey there is a core of first aid trained staff who are on a rota to attend any emergencies in the prison.)
82. In the meantime, the third officer checked the man for signs of life and then took over chest compressions from the first officer at a rate of 15 compressions to two breaths. The second officer continued mouth to mouth resuscitation. The first officer remained in the cell in case she needed to assist again. As the

man's chest was compressed, vomit came from his mouth. The second and third officers turned the man on his side to clear the vomit from his mouth, but the third officer was unable to fully clear his airway as he could not open his jaw. Despite this, they resumed CPR. The B wing senior officer gave the second officer a face mask which he carried with him (and are also kept in each landing office) to use whilst administering the breaths. The fourth senior officer remained in the cell as support for the officers, should they have needed it.

83. The principal officer, third senior officer and the B wing senior officer began to move prisoners away from the man's cell. The prisoners on the landing where this was taking place were taken to the television room and the B wing senior officer ensured that they were able to watch television to try and distract them. Prisoners on other landings were returned to their cells.
84. A fourth officer arrived at the cell and saw the second and third officers carrying out CPR. The fourth officer is the prison's Family Liaison Officer and part of the prison's Care Team. He could see that the B wing senior officer was quite distressed and took him to the landing office, where they talked through what had happened.
85. The paramedics arrived at the man's cell at 8.05pm. They were slightly delayed entering the prison as the electronic gate failed to open and they had to wind the gates open manually. This took a couple of minutes. A paramedic arrived as a first responder in a car, followed by an ambulance shortly afterwards at 8.10pm. The car and the ambulance parked outside the wing and the paramedics were escorted up to the man's cell.
86. The paramedics carried the man out of the cell and placed him on the landing floor, so they had more room to work on him. A paramedic asked the second and third officers continue CPR whilst he unpacked his kit. The first response paramedic then took over and began to check the man. The second officer recalled the paramedic inserted a tube down the man's throat, presumably to suction out the vomit in an attempt to clear his airway. He also attached a defibrillator to the man's chest to check whether his heart could be shocked into re-starting. It is unclear from prison records whether the defibrillator instructed the paramedics to shock the man or not. The two paramedics who arrived in the ambulance joined him within a couple of minutes. All three paramedics then resumed CPR until 8.36pm when the paramedics pronounced that the man had died. The man was carried back into his cell and placed onto his bed.
87. The third senior officer was responsible for securing the man's cell and the area around it, and maintaining a log of all people who entered it. The senior officer also acted as the police liaison that night.
88. The fourth officer was still with the B wing senior officer when the principal officer told him that the head of the Care Team was on his way to the wing and that the fourth officer should now take over the role of Family Liaison Officer as the man had died. The fourth officer gathered some paperwork and then at 10.00pm the duty Governor told him that they were going to visit the man's sister to break the news of his death. They left the prison at 10.20pm.

89. The duty Governor and the fourth officer arrived at the man's sister's house at 12.15am. It had been raining hard and driving conditions were difficult and there were diversions on the motorway, which meant the journey took some time. Once they arrived at the house they spent 30 minutes trying to raise someone by ringing the doorbell and knocking on the door, but nobody answered. The fourth officer rang the local police to obtain a telephone number for the man's sister (there was not one on the prison records) but the number showed as unobtainable. Due to the lateness of the hour and that they had been trying to raise a response for half an hour without success, the duty Governor and the officer returned to the prison.
90. In the meantime the principal officer organised a meeting in the chapel for all staff to inform them what had happened and why they had been late getting off duty. He then held a hot debrief on B wing for staff who had been involved in the discovery of the man and also those who carried out CPR attempt. The head of the Care team was in attendance and staff had the opportunity to discuss what had happened and how they felt. Staff also had to wait to give their statements to the police (who had arrived at 9.20pm and stayed at the prison till gone 1.00am).
91. The fourth senior officer went to speak to the prisoners who had been told to wait in the television room. She explained what had happened to the man and that they could not go back to their cells that night to collect any of their belongings. She asked whether any of the prisoners needed to speak to anyone about what had happened and how they felt and that they could speak to a Listener if they wanted to (two Listeners were already in the television room). One prisoner was badly shaken and did ask to speak to a Listener. The prisoner was located in a cell in the Care and Separation Unit (CSU) with a Listener, and he was monitored throughout the night. The rest of the prisoners were re-located on E wing for the night.
92. The next morning the deputy Governor rang the man's sister to say they would be coming to see her that morning, but did not say why. They believed that the man's sister thought the visit was about the man's mental health. The deputy Governor and the Safer Custody Officer then left the prison at approximately 10.00am. The fourth officer did not attend as he had not returned to the prison until after 2.00am that morning. When they met with the man's sister, the deputy Governor explained what had happened to her brother and that they had made the journey there the night before, but had no reply from them. The deputy Governor told the man's sister that she could visit the prison if she thought that might be of help to her and that the prison would help contribute towards funeral expenses. They gave the contact details of the fourth officer, the prison's Family Liaison Officer.
93. On 30 April a prisoner wrote to the Governor. He was located on B wing (but on a different landing to the man) and could see from his window what had happened in the man's cell the night before. The prisoner said that he could see two officers obviously trying to save someone's life and felt they should be

commended in some way. He was able to identify one officer as the second officer, but did not know the other officer.

94. Two pieces of paper were found in the man's cell after he had died. One, dated 3 April 2008 was entitled "Will" and described what he would like to happen to his assets. The second note is dated 20 April 2008 and entitled "Funeral". It gave details of what the man wanted for his funeral.
95. The fourth officer attended the man's funeral and flowers were sent on behalf of the prison. Prisoners on B wing also held a collection for some flowers. The fourth officer spoke to the man's sister several times on the telephone and visited her twice (he took her the majority of the man's belongings on 6 May). At the time of the interview with my investigator, the fourth officer still had some paperwork and the man's guitar case that he needed to return.
96. A critical incident de-brief was held on 20 May and all of the staff who were involved in the man's discovery and resuscitation were invited to attend. This was run by the Staff Welfare and Support Group and the staff who did attend said that, in the main, they found it helpful.

ISSUES

Clinical Care

97. The Clinical Review did not highlight any issues nor make any recommendations in respect of the man's care whilst he was at Littlehey prison. The Review said that the "quality of care that the man received was good and entirely equitable with that he would have received outside prison." The clinical reviewer also noted that all appropriate NHS procedures were followed and said that he could "find no evidence to suggest that the death could have been avoided."
98. The man's sister was concerned that he had not been on medication or treated for his depression. The clinical reviewer noted that the man had been treated with anti-depressants in the past but it appeared that he had stopped taking the medication and had decided not to accept further anti-depression medication. The man was later seen by a psychiatrist who assessed him and decided that further anti-depression medication would not have helped his condition. The clinical reviewer summed up by saying he was not critical of the actions of healthcare staff. The clinical reviewer also said that staff should be commended for the high quality of record keeping in the IMR.

Was the man bullied whilst at Littlehey?

99. During her interview with my investigator, the PCT nurse said that the man had been bullied, but could not give any specific details. Apart from a fight the man had with another prisoner on 16 January (which the PCT nurse may have been referring to) my investigator could find no evidence of this, either from staff, other prisoners or from prison documentation. The man certainly never spoke of being bullied to staff, in his letters to his sister, or at any of the ACCT reviews.
100. The man appeared to have been cared for well by staff on the wing and by the healthcare staff. The B wing senior officer and the PCT nurse, in particular, spent time trying to persuade the man to take up employment in the gardens (which he did) and the senior officer gave the man puzzles and crosswords to try to keep his mind occupied. They both spent time talking to the man and the impression given to my investigator is that they were happy to do so as they wanted to help him as much as they could.

Responding to the emergency call

101. The third officer told my investigator that he was shocked when he saw the red ligature mark around the man's neck, as he did not know he was attending an emergency where a prisoner had hung himself. The principal officer said at interview that Littlehey do not use a coded emergency call (for example Code Red indicates there is an emergency and bleeding is present and a Code Blue indicates that someone is not breathing or is having difficulty doing so). Although a Code Blue call would not have specifically informed staff that they were responding to a prisoner who had attempted to hang himself, it may have

given them a better idea of what to expect. I therefore make a recommendation in this regard.

The Governor should consider adopting a code type emergency call, so staff have a better idea of the type of incident they are responding to.

102. The senior officer was unable to make an emergency call using his radio as the battery was flat. A system should be put in place to ensure that staff check that the radio batteries are working when they collect a radio.

The Governor should put a system in place to ensure that staff check the radio batteries are working when they collect a radio.

103. My investigator found that all the staff who were involved in this emergency (from the principal officer who managed the incident, to the staff who supported their colleagues) were professional and worked as hard as they could to save The man. The Governor should officially commend them for their efforts.

The Governor should officially commend those staff involved in this emergency.

First aid training

104. Littlehey have a system where first aid trained staff are on a rota, carry a radio and attend any emergency calls. My investigator thought this was an excellent initiative. However, the prison does not have 24 hour healthcare, and at least three of the officers who attended to the man in the first instance were not first aid trained. It would benefit the prison if more staff could be trained in first aid, especially senior officer grades. (However, in this case the third officer was a trained first aider and arrived at the man's cell very quickly).

The Governor should consider developing a training programme to train more prison staff in first aid, especially senior officer grades.

Aftercare for staff

105. Members of the Care Team were available to support staff during the CPR attempt and afterwards. A hot de-brief was held on the night the man died and a critical incident de-brief was held on 20 May. Staff said they felt well supported by their peers and the Care Team in particular.

Aftercare for prisoners

106. My investigator was impressed with the level of care given to the prisoners on B wing and to those who were affected by the man's death. Staff took the time to explain to prisoners what had happened and offered the support of a Listener. A prisoner who was distressed was moved to the CSU for the night and located in a cell with a Listener.

Family Liaison

107. It was evident to my investigator that the fourth officer is a caring and conscientious Family Liaison Officer who maintained contact with the man's sister after breaking the news of his death with the deputy Governor, and continued to be as helpful as possible. The fourth officer fulfilled his role well and should be commended by the Governor.

The Governor should commend the fourth officer on the way in which he fulfilled his Family Liaison Officer duties.

RECOMMENDATIONS

1. The Governor should consider adopting a code type emergency call, so staff have a better idea of the type of incident they are responding to.
2. The Governor should put a system in place to ensure that staff check that the radio batteries are working when they collect a radio.
3. The Governor should officially commend those staff involved in this emergency.
4. The Governor should consider developing a training programme to train more prison staff in first aid, especially senior officer grades.
5. The Governor should commend the fourth officer on the way in which he fulfilled his Family Liaison Officer duties.

GOOD PRACTICE

1. Staff should be commended for the high quality of record keeping in the IMR.