

**Investigation into the circumstances surrounding the
death of a man in June 2011,
while in the custody of HMP & YOI Littlehey**

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

October 2012

This is the report of an investigation into the death of a man, a prisoner at HMP & YOI Littlehey, who died in June 2011. He was 36 years old. He was discovered hanging from the bars of the window in his cell. The post mortem examination concluded the cause of death was hanging. I offer my condolences to his family and to all those affected by his death.

The investigation was undertaken by an investigator. Staff at Littlehey cooperated fully with the investigation. A clinical review into the man's medical care at Littlehey was commissioned from the local Primary Care Trust. They appointed a clinical reviewer to conduct the review. I apologise for the late issue of this report.

The clinical review concludes that the man's clinical care was equivalent to that which he could have expected in the community. The clinical reviewer makes two recommendations, which I endorse, relating to the need to improve oversight of medication at Littlehey and the need for Cambridgeshire and Peterborough NHS Foundation Trust to ensure that its policies for identifying the care needs of people with mental illness are fully implemented in the prison. I am also concerned that the man was able to obtain a number of medications that were not prescribed to him. I share the concerns expressed in a recent report by HM Inspectorate of Prisons that the management of in-possession medications at Littlehey is not sufficiently robust and make a recommendation accordingly.

The man had significant mental health issues and was also clearly frustrated by his inability to progress in his sentence and move to open conditions. However, both my investigator and the clinical reviewer conclude that there were no indications that he was at any significant risk of self-harm or suicide and both prisoners and staff were shocked that he apparently took his own life.

The recommendations made in the draft report have been accepted by HMP Littlehey and Cambridgeshire and Peterborough NHS Foundation Trust. I have included the response to the recommendations at the end of this report.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man was born in 1974. He was 36 when he died in June 2011 at HMP & YOI Littlehey having been found hanging from the bars of his cell window.
2. On 5 July 1996, the man was found guilty of arson and possession of a Class A drug with intent to supply. He received a discretionary life sentence which required him to serve a minimum period of four years before he could be considered for release. When he arrived in custody, it was recorded that he had a history of depression, drug misuse and poor sleep. He spent time at Belmarsh, Brixton, Wormwood Scrubs, Coldingley and Maidstone prisons before moving to Littlehey on 20 December 2006.
3. In the months leading up to his death staff noted that the man seemed to be in an improved state of health since he had started working part-time in the gardens at Littlehey. There were no concerns that he was a risk of self-harm or suicide. After his death some prisoners said that he had not seemed his usual self on the day before his death and suggested he might have been worried about a tobacco debt. Another prisoner also alleged that he had been upset after being reprimanded by the deputy governor for attempting to contact the media with information about an inappropriate relationship between a member of staff and a prisoner at Littlehey. The investigator found no evidence to substantiate either of these two allegations.
4. One morning in June 2011, prison staff discovered the man hanging with a bed sheet tied to his cell window bars. Officers cut the sheet but it was apparent that he had been dead for some time and, therefore, they did not attempt to resuscitate him. An ambulance was called but when paramedics arrived they confirmed he had died.
5. A clinical reviewer carried out a review which considered the care provided for the man throughout his time in prison. In his view the quality of care given to the man was equitable with what he would have received in the community. We have also concluded that staff used self-harm observation and support plans appropriately and that his death was not foreseeable. The clinical reviewer made two recommendations, which we endorse, about prescribing practice and the need for an effective planned care approach for prisoners with mental health problems. We make an additional recommendation concerning the control of in-possession medication.

THE INVESTIGATION PROCESS

6. The investigator was formally notified of the man's death on 14 June 2011. Notices were issued to staff and prisoners at Littlehey informing them of the investigation and asking anyone who had relevant information to contact the investigator. One prisoner asked to be seen but when approached by the investigator he chose to provide a statement rather than be interviewed. The investigator examined all the man's relevant prison records, including his medical records.
7. A clinical review was commissioned by the local Primary Care Trust into the man's medical care in custody to establish whether the care which he received in prison was comparable with that in the community and to identify any points of learning. The clinical reviewer's report was not received until 9 January 2012. Unfortunately, the case was then further delayed due to work load pressures in this office.
8. The investigator contacted Her Majesty's Coroner to inform him of the investigation and to request a copy of the post mortem report. This report will be sent to the Coroner to assist his enquiries.
9. One of our family liaison officers and the investigator met the man's mother and her legal representative to discuss some issues they wished to raise. She was concerned that her son's mental health appeared to have deteriorated quickly and they wanted clarification about the sequence of events leading up to his death and information about his care. We have aimed to address these issues in this report. She received a copy of the draft report and they raised further concerns in light of the findings. Another of our family liaison officers and the investigator met with her and her legal representative to discuss these issues. She still remains concerned about the quality of medical care her son received and expressed a belief that he was being bullied while in custody. She also explained that although her son was living with his grandmother, she continued to play a regular and active part in his life during this period. Further concerns raised at the meeting do not fall within the remit of this investigation and have been addressed in separate correspondence.
10. The investigator visited HMP & YOI Littlehey on 16 June and spoke to the then Governor and other staff involved in the man's care. He returned to Littlehey on five occasions during July and August to conduct a range of interviews with staff and prisoners. Initial feedback about emerging findings was given to the prison on 2 August, which was subsequently confirmed in writing.

HMP & YOI LITTLEHEY

11. HMP Littlehey is a category C¹ male prison outside the village of Perry in Cambridgeshire. It has a maximum capacity of 726 adult male prisoners plus with 480 young adults accommodated in a new young offender unit opened early in 2010.
12. Healthcare at Littlehey is provided by NHS Cambridgeshire. The prison does not have 24 hour healthcare facilities. A nursing team works on site during the day on weekdays and Saturday mornings. There is a GP service and a local out of hours medical service covers periods when doctors are not on duty. Mental Health Inreach services are provided by the Peterborough and Cambridgeshire NHS Foundation Trust.
13. The investigator reviewed the Ombudsman's reports into the two earlier self-inflicted deaths (in 2006 and 2008) at Littlehey. There are no similarities between those deaths and the man's.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) appointed by the Secretary of State for Justice. IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. The last annual report published by the IMB at Littlehey covers the period from February 2010 to January 2011. The report focused mainly on the challenges the prison faced with opening the young offender unit but also commented positively about mental health services.

HM Chief Inspector of Prisons

15. The last published inspection report of Littlehey by the HM Chief Inspector of Prisons covers an inspection in November 2011. The Chief Inspector expressed serious concerns around medicines management and noted that:

“Decision making in relation to prisoners having in-possession medication was also inconsistent and at times haphazard, with nurses and the pharmacy technician making decisions that were unclear. There was no straightforward way of checking the administration was taking place against a valid prescription.”
16. Mental health services were judged as excellent with good access to a wide range of primary and secondary services, including psychiatrists, a psychologist and a psychotherapist. The Chief Inspector pointed out that the mental health team at Littlehey had received an award in recognition of their work.

¹ When they enter prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D, with category A being the most dangerous. Category C are those who cannot be trusted in open prison conditions, but would not have the ability or resources to make a determined escape.

The Parole Board

17. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to decide who may safely be released into the community once they have served the minimum term imposed by the courts.

Assessment, Care in Custody and Teamwork (ACCT)

18. ACCT procedures operate in all prisons to monitor and support prisoners assessed as at risk of suicide or self-harm. Once placed on ACCT, the prisoner is subject to regular case reviews that should direct observations/conversations to be carried out at intervals determined by their perceived level of risk and check whether identified actions to support the prisoner have been achieved.

KEY EVENTS

19. The man was born in 1974 in London. He was 36 years old when he died in June 2011 at HMP Littlehey.
20. On 10 January 1996, following a fire at his flat, the man was charged with arson and remanded into custody. He was initially held at HMP Belmarsh and then HMP Brixton. This was his first time in prison.
21. A psychiatric report completed by a Senior Registrar in Psychology on 4 July 1996, recorded that alcohol had been a problem for the man for a number of years and that he had a history of depression, poor sleep and also suffered from abuse of drugs. He admitted that he had been involved in setting fires in his early teens. The report concluded that he had an underlying anxiety disorder and represented a considerable danger, particularly when he was abusing drugs and alcohol.
22. On 11 July 1996, the man was convicted and sentenced to a discretionary life sentence with a minimum term of four years before he could be considered for parole.
23. A post sentence report on 18 November 1996, recorded that the man had lived with his grandmother from the age of 14 after he refused to attend school. He moved back to live with his mother when he was 18. He was not fit for work and received incapacity benefit. He had been offered out-patient support from his local mental health services in January 1994, but stopped attending the clinic after eight months. After receipt of the draft report, his family stated that although he did live with his grandmother some of the time his mother dealt with all of his schooling problems. They also pointed out that he only went to live with his grandmother after he left school until he was 18.
24. During his sentence the man spent time in Wormwood Scrubs, Coldingley and Maidstone prisons before his move to Littlehey on 20 December 2006.
25. On 7 September 2001, the Parole Board considered the man's suitability for release or for a move to an open prison. Neither was agreed because the Board considered there were ongoing risk and mental health issues which had yet to be fully addressed. He had further reviews by the Parole Board in 2003 and 2004. Although some offending behaviour work had been undertaken, the Board was still not satisfied that he was suitable for release on licence or transfer to open conditions.
26. The man had his fourth review by the Parole Board on 9 March 2006. This time the Board recommended that he should transfer to open conditions. It noted that he had been drug free since his arrival at Maidstone in March 2005 and that he would be able to undertake a cognitive skills booster course in an open prison. The Secretary of State rejected the Parole Board's recommendation and noted concerns about an adjudication for cannabis (which was discovered in his cell in August 2005), his behaviour before his transfer to

Maidstone in 2005 and further work that was needed on his thinking and problem solving skills.

27. The next year in August 2007, the Pre-Release Section of the Public Protection Unit of the National Offender Management Service (NOMS), outlined in a letter to the Lifer Manager at Littlehey the Secretary of State's position about the man's sentence progression. It said that he did not meet the test for release or transfer to open conditions. Although he had completed some offending behaviour work, it was noted that at the time he was de-motivated and was not engaged with the life sentence planning process. His risk of re-offending and risk of harm to the public were both assessed as medium and none of his reports supported his release or move to open conditions. The letter said:

"The Secretary of State notes that the man has had no contact with the psychology department at HMP Littlehey and declined to participate in a risk assessment, with this in mind, the Secretary of State therefore does not support release or transfer to open conditions."

28. On 26 August 2009, the following entries were recorded in the sentence planning and review meeting notes:

"The man is a very quiet individual who maintains a low presence. He self manages himself extremely well and does not cause staff any concerns. His behaviour is described as excellent by the wing staff."

29. It was recorded that the man's own perspective on his progress was that he had completed as much offending behaviour work as had been available to him. He was frustrated that he had not had the opportunity to prove he had sufficiently lowered his risk of re-offending to progress. He also drew attention to his engagement with mental health services at Littlehey.
30. In July 2010 following an agreement with his community psychiatric nurse the man began working in the gardens at Littlehey as part of his recovery plan to reduce his isolation from other prisoners. He was reported to have enjoyed the work.
31. He had been prescribed medication for mental health problems from shortly after he came into custody and had had a number of psychiatric assessments. On 2 November, he was seen by a psychiatrist. They discussed his paranoia and that he was hearing voices and the doctor increased his previous prescription of olanzapine (an anti-psychotic medication) to 15milligrams a night. On 16 December, it was recorded in his medical record that he was not taking his medication. He explained that he had stopped taking his medication for a while and when the psychiatrist increased the dosage he had tried to collect it again, but had been refused. His psychiatric nurse discovered that the pharmacist had stopped dispensing his medication because of his poor compliance with taking his medication and because he had not attended appointments for blood tests. The pharmacist did not inform her before the medication was stopped.

32. On 21 December, the psychiatrist saw the man and they discussed his hearing of voices and thoughts of self-harm. He was encouraged to restart his medication of olanzapine as the issues relating to compliance had now been addressed.
33. On 17 February 2011, the man's offender manager, who had been his probation officer for a number of years, visited him at Littlehey to discuss a psychology report that had been prepared for his forthcoming parole review. In her statement to the investigator, she wrote:

“He [the man] suffered from depression and tended to withdraw and isolate himself when he was feeling low so that until his problem was properly understood help was not always easy for him to access. Over the last 2 years however [Mental Health] In Reach staff had worked extensively and largely successfully with him, not fully addressing the underlying issues related to his depression as he was not willing or able to do this in prison, but helping him learn to use strategies to manage his feelings and obtain help when he needed it. In general I would have said he had made significant progress as a result of their attentions.”

34. During their final meeting, she said that he was quite forthcoming and willing to discuss aspects of his life which he had not spoken about before. She said that this was because they were implied in the psychology report. She said that he had expressed some anxieties about a role he had planned to undertake as a mentor for inmates on the Thinking Skills Programme but this was not an immediate issue as he was not currently or about to be involved in this work in the near future.
35. During their discussion she said that he appeared to be under the impression that there was a plan that he should go to hospital for treatment for his mental health problems. She discussed this afterwards with the psychiatric nurse who confirmed that there were no plans for hospitalisation, but she said that he had started to withdraw into himself again (a sign of depression) and appeared to have stopped taking his medication for a while. The nurse said she had discussed this with him and he had started taking his medication again.
36. The probation officer said that the man made no mention of any particular problems he had in the prison such as debts. She wrote that her interview with him was “was quite positive, we were looking towards a move to Cat D. He was keen to progress though appropriately anxious as to how he would cope after so long in closed conditions”. However, she noted that he was not hopeful about the forthcoming review because he had been very badly affected by the Secretary of State's decision (in 2006) not to accept the Parole Board's recommendation. She wrote:

“This had devastated him, playing into all his personal issues about other people not being reliable, willing to help, and him being overlooked and just considered a nuisance. It had taken him a long

while to get over this, and he was afraid of a repetition of the disappointment and the depression if he had another oral hearing.”

37. On 23 February, the psychiatric nurse recorded in the medical record that the man was becoming more isolated; less motivated and had not been taking his medication. Neither the investigator nor the clinical reviewer found records which showed that he had been taking his medication.
38. On 1 March, the man was prescribed quetiapine (an anti-psychotic medication used to treat severe mental disorders) and venlafaxine (an anti-depressant). Three days later, on 4 March, he was seen by the psychiatric nurse. She recorded that he “felt brighter”. On 8 March, she recorded that he had started his new medication and had no side effects. When she next saw him on 10 March, it was recorded that he had not been sleeping properly. When she saw him on 25 March she recorded that his sleep was still poor and he was lethargic. He had also missed a recent psychiatric clinic appointment but no reason was given.
39. On 5 April, the man informed the psychiatric nurse that he was now taking olanzapine as well as quetiapine and venlafaxine. He queried this with her and she took the medication and completed an incident form as he was receiving two anti-psychotic medications which should not have happened. The prescription for olanzapine was stopped on 14 April. On 27 May, he informed her that he was still not sleeping and did not feel as though he was getting any better with the new medication.
40. On 3 June, the psychiatric nurse recorded that he had been unable to collect his medication, as he had been late. To avoid this he was given a week’s supply.
41. A prisoner at Littlehey said that on 4 June the man told him that he had attempted to contact the press about inappropriate conduct between a member of staff and a prisoner. He said that the man was not pursuing this as the deputy governor had warned him off and he seemed “shaken even frightened” about this. (This matter is discussed in the issues section.)

Events leading up to the man’s death

42. The cells on B wing were unlocked at around 7.45am and Officer A unlocked the man’s cell (B3-03). In his statement to the Governor, he said that before he unlocked the cell, he had looked through the observation hatch in the door and he appeared to be asleep. Just under an hour later, at 8.40am, when the officer carried out a roll check, he was sitting on a chair watching his television. He checked that the man had no appointments to attend and then locked his cell door. He next saw him after lunch when he collected the items he had ordered from the prison shop and he “appeared to be in good spirits”.
43. The next time Officer A saw the man was when he collected his tea, the last meal of the day, and he said he “appeared to be in a good mood, he was

chatting to a number of prisoners in the queue and there didn't appear to any obvious issues".

44. Officer B was working on the wing at the time and recalled seeing the man return to his cell and said "his demeanour did not suggest anything untoward". He started locking prisoners into their cells around 4.45pm and the man was one of the first people he locked away. He asked whether he had finished his meal and had everything he needed. He replied "Cheers Gov" and gave a "thumbs up". The officer wrote:

"He appeared in a good mood with no obvious signs of distress. Once I had locked up the rest of the landing I went around counting and proving the doors, when I looked into his cell he was sitting on his chair watching TV, smoking a cigarette."

45. At around 6.00am an Operational Support Grade (OSG)² started the morning roll count. At 6.11am, when he arrived at the man's cell, he pulled down the observation flap in the door and looked inside. He could see he had hanged himself using a bedsheet attached to the bars on his window. He immediately radioed for assistance. A Senior Officer (SO), the Night Orderly Officer³, immediately made her way to B wing and asked an officer to follow her.
46. The officers went into the cell, cut the sheet and lowered the man to the floor. The SO noted that his body was cold and that rigor mortis⁴ was apparent in his limbs. She said that she believed he had been in the same position for some time and it was clear from his appearance he was dead, so she did not attempt resuscitation. An ambulance was requested at 6.18am and the paramedics arrived on the wing at around 6.34am. After the paramedics examined him at 6.37am they confirmed his death.
47. The prison activated its death in custody contingency plan. As usual with a death in custody, the police visited Littlehey and interviewed staff. They found no suspicious circumstances.
48. A family liaison officer and a prison chaplain visited the man's family to inform them about his death. The prison's family liaison officer assisted with the funeral arrangements and arranged for the man's belongings to be returned to his family. In line with Prison Service guidance Littlehey offered financial assistance with the costs of the funeral, which took place on 8 July 2011.
49. Prisoners were informed of the man's death during the morning and asked whether they required any additional support. All the prisoners who were subject to self-harm and suicide monitoring were reviewed. Prison managers held a 'hot debrief' for staff immediately involved to share information and

² An Operational Support Grade is a basic grade member of staff who will not have received the same level of training as a prison officer and he/she will have much less interaction with prisoners.

³ The Night Orderly Officer is the person in charge of the prison at night time.

⁴ Rigor mortis is a condition of extreme stiffness affecting the arms and legs after death making it virtually impossible to bend the wrists, elbows or knees.

provide reassurance and support. Both staff and prisoners were shocked that he had apparently hanged himself. Staff never considered it was something he would do.

50. In the days after the man's death some prisoners suggested that he was in debt to another prisoner for tobacco which he had been asked to repay and this had been the trigger for his act of self-harm. It was also later alleged that he had felt "shaken" after being reprimanded by the deputy governor after he had contacted the press with a story about an inappropriate relationship between a member of staff and a prisoner.
51. The post mortem examination recorded the man's death as being due to hanging. The report revealed that his blood contained evidence of the drugs citalopram (an anti-depressant), carbamazepine (anti-convulsant and mood stabilising drug used in treatment of epilepsy bi-polar disorders and for alcohol withdrawal), paracetamol and mirtazepine (prescribed for depression and anxiety). None of these drugs were prescribed for him at the time. Well healed scars were found on his forearms and lower leg indicative of previous self-harm. There were no recorded incidents of self-harm whilst he was at Littlehey, prior to his death. The verdict of the jury at inquest which took place in October 2012 was that the man took his own life by hanging.

ISSUES

Medical care

52. The man's family wanted to know more about his medical care. The clinical reviewer who carried out the clinical review was assisted by a consultant clinical and forensic psychologist. This helped give a perspective on his clinical care from a mental health specialist familiar with the prison environment. From the medical records, it was clear that he was seen regularly by healthcare staff and, when necessary, referred to secondary care services.
53. From virtually the time the man was received into custody until he died, he was prescribed medication for his mental health and had a number of psychiatric assessments. The clinical reviewer comments:

“The notes document a history of many episodes of low mood, suicidal thoughts and variable compliance with prescribed medication. However the healthcare professionals involved with his care did not feel he had a high suicide risk in the period leading up to his death and he was not on the prison's Assessment and Care in Custody Teamwork (ACCT). He had completed his schema therapy (a psychological therapeutic intervention) that was felt by his therapist to have been effective and he had been allowed to work in the garden. My interviews and those of the investigator have not concluded that he was at high risk of suicide when he took his own life, and it came as a surprise to those who knew him. After his death there were various rumours as to why he killed himself, but to my knowledge none are proven.”

54. The clinical reviewer notes that there were some issues with prescribing practice at Littlehey and that it was not always clear whether the man had been compliant with his medication.
55. At post mortem it was discovered that the man had taken medication which he had not been prescribed. Consistent with patients in the community, he was allowed to keep a quantity of his own medication in his possession, although because of the potential of abuse in prisons some drugs are issued only at daily medication times. However, it is clearly of concern that he had still been able to take a significant amount of medication that had not been prescribed to him. HM Inspectorate of Prisons also raised concerns about the somewhat 'haphazard' decision making around in-possession medication. Unless there is effective control of in-possession medication, the risk of illicit trading amongst prisoners remains unacceptably high.

The Governor and Head of Healthcare should ensure the effective management of prescribed medication so that opportunities for diversion are minimised and in-possession medication properly overseen.

56. The clinical reviewer interviews with healthcare staff indicate they were unaware that the man was not taking his prescribed quetiapine and venlafaxine. In relation to the other medication found in his blood at the time of

his death they could only conclude he had obtained the drugs from other prisoners. They said that trading of drugs between prisoners is a problem that it is difficult to prevent when prisoners are given charge of their own medication. All decisions to allow prisoners medication should be based on an individual risk assessment. Neither the clinical reviewer nor the investigator found any systems in place to check that prisoners are compliant with their medication and to confirm whether prisoners who are dispensed medication daily are observed taking it.

57. In December 2010, the man had not been able to obtain the medication he had been prescribed. The Head of Healthcare at HMP Littlehey was asked whether it was usual for the pharmacy not to dispense prescribed medication to a prisoner in the man's circumstances who had not attended for blood tests. He said it was not and he would expect the staff immediately to inform the Mental Health Inreach Team. He was surprised to be told that Mental Health Inreach staff when interviewed had said that they had never been informed of such an event.
58. The clinical reviewer also draws attention to an episode on 28 March 2011 when the man was prescribed olanzapine in addition to two other drugs, quetiapine and venlafaxine. It was only when he himself raised the matter, on 5 April, that the community psychiatric nurse identified that the olanzapine should not have been prescribed and removed the medication. This episode does not appear to relate to his death, but it is a concern that he was given the wrong combination of drugs and it took a week for this to be identified. There did not appear to be appropriate safeguards to prevent this.

The Head of Healthcare at Littlehey should implement robust medicines management procedures to ensure prisoners are prescribed and dispensed the correct medication at all times.

59. Healthcare records demonstrate that the Mental Health Inreach Team were routinely in contact with the man and reviewed his care. However, this was not always translated into formal assessments and plans and the policies of the Care Programme Approach (CPA) and clinical risk management do not appear to have been followed. The CPA is the process of identifying the care needs of people with a mental illness and is for anyone in touch with mental health services. It provides an organised way of assessing all of a person's needs, and developing a single care plan which will ensure those needs are met. The care plan is updated at regular intervals.
60. The CPA is meant to occur annually but the most recent documented assessment was dated 2 March 2010. The Mental Health Inreach Team was aware that the next CPA was overdue. The psychiatric nurse identified herself as the man's care co-ordinator but this was not recorded on the CPA. The most recent update of the CPA risk assessment was dated 25 November 2010 but was identical to the March assessment. A documented care plan agreed on 11 March 2011 had an update of care plan review date of 11 May 2011 but this review does not appear to have taken place. The clinical reviewer noted that while healthcare staff who looked after the man did not regard him as at

high risk of suicide the formal assessments and risk documents were not adequately completed. The CPA procedures and the need to translate assessments into robust action plans are important ways to help prevent future self-inflicted deaths.

Cambridgeshire and Peterborough NHS Foundation Trust should ensure that the Care Programme Approach (CPA) and clinical risk assessment policies are fully implemented in the prison.

61. Despite the flaws in medicines management and the CPA, the clinical reviewer concludes that, overall, the care received by the man was “equitable with that received in the wider community, and may well have been greater”. He remarked that the consultant clinical and forensic psychologist regarded the provision of psychological therapy as beyond the level of service an individual with his problems would routinely be offered in the wider community.
62. The clinical reviewer finds the provision of psychological therapy was “beyond the level of service an individual with the man’s problems would routinely be offered in the wider community. This was delivered by an experienced and appropriately qualified clinician”. He finds the use of the medical computer system enabled prompt and effective communication between mental health services and prison healthcare staff. He also draws attention to the positive relationship between the man and staff from the mental health services at Littlehey.

General care and possible bullying

63. When the man’s aunt viewed his body after his death she said he looked dishevelled and unkempt, leading his family to be concerned that he had not been cared for appropriately. They said that he did not like being held at Littlehey where many of the other prisoners were sex offenders and they were aware from the documents they had seen that he did not come out of his cell very often and did not interact much with many other prisoners. The family were also concerned that he may have been a target for potential bullying as he was receiving money.

64. In response to these concerns, a Senior Officer wrote:

“At HMP/YOI Littlehey we encourage all prisoners to maintain high levels of personal hygiene. We also promote a ‘zero tolerance’ approach to violence and encourage all prisoners to report any forms of bullying/violence either directly to staff or through prisoner support groups. There is no evidence to suggest he had reported any bullying/violence issues”.

The investigator could find no evidence that he was not well cared for while he was at Littlehey.

65. According to prisoners and staff interviewed as part of this investigation, the man mostly kept his own company. He had a very small circle of friends and

he enjoyed spending time in his cell playing computer games. The man was assigned a personal officer (a named officer assigned to be the first port of call for a prisoner, to look after his welfare and help with general prison issues including sentence planning). He told the investigator that he believed that the man had a good relationship with staff from the Mental Health Inreach Team. The officer said they had a good relationship and the man was able to talk to him if he was having any problems. He confirmed that neither staff nor prisoners raised any concerns about him in the weeks and days leading up to his death. He said:

“I think Inreach did mention that he seemed to be going a little bit backwards, back to how he used be and they were looking into that. I mean that was just a passing comment one day. But he never avoided work, he always went to the gardens and whenever I spoke to him about it he said how he enjoyed it. He would have a laugh and a joke if I saw him out on the grounds.”

66. After the man’s death, some prisoners suggested that he had been asked by another prisoner to repay a tobacco debt (in prison tobacco acts as a currency for trading items between prisoners) on the day before his death and this had been the trigger for his apparent suicide. It was suggested that he was in debt to Prisoner A, who in turn was in debt to another prisoner. When interviewed as part of this investigation, Prisoner B said he had heard that this prisoner had asked for the man to repay his tobacco debt. Prisoner B was not told this information by the man.
67. When interviewed as part of this investigation, Prisoner A was adamant that he did not ask for a tobacco debt to be repaid on the day before the man’s death. He was very surprised by the accusation as he said he knew that the man had a lot of money in his prison account. He said: “He must have over £300 in his account; he doesn’t need to run around and do anything with anyone ... He had a ridiculous amount of money, I couldn’t believe it”.
68. The investigator could not find any evidence to substantiate the allegation that the man was in debt to Prisoner A, or that he had asked for the debt to be repaid. We confirmed that he had a substantial amount of money in his prison account when he died and had managed his financial affairs well for a number of years and that it was unlikely that he had any significant tobacco debt.

Sentence progression

69. The man’s family were concerned that although he was re-categorised to a D (open conditions) this was overruled by the Secretary of State. They wanted to know why he was located at Littlehey and why he was still in custody, although his tariff had expired.
70. The man received a discretionary life sentence in 1996 after his conviction for arson and possession of a class A drug with intent to supply. Discretionary life sentences are imposed when a person is convicted of a very serious offence, and the courts consider that at the time of sentencing there are good grounds

for believing that the offender may remain a serious danger to the public for a period which cannot be reliably estimated at the date of sentence. He had a minimum period of four years to serve (known as the tariff) before he could be considered for release. Because of the reason behind the original sentence, most offenders sentenced to discretionary life sentences serve well beyond their tariff. To be released after the minimum term the Parole Board must be satisfied that the person is no longer a danger to the public.

71. The Parole Board considered the man's suitability for release a number of times after his tariff expired, but on each occasion was not satisfied that his risk to the public had reduced sufficiently to direct his release, so he remained in prison. He was due to have a further Parole Board review later in 2011.
72. The Secretary of State seeks the views of the Parole Board about the suitability of a life sentenced prisoner for open conditions, but the Board itself does not make the decision about categorisation. Thus it was simply a recommendation from the Parole Board in 2006 that the man was ready to be tested in an open prison. He was not recategorised at that time and the Secretary of State rejected the Board's advisory recommendation, as he was entitled to do.
73. The man moved to Littlehey in December 2006 as part of his normal sentence progression to engage in further rehabilitation courses. Because of his mental health problems and the risk of harm he was judged to present, it had not been possible for him to progress to a lower category of prison or to be released. We understand this must have been difficult for him. His probation officer said that at an interview in February 2011 he was quite positive about the possibility of a move to open conditions but at the same time anxious in case he had a further rejection.

Cell bell records

74. The man's family wanted to know whether he had used his emergency cell bell during the night before his death and if so how many times. Unfortunately, there is no electronic auditable cell bell system which logs when a cell bell is used on the wing where he was held so we are unable to confirm if he used his bell. From interviews conducted with staff and from the information recorded in the wing observation book, there is no evidence that he used his cell bell to summon assistance on the night before his death.

Contact with family

75. The man's mother wondered whether he had tried to contact her during the week before his death as she had missed calls where the number was withheld. The investigator checked the telephone records at Littlehey and can confirm that no calls were made by him to his mother in the week leading up to his death.

The emergency response

76. The man was discovered hanging by an officer during their morning roll count. Within a few minutes of this discovery, the officer had radioed for and received assistance and an ambulance had been called. The officers cut him down from his hanging position and made an assessment he was dead and, appropriately, did not attempt resuscitation. When the paramedics arrived they confirmed his death.
77. From all the evidence it appears that those involved acted quickly and in a professional and considerate manner. Sadly, he had already been dead for some time when he was discovered.

The man's possible contact with the media

78. Prisoner C made a written statement to the investigator in which he said that on 4 June, the man told him and another prisoner, Prisoner A, that he had contacted the press about inappropriate conduct between a member of staff and a prisoner. He told them that he had been offered money for his story but he was not going to pursue it as he had been reprimanded by the deputy governor for contacting the press. He said that the man seemed "shaken even frightened" as he recalled the governor's warning. Although Prisoner C had at first asked to be seen by the investigator he declined an interview. At the request of the investigator he was asked whether he could provide a statement in relation to his concerns which he agreed to do. In his statement he said that Prisoner A would be able to substantiate what the man had said to them.
79. Prisoner A told the investigator that although the man had spoken about taking action about the alleged inappropriate relationship his plans did not come to anything. He said that he was going to arrange a visit with a relative and for them to show him the telephone number for the News of the World or the Sun which he would remember as he had "a photographic memory". He would then asked for it to be added to his PIN⁵ account but was going to put it under a fake address. The prisoner said that the man told him that he had been warned about taking the issue further by a member of the prison's Security Department. He did not say that he had mentioned that the deputy governor was involved. He was adamant that he did not believe that this issue played any part in his death.
80. The investigator spoke to the deputy governor about Prisoner C's account and she said she had no recollection of receiving any information about a prisoner trying to contact the media about an inappropriate relationship between a member of staff and a prisoner. In her statement, she wrote that had such information come to light it would have been through the prison's Security

⁵ PIN telephones are used in prisons and each prisoner is given a PIN number which they key in before making a call. Prisoners complete a form to select telephone numbers for their family, friends and legal contacts, which has to be agreed by the prison. The system works on a credit basis and prisoners buy credit from the prison shop, the cost of the calls being automatically deducted from their PIN account.

Department who she would have expected to act on it and inform her. She said she had no recollection about having a meeting with the man or reprimanding him. She explained that had she done so she would have completed a security incident report, recorded her actions on his personal record and contacted the Prison Service Press Office to advise them that this might become an issue. None of these things were done and the investigator could not find anything recorded about this in either his records or in any security records held by the prison. She also wrote: "I would also question how he would have the ability to do this, as he would not have such a number [press contact] on his PIN account. If he did have access to a mobile phone, I am not then sure how we would have known about this".

CONCLUSION

81. The man arrived at HMP Littlehey in 2006. It was discovered on a morning in June 2011 that he had hanged himself. Attempts to resuscitate were not carried out as it appeared that he had been dead for some time.
82. Following his death a prisoner suggested that the man had felt “shaken” after being reprimanded for trying to contact the press. It was also later alleged that he might have been concerned about a tobacco debt. The investigator looked into these allegations and could find no evidence to substantiate them.
83. The clinical reviewer concludes that: “the care received by the man was equitable with that received in the wider community, and may well have been greater”. The provision of psychological therapy was also “beyond the level of service an individual with his problems would routinely be offered in the wide community. This was delivered by an experienced and appropriately qualified clinician”.
84. However, the clinical reviewer has highlighted certain areas for improvement at Littlehey. The systems for issuing medication were not robust. Healthcare staff did not realise that the man had been issued additional medication until this was brought to their attention. The clinical reviewer recommends that the Head of Healthcare reviews the prescribing processes to ensure prisoners are prescribed and dispensed the correct medication. We are also concerned that the control of in-possession medication is not sufficiently robust and make a recommendation concerning this.
85. The clinical reviewer also draws attention to the need for Cambridgeshire and Peterborough NHS Foundation Trust to implement the Care Programme Approach for prisoners with mental health needs in the prison.

RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included in italics below the recommendation.

HMP Littlehey

1. The Governor and Head of Healthcare should ensure the effective management of prescribed medication so that opportunities for diversion are minimised and in-possession medication properly overseen.

Accepted - The in possession policy has been revised and is currently in an interim stage having been ratified by the Medicines Management Committee. This is will be subject to further review. Robust mechanisms are in place to ensure supervised consumption is managed effectively.

2. The Head of Healthcare at Littlehey should implement robust medicines management procedures to ensure prisoners are prescribed and dispensed the correct medication at all times.

Accepted - The medication regime is reviewed at the Medicines Management Committee on a bi-monthly basis. This is directly linked to recommendation 1.

HMP Littlehey and Cambridgeshire and Peterborough NHS Foundation Trust

3. Cambridgeshire and Peterborough NHS Foundation Trust should ensure that the Care Programme Approach (CPA) and clinical risk assessment policies are fully implemented in the prison.

Accepted - Cambridgeshire and Peterborough NHS Foundation Trust have fully implemented this recommendation.