Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dean Briant, a prisoner at HMP Littlehey, on 18 July 2020

A report by the Prisons and Probation Ombudsman

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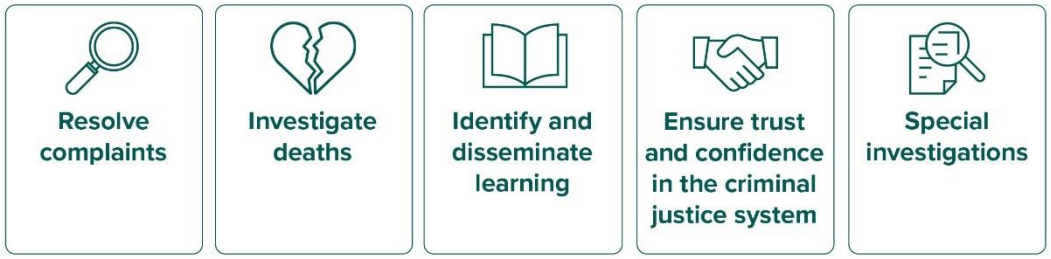
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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

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

Mr Dean Briant was found hanged in his cell at HMP Littlehey on 18 July 2020. He was 48 years old. I offer my condolences to his family and friends.

Mr Briant was serving an indeterminate sentence of Imprisonment for Public Protection (IPP) for historic sex offences and had been recalled to prison.

Following a police interview in January 2020, Mr Briant became increasingly anxious about the likelihood of being charged with further serious offences and I am concerned that staff missed an opportunity to assess whether his risk of suicide had increased after the police interview.

Although his anxieties about possible further charges appear to have contributed to Mr Briant's decision to take his life, there is no evidence that Mr Briant shared his concerns with staff in the four months before his death. I have therefore concluded that they had no reason to consider he was at imminent risk of suicide at the time of his death.

I am, however, concerned that the very restricted regime introduced in response to the Covid-19 pandemic, meant that staff had no meaningful engagement with Mr Briant in the months before he died and that this significantly reduced their opportunity to identify that he might be at risk. The very restricted regime may also have affected Mr Briant's mental health.

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

Sue McAllister CB
Prisons and Probation Ombudsman **October 2021**

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Summary

Events

1. On 10 January 2019, Mr Dean Briant was recalled to prison. He had received an indeterminate sentence of Imprisonment for Public Protection (IPP) in 2010 for historic sex offences. On 30 May 2019, Mr Briant was transferred to HMP Littlehey. He had a history of self-harm and had previously been monitored in prison under suicide or self-harm procedures (known as ACCT).

2. Mr Briant was assessed at Littlehey for his suitability to take part in offending behaviour programmes, but he did not meet the eligibility criteria. He was concerned about this and his parole but otherwise appeared to have settled.

3. In January 2020, police interviewed Mr Briant about serious offences allegedly committed while he was released on licence. Over the following months, Mr Briant became increasingly anxious about the possibility of facing further charges.

4. At around 3.50pm on 18 July, an officer found Mr Briant unresponsive in his cell, with a ligature tied around his neck. Nurses and officers tried to resuscitate him, and they were later assisted by paramedics. Their attempts were unsuccessful, and paramedics confirmed Mr Briant's death at 4.49pm.

Findings

5. Although Mr Briant had several risk factors for suicide and self-harm and frequently discussed his anxieties about further charges with other prisoners, he did not share his concerns with prison officers in the last few months of his life and we have concluded that staff could not reasonably have been expected to consider that he was at imminent risk of suicide at the time of his death.

6. We are, however, concerned that the daily and weekly welfare checks on prisoners during the very restricted Covid-19 regime did not provide an opportunity for meaningful conversations in which Mr Briant might have felt able to share his concerns with officers.

7. The very restricted regime also meant that Mr Briant spent up to 23 hours a day alone in his cell, and this may have affected his mental health.

8. We are also concerned that staff did not see Mr Briant after he was interviewed by police about possible future charges. This was a missed opportunity to assess whether Mr Briant was at an increased risk of suicide or self-harm.

9. We are concerned that there are insufficient opportunities at Littlehey for prisoners to participate in offending behaviour programmes. This is a particular problem for those serving an IPP sentence. This is an issue that HM Inspectorate of Prisons also raised in their last inspection.

Recommendations

- The Governor and Head of Healthcare should ensure that prisoners are screened after an interview with the police to assess their risk of suicide or self-harm.

- The Governor should ensure that staff understand the importance of having meaningful conversations with prisoners where possible when carrying out welfare checks during the restricted regime.

The Investigation Process

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

11. The investigator obtained copies of relevant extracts from Mr Briant's prison and medical records.

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

13. The investigator interviewed twelve members of staff and five prisoners at Littlehey, some jointly with the clinical reviewer. All the interviews were conducted remotely by Microsoft Teams because of the restrictions imposed as a result of the Covid-19 pandemic.

14. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. He provided us with a copy of the post-mortem report. We have sent him a copy of this report.

15. We contacted Mr Briant's family to explain the investigation and to ask if they had any matters they wanted us to consider. They asked why Mr Briant was at Littlehey prison, why he had not completed sex offender treatment programmes and what had happened in the weeks before his death. They also asked whether he had been told something which upset him, and whether he was receiving mental health support or taking antidepressant medication. These concerns are addressed in this report and in the clinical review.

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

Background Information

HMP Littlehey

17. HMP Littlehey is a medium security Category C prison in Cambridgeshire, holding around 1,200 men. A high proportion of prisoners at Littlehey have been convicted of sex offences. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

18. HMIP's most recent full inspection of Littlehey was carried out in July/August 2019. Inspectors reported that Littlehey continued to be an overwhelmingly safe prison and, although self-harm had increased in recent years, it remained low. Inspectors reported that the quality of ACCT documentation was good and there were enough Listeners (prisoners trained by the Samaritans to provide confidential and emotional support) and that prisoners in crisis said they were well cared for.

19. Inspectors reported that at the time of the inspection, Littlehey held 80 prisoners subject to IPP, 75 of whom were over tariff. They noted that there were not enough opportunities to enable prisoners who did not meet the threshold to participate in offending behaviour programmes to reduce their risk. Inspectors reported that prisoners often only became eligible to complete the programmes before their release date, which limited their opportunity to progress earlier in their sentence and be considered for re-categorisation.

20. In June 2020 HMIP issued an aggregate report on their short scrutiny visits to three prisons holding prisoners convicted of sexual offences (HMP Littlehey, HMP Rye Hill and HMP Stafford) focussing on key issues for prisoners during the Covid-19 pandemic. Inspectors reported that Littlehey had been declared an official Covid-19 outbreak site in March 2020 and it was therefore understandable that the prison had initially adopted a very cautious approach to shielding prisoners. However, they noted that after the prison succeeded in taking hold of the situation in early April, progress in improving the severe regime was slow and that by time of HMIP's visit in early June, Littlehey was still providing a comparatively poor regime even though the risks had reduced.

21. Inspectors reported on the widespread cancellation of offender programmes in the three prisons which had all but eradicated offending behaviour work. They noted that there were few detailed plans to reintroduce important interventions.

22. In August 2020, HMIP issued a further aggregate report on their short scrutiny visits to 35 prisons, including Littlehey, during the pandemic. Inspectors noted that, as their visits had progressed through the spring and summer, they identified increasing levels of stress and frustration among many prisoners and evidence that prisoner well-being was being increasingly affected by the continuing Covid-19 restrictions.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year ending January 2019, the IMB reported that Littlehey continued to be a safe and secure prison, where prisoners were treated fairly and with respect, decency and humanity.

24. However, the IMB reported that a significant section of the Littlehey population was not eligible to participate in an accredited offender programme because they had no more than a low risk of reconviction for a sexual offence. They noted that the majority of the population was released without increasing their own understanding of their sexual offending.

Previous deaths at HMP Littlehey

25. Mr Briant was the third prisoner to take his life at Littlehey since August 2012. In our investigation into the death of a prisoner in October 2018, we expressed concern that staff did not consider whether a parole board decision might have impacted on a prisoner's mood. There were no other similarities between this death and the circumstances of Mr Briant's death.

26. Between January 2019 and Mr Briant's death, there were 11 deaths from natural causes. Since his death, there have been a further 13 deaths, 12 from natural causes and one where the cause has not yet been ascertained, which we are still investigating.

Assessment, Care in Custody and Teamwork

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. As part of the process, a risk reduction plan, also known as a caremap (a plan of care, support and intervention) should be put in place. The ACCT plan should not be closed until all the actions of the risk reduction plan have been completed. After closure, a follow-up interview should take place within seven days.

28. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Prison Service Instruction (PSI) 64/2011 on safer custody sets out how staff should operate ACCT procedures.

Offending behaviour programmes

29. Littlehey delivers three accredited offending behaviour programmes: Horizon (a moderate-intensity programme for prisoners convicted of sex offences); Kaizen (a high-intensity programme for prisoners convicted of sexual offences) and the Healthy Sex Programme (for prisoners who have already completed an accredited programme but need further interventions).

Impact of Covid-19

30. On 24 March 2020, in line with Government advice, HMPPS issued an instruction to all prisons to introduce social distancing and a restricted regime for staff and prisoners, wherever possible. On 27 March, HMPPS issued operational guidance to prisons on exceptional regime and service delivery, which reflected government restrictions following the national lockdown of 23 March.

31. This guidance resulted in significantly restricted prisoner activities. Prison visits were suspended, education and non-essential work was cancelled, and healthcare delivery was also affected. This meant that prisoners spent up to 23 hours a day locked in their cells. However, prisoner safety and welfare and the provision of healthcare were two of several key regimes elements that were identified as requiring priority.

Key Events

32. On 12 November 2009, Mr Dean Briant was remanded into custody, charged with historic sex offences against family members. He had depression and a history of self-harm.

33. On 30 April 2010, Mr Briant was given an indeterminate sentence of Imprisonment for Public Protection (IPP), with a minimum tariff to serve of four years and six months before he could be considered for parole. Mr Briant did not complete the Sex Offender Treatment Programme (SOTP) as he was assessed as posing a low risk of reoffending.

34. On 20 February 2018, Mr Briant was released on licence from HMP Leyhill. While on licence, he was told that he was eligible to take part in the Horizon Programme (HP), the replacement for the SOTP, in the community.

35. On 10 January 2019, Mr Briant was recalled to HMP Exeter after breaching his licence conditions. This meant that he was not able to attend the HP.

36. On 8 February, Mr Briant was transferred to HMP Dartmoor. A week later, staff began ACCT procedures after Mr Briant told staff that he felt low due to his father's death and because he did not know how long he would spend in prison. He said that he wanted to sleep and not wake up. ACCT monitoring was stopped on 23 February.

HMP Littlehey

37. On 30 May, Mr Briant was transferred to HMP Littlehey to complete an offending behaviour programme needs assessment (PNA). At his initial health screen, he was referred to the prison's mental health team.

38. On 6 June, Mr Briant asked for his parole hearing be deferred while the process of assessing his eligibility for offender programmes took place. An offender manager said that Mr Briant was anxious when he first arrived at Littlehey because he was further from home and because he did not know how long he had to serve.

39. On 20 June, a mental health nurse assessed Mr Briant. He told the nurse that he felt low and was constantly thinking about "issues". She noted that Mr Briant was socially withdrawn but showed no signs of having psychosis, a thought disorder or delusions. Mr Briant denied thoughts of suicide or self-harm. The nurse completed a Patient Health Questionnaire (PHQ9), a tool used to identify depression and treatments, and assessed that Mr Briant had severe depression.

40. The mental health nurse referred Mr Briant to the prison's chaplaincy for bereavement counselling and to the prison's mental health support group for his low mood. Mr Briant also sporadically attended the prison's mental health drop-in group.

41. On 8 August, an officer introduced herself to Mr Briant as his keyworker. (The keyworker scheme is designed to help reduce violence and self-harm by

encouraging meaningful contact and positive relationships between officers and prisoners.) She described him as polite, pleasant and chatty.

42. At the end of August, Mr Briant's PNA concluded that he required no further offender-related programme work, despite the concerns of Mr Briant's community offender manager that the assessment was not accurate.

43. On 29 October, the offender manager met Mr Briant to discuss his PNA and parole report. He noted that Mr Briant felt low and was worried about his parole hearing. He told Mr Briant that he and the community offender manager would not support his release as he had seriously breached his licence conditions. Mr Briant was told that at that time, there was no intervention pathway to be taken. Mr Briant told the offender manager that he had felt like harming himself, he was anxious and felt low. Staff began ACCT procedures, which were closed two days later.

44. Both offender managers considered that Mr Briant needed to complete offending programmes before his release could be considered. They agreed with Mr Briant and his solicitor that they should obtain an independent psychological report. The offender manager noted that Mr Briant appeared 'okay' with what he had been told.

45. On 7 November, the offender manager spoke to Mr Briant about not being suitable for release. Although Mr Briant said he understood the situation, he wanted to know the way forward. The offender manager told him that the referral for a psychological report had been made and that he should accept the situation rather than continuously asking officers about his parole because they would not be able to answer his questions.

46. On 9 November, Mr Briant told his keyworker that he felt probation were stopping him from progressing towards release by saying he was not suitable for offender programmes.

47. On 14 November, Mr Briant told his keyworker that he remained stressed about his parole status and that he was not able to see his family. On 27 November, he told the officer that he was going to be more positive about his situation and not become stressed. On 10 December, Mr Briant told his keyworker that although he felt better, he was still concerned about his parole and being far from home.

48. A prisoner and safer custody representative said that from the end of 2019 to his death, Mr Briant would ask prisoners daily about his recall, his offending and the possibility of facing further charges. He said that Mr Briant would repeatedly say that he "was doomed" and that he would reassure him and tell him not to be so pessimistic. He said officers were always telling Mr Briant not to discuss his offending with other prisoners.

49. On 29 November, a mental health nurse noted that Mr Briant had not been attending the mental health low mood group and invited him to the prison's mental health drop-in support group.

50. On 18 December, Mr Briant told his community offender manager that he was feeling down about the outcome of his PNA and that he wanted to do offender programmes. She told him that she too was frustrated about the situation and would challenge the PNA decision. However, she also reiterated to Mr Briant that

because of his behaviour in the community, she did not consider that it was safe for him to be released.

2020

51. On 8 January 2020, Mr Briant told his keyworker he was worried that an upcoming interview with the police might affect his chances of parole.

52. On 9 January, an intelligence report noted that Mr Briant was not going to tell the police the truth about new alleged offences.

53. A prisoner safer custody representative described Mr Briant as “a loner”. He said that Mr Briant was getting “worked up” about the police interview and would constantly say “I’m doomed” and “I’m fucked up”. He said that Mr Briant would give other prisoners different accounts of the offences he had committed and told them about his police interview. He said he and another prisoner safer custody representative and staff told Mr Briant not to talk to other prisoners about his offending.

54. On 22 January, the police interviewed Mr Briant about allegations of child rape in December 2018. Mr Briant’s legal representative was also present. Mr Briant denied the allegations and said that a medical condition would have prevented him from offending.

55. After his police interview, Mr Briant told both prisoner safer custody representatives that he was to face further charges. The prisoners said that Mr Briant spoke to them frequently about this. On representative said that Mr Briant continued to tell him different accounts of what had happened and that he did not know when Mr Briant was telling the truth. He said that Mr Briant never talked about self-harm but until his death, would repeat that he was “doomed”.

56. A prisoner who lived in the cell next to Mr Briant’s said that after the police interview, Mr Briant talked about being charged and the sentence he might receive as an IPP prisoner. He said that Mr Briant was always polite, but his mood seemed to fluctuate. He said that Mr Briant told him many times that he would kill himself if charged with further offences as he would face a long time in prison. He said he did not tell anyone that Mr Briant had said that he would kill himself.

57. On 23 January, Mr Briant told his keyworker that he was doing well and that his police interview had gone okay.

58. On 29 January, an officer noted that Mr Briant was again telling other prisoners about his offending despite the advice of senior officers.

59. On 30 January, Mr Briant told an officer that he was worried about his parole hearing and said that he had told other prisoners about his offence for support.

60. On 31 January and 17 February, Mr Briant told his keyworker that he was stressed and worried about further possible charges as they were similar to his previous offending. She said Mr Briant wanted to know how this might affect his sentence.

61. On 20 February, a consultant clinical forensic psychologist completed Mr Briant's psychological assessment for his parole hearing. The report described Mr Briant as feeling low, that he was far from home and could not receive visits. (The report was prepared for legal purposes on Mr Briant's behalf and was not shared with the prison's mental health team.)

62. The psychologist told the community offender manager that she agreed that the PNA had not correctly identified Mr Briant's risks and that he needed to complete further offender programmes before he could be recommended for release. It was noted that Mr Briant and his solicitor had agreed with the report's conclusion. The report was disclosed to the parole board.

63. On 25 February, Mr Briant told a prison chaplain that he was anxious about further allegations against him and asked her to pray for him.

64. On 29 February, Mr Briant told his keyworker that he felt better as he had started education classes and attended chapel. On 4 March, the keyworker noted that Mr Briant appeared to be doing well. He told her he was keen to be transferred closer to home. She told him to make an application.

65. On 16 March, Mr Briant told his keyworker that he was doing well and felt less stressed as he had heard nothing more from the police. However, two days later, a DC wrote to Mr Briant asking for his consent to share his medical records.

66. A prisoner told the investigator that around March, he became aware that Mr Briant was self-harming by making scratches to his arms but was hiding them from officers. Mr Briant told him that he had harmed himself because he could not cope with what was going on in his life. He said that Mr Briant did not like to talk to the officers as he did not trust them, and that he encouraged Mr Briant to talk to the Listeners, but Mr Briant did not trust them either. He said that he did not tell anyone about Mr Briant's self-harm because Mr Briant had told him not to.

67. Although, the prison's key worker scheme was suspended at the end of March because of the Covid-19 pandemic, staff continued to check on prisoners weekly, in addition to the usual daily interactions to check on their welfare. During these checks, officers noted that Mr Briant raised no concerns.

68. On 7 April, Mr Briant gave his consent for the police to access his medical records.

69. On 9 April, Mr Briant was isolated, as a precaution, due to an outbreak of Covid-19 at the prison. On 15 April, an officer noted that Mr Briant continued to isolate but raised no concerns during a welfare check.

70. On 17 April, a nurse noted during a routine blood pressure test that Mr Briant was struggling due to the Covid-19 pandemic. He was given a distraction pack.

71. In April, Mr Briant's solicitor wrote to confirm that he wanted to proceed with writing to the prison about his future participation in offender programmes. Mr Briant told her that the police were investigating him for alleged rape.

72. On 1 May, Mr Briant told an officer that he was fine, and the officer noted that Mr Briant had "got his head around the current regime". On 7 May, Mr Briant told an

officer that he had struggled with being locked in his cell, due to Covid-19 but had managed to stay busy with the distraction packs and by watching television.

73. On 11 May, the community offender manager asked a Police Constable (PC) for an update about Mr Briant's alleged offences as his parole date was approaching. The PC told her that once medical records had been received, the file would be given to the Crown Prosecution Service (CPS) to decide but it would be some time before a charging decision was made.

74. On 14 May, Mr Briant wrote to his solicitor about the new allegations. He said that he was worried and needed legal assistance. A week later, she told Mr Briant that his solicitors did not have a criminal law department and could not assist him about further charges. She encouraged Mr Briant to seek a local firm to represent him and offered her assistance.

75. On 18 May, a nurse referred Mr Briant to the mental health team after he told her that he felt down and isolated and had mentioned further charges against him.

76. On 26 May, a mental health nurse and the mental health team leader assessed Mr Briant at his cell door due to the Covid-19 restrictions. Mr Briant told her that he felt low due to further charges brought against him. She reassured him and advised him to speak to his solicitor. Mr Briant confirmed that he was using the distraction pack. He denied thoughts of self-harm and told her that he would speak to wing staff if this changed. She noted that no further input was needed.

77. On 18 June, Mr Briant's solicitor wrote to tell him that his parole hearing had been listed and asked how he wanted to proceed. She tried to arrange a video link meeting with Mr Briant, but there was no availability before his hearing.

78. On 2 July, the offender manager asked the community offender manager if the police had made a charging decision about the new offences.

79. On 10 July, Mr Briant spoke to a legal representative at a solicitors' firm. (The Prison Service does not record such calls as they are legally privileged, and the solicitors declined to be involved in our investigation on the grounds of client confidentiality. However, it seems reasonable to assume that the conversation was about the further charges Mr Briant might be facing.) At 10.21am, Mr Briant spoke to his mother by telephone.

80. That day, the offender manager spoke to Mr Briant about his parole hearing. He said that Mr Briant was in good spirits and acknowledged that he had further offender work to complete, even though he denied the further charges against him. Mr Briant asked for his parole hearing to be cancelled. He told Mr Briant that if he was charged with the further offences, he would be eligible to take part in offender programmes. Mr Briant told him that he wanted to remain at Littlehey to complete any required programmes rather than move to a prison nearer home.

81. Mr Briant told the offender manager that he had spoken to his solicitor. The offender manager said that Mr Briant looked well and appeared calm. He said that he understood that he would remain in prison, regardless of the outcome with the new offences. Mr Briant expressed no thoughts of self-harm.

82. On 11 July, Mr Briant telephoned his mother. He told her that the offender manager had told him that he might be charged and that he would probably get a long sentence and might never be released from prison. He said, "I'm better in a box, I think". Mr Briant spoke to his mother again the following day and told her that he was a "let-down" to her. In a further call to his mother around 15 minutes later, Mr Briant again talked about "letting her down" before concluding the call by telling her to "be prepared for the worst".

83. A prisoner said that in the week before Mr Briant's death, he did not talk about self-harm but said that he was no longer coping as he was waiting for news from the police, which was putting pressure on him.

84. On 13 July, Mr Briant spoke to his mother again. He told her he had lost weight due to stress and said that he was not coping anymore. Mr Briant told his mother that being locked in his cell all day was "doing his head in".

85. During the day, Mr Briant briefly called his solicitor. (The call was not recorded).

86. On the morning of 14 July, Mr Briant spoke to his mother. He told her that he had thought about telephoning his probation officer to tell her the truth about what he had done. He asked for his mother's advice. She told him to use his "initiative". Mr Briant repeated that he thought he would be charged, he told his mother that he could not cope with spending the rest of his life in prison.

87. That morning, Mr Briant also made two telephone calls to his community offender manager, but she was not available to take his call.

88. On the morning of 15 July, Mr Briant spoke to his mother and told her that he had not heard anything further about his case and that he would call his solicitor later that morning.

89. That day, the community offender manager spoke to a member of the prison psychology team, who had signed the original PNA. The community offender manager told her that the independent psychology report had said that Mr Briant needed to complete more offender-related work and that Mr Briant would not be released at his forthcoming parole hearing as his risk was not considered to be manageable without further programme interventions. The community offender manager told her that they were waiting for an outcome to the latest allegations against him and that consideration was being made to refer Mr Briant to a therapeutic community prison. He asked for her opinion.

90. On the afternoon of 16 July, Mr Briant spoke to his mother. He told her that he was bored and had not heard anything about possible further charges and that if his case went to court, he would plead not guilty.

91. An officer met Mr Briant for a keyworker session. He told her that he was doing okay. She gave Mr Briant a letter about opting out of shielding for Covid-19, which he said he was thinking of doing.

92. Mr Briant's solicitor wrote to ask him to contact her urgently.

93. A prisoner said that Mr Briant told him that he would tell his solicitor everything that he had done as his life was over. He said that in the week before his death, Mr

Briant became increasingly anxious and appeared depressed but never talked of self-harm. He said he thought that Mr Briant was concerned about serving a long sentence.

94. A prisoner said that during the day, Mr Briant was anxious and said he did not want to be in prison anymore and could not cope with the pressure. He said Mr Briant would say these things every day.

95. On the morning of 17 July, Mr Briant called his legal representative. He then called his community probation office and spoke to a probation officer. Mr Briant asked her about the ongoing police investigation that had led to his recall to prison. She told Mr Briant that the office did not have access to this information and told him to speak to his community probation officer or the police about it. Mr Briant said he would call her the following week when she had returned to the office.

96. Mr Briant also telephoned his mother. He told her that he had spoken to the probation office who had no information about the police investigation or whether he would be charged, and that it was "doing his head in" as he wanted to know what was happening.

97. A prisoner and safer custody representative said that during the day, Mr Briant told him that the police would charge him with rape on 20 July. He said that Mr Briant seemed relieved that he had an answer to his questions and was adamant that he was guilty. He said that he told Mr Briant that it was for the courts to decide. He said that Mr Briant said nothing about self-harm. He offered to arrange for Mr Briant to speak to Listeners, but he declined.

98. The prisoner and safer custody representative told the investigator that, before prisoners were locked in their cells, he asked Officer A if he could "keep an eye" on Mr Briant because he had just been given the bad news that he would be formally charged the following Monday. He said that he asked the officer if Mr Briant could be monitored under ACCT procedures. He said that the officer told him that he had not heard anything formally from the "office" and he would try to keep an eye on Mr Briant. Another representative said he confirmed with the officer what the prisoner had said.

99. Officer A said he recalled the prisoner and safer custody representative telling him to "watch him", while pointing at Mr Briant, but that was all that he had said. The officer said that he interpreted the comment as Mr Briant possibly being "up to no good", such as stealing food packs left on cell door handles. He took no further action.

18 July 2020

100. At around 8.30am, Mr Briant went to the wing office and spoke to an officer. (She said she could not recall the conversation.) He also spoke to both prisoner and safer custody representatives on the wing and in his cell at about 8.36am. One representative said that he was concerned that Mr Briant was bubbly as he had previously not been cheerful, but he put this down to Mr Briant having been given an answer about court. Mr Briant asked both representatives about his offences and what sentence he might get, and the prisoners told him it would be for the judge

to decide but that if he had committed the offences, it might be better to plead guilty and speak to his solicitor.

101. At 8.44am, CCTV shows that Mr Briant spoke to an officer as she arrived on the wing. He then spoke to his mother by telephone and told her that he would only be let out of his cell for half an hour that day and that it was "boring". After a brief conversation about the weather, he told her that he loved her and would speak to her later, and then ended the call.

102. At 8.52am, Mr Briant went back to the wing office and spoke to two officers for around a minute. (Both officers said that they could not recall the conversation.)

103. A prisoner and safter custody representative said that as they were being locked up, Mr Briant asked if they would be let out of their cells again that day. He told him they would be let out to collect their lunch, but they would next be out for association the following day. At about 9.10am, Mr Briant was locked in his cell.

104. At 11.09am Mr Briant left his cell to collect his lunch, before an officer locked him in his cell. (The officer said she did not recall locking Mr Briant up but that he raised no concerns.)

105. At 3.50pm, a Physical Education Officer (PEO) escorted a nurse to Mr Briant's cell to give him his medication. The PEO looked through Mr Briant's cell door observation panel before he closed it again. He could not see Mr Briant and initially thought he was using the toilet. Seconds later, he looked again as he thought something was not right, and noticed a knot, wedged into the side of the door and saw that Mr Briant was suspended from a ligature.

106. The PEO shouted to colleagues for assistance and unlocked the cell door. Initially, the PEO and nurse struggled to open the door as Mr Briant was suspended behind it. The PEO immediately called a medical emergency code blue (used when a prisoner is unresponsive or has breathing difficulties). The nurse then squeezed through the door, removed the ligature which Mr Briant had wrapped around his neck, and moved him so that the PEO could get into the cell to help her. The PEO said that he noticed what appeared to be fabric conditioner on the cell's floor.

107. The nurse checked for signs of life but there were none. The nurse said that Mr Briant's lips were very blue, but that rigor mortis was not present. She started cardiopulmonary resuscitation (CPR).

108. Other officers responded promptly to the code blue. At 3.52pm, two nurses attended and brought an emergency response bag. The defibrillator, which an officer collected, was used but it advised no shock. One nurse, with the assistance of other officers, continued their resuscitation attempts until paramedics arrived and took over at 4.15pm. At 4.49pm, paramedics stopped CPR, and confirmed Mr Briant's death.

109. Staff found a note in Mr Briant's cell after his death. In the note, Mr Briant said that he had needed help for what he had done but had not got any, his life was a mess, he did not want to be in prison anymore, he hated himself, he was lonely with no friends, his life was one big mess, he could not cope anymore and it was time to end his life.

110. After Mr Briant's death, a DC told the investigator that she had not told Mr Briant that evidence had been submitted to the CPS, as the police were waiting for evidence before forwarding the case.

Contact with Mr Briant's family

111. On the afternoon of 18 July, the prison's lead chaplain and family liaison officer asked the police to break the news of Mr Briant's death to his mother, his next of kin. Littlehey offered funeral expenses in line with national instructions.

Support for prisoners and staff

112. The Head of Residence debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

113. The prison posted notices informing other prisoners of Mr Briant's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Briant's death.

Post-mortem report

114. The post-mortem examination found that Mr Briant died from hanging by ligature. Post-mortem toxicology results found no substances in Mr Briant's body.

Findings

Assessment of Mr Briant's risk

115. Prison Service Instruction (PSI) 64/2011 on safer custody requires that all staff who have contact with prisoners are aware of the risk factors and triggers that might increase the risk of suicide and self-harm and manage prisoners identified as at risk under ACCT procedures. The PSI lists several risk factors and states that potential triggers should be continually assessed. We have, therefore, considered whether staff at Littlehey should have recognised Mr Briant as at risk of suicide and started ACCT monitoring.

116. Mr Briant arrived at Littlehey with a number of risk factors: his offences were sexual and against family members, he was an IPP prisoner, he had been recalled to prison, he was facing possible charges for further alleged offences, and he was anxious that had not been able to address his offending through a rehabilitation programme, which he had wanted to do but was not eligible for. However, when asked, he denied thoughts of suicide and self-harm.

117. In the months and weeks before his death, Mr Briant appears to have become increasingly distressed and anxious about the possible further charges which had led to his recall, and it seems likely that this contributed to his decision to take his life. Other prisoners told us that Mr Briant discussed his offences, further charges and his police interview with them daily, and officers warned him about doing this. We also note that he discussed thoughts of suicide and self-harm with two other prisoners. He told one prisoner that he would kill himself if charged and another prisoner said that Mr Briant had previously made scratches to his arms. Neither of these prisoners nor Mr Briant told staff about this.

118. Prior to the pandemic lockdown, Mr Briant had weekly sessions with his key worker. The last took place on 16 March. He appears to have shared some of his concerns with her (for example, about wanting to be closer to his family) and, on 17 February, told her that he was stressed following his police interview because of the possibility of further charges.

119. If the keyworker had continued to see Mr Briant regularly, it is possible that she would have become aware that the possibility of further charges was a significant issue for Mr Briant and she may, therefore, have considered opening ACCT procedures. We cannot know whether this would have happened as other prisoners told us that Mr Briant did not trust prison officers, but she appears to have had a good relationship with Mr Briant.

120. However, once the restricted pandemic regime was in place, there is no evidence that Mr Briant told prison officers about his concerns or that they were even aware that he may be facing further charges. We are concerned that there is no evidence that he had any meaningful exchanges with prison officers at all. We note that the daily checks were all recorded in exactly the same, very generic terms:

> "Currently in isolation, in accordance with the NHS guidelines due to personal medical conditions or those of his cell mate. They are currently following all isolation procedures. Support is continually offered by staff

> through a minimum of 5 checks daily, communication available 24/7 and distraction packs. This individual has not presented any issues at the time of this welfare entry. This individual has not informed any staff of any symptoms at this stage. All above confirmed by day staff."

This does not suggest that any meaningful engagement took place during these checks or that they were an opportunity for Mr Briant to share his concerns with staff.

121. Although there was also a weekly welfare check, the records suggest these did not provide an opportunity for a meaningful discussion either: the entries are brief and Mr Briant is recorded as being 'fine' or 'OK', or as having presented 'no issues', with the occasional mention that he was 'bored'. At the last such check, two days before he died, the officer recorded that Mr Briant "said he's doing okay in himself at the time and didn't raise any particular issues with me".

122. We note that a prisoner says that he told Officer A to keep an eye on Mr Briant on the evening before his death because he was concerned about his welfare. The officer accepts that the prisoner asked him to keep an eye on Mr Briant, but that the prisoner did not say he was concerned about Mr Briant's welfare. We have no way of knowing whose account is the more accurate.

123. We also note that CCTV shows that, on the day of his death, Mr Briant spoke to three officers. The officers say they cannot recall these conversations and we cannot, therefore, say whether Mr Briant spoke about his anxieties or whether they simply discussed routine matters.

124. We have found no record that Mr Briant shared his concerns about the possible further charges with prison staff in the four months before his death, or that he gave them any reason to consider that he was at imminent risk of suicide. On this basis, we are satisfied that staff could not reasonably have been expected to have foreseen or prevented his death.

125. However, we are concerned that the very restricted pandemic regime meant that staff had no meaningful contact with Mr Briant. In normal times, key worker sessions would have continued to take place and wing staff would have had regular interactions with him, and it is therefore possible that they may have become aware of his increased risk. However, we cannot know whether Mr Briant would have shared the depth of his anxieties with staff even in normal times.

126. It possible that the very restricted regime and the long periods Mr Briant spent alone in his cell, without contact with either staff or other prisoners, affected his mental health and contributed to his low mood and his feelings that he could not cope in prison any longer.

127. We recommend:

The Governor should ensure that staff understand the importance of having meaningful conversations with prisoners where possible when carrying out welfare checks during the restricted regime.

Police interview

128. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners says that events such as attending court, sentencing at court or being questioned by police may have a significant impact on a prisoner's health. PSI 07/2015 on early days in custody says that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance.

129. We are concerned that there is no evidence that anyone at the prison spoke to Mr Briant after his police interview to assess whether he was at an increased risk of suicide or self-harm or needed to see the prison's mental healthcare team. Although PSI 07/2015 does not mention police interviews, common sense suggests that such interviews may raise stressful matters, including the possibility of further charges.

130. We understand that confidentiality means the exact nature of a police interview would not be disclosed to staff, unless a prisoner consents to sharing the information. However, prisoners should be given the opportunity to discuss any concerns they have. Although we accept that this might not have led to staff starting ACCT monitoring and that the interview took place months before Mr Briant's death, it was nevertheless a missed opportunity to identify any increased risks. We make the following recommendations:

The Governor and Head of Healthcare should ensure that prisoners are screened after an interview with police to assess their risk of suicide or self-harm.

Offending programmes issues

131. Mr Briant was concerned that he was not able to take part in offender rehabilitation programmes which he considered would have enabled him to progress towards parole. The PNA concluded that his risk was not high enough to qualify for such programmes, despite probation staff raising concerns about this.

132. Although Mr Briant was concerned about possible further police charges, there is evidence that his sentence progression as an IPP prisoner and his inability to access offending programmes played on his mind in the months before his death and may have been a contributory factor in his decision to take his life.

133. HMIP commented on the availability of offender rehabilitation programmes at Littlehey. They expressed concern that there were not enough opportunities for prisoners who did not meet the threshold to participate in offending behaviour programmes, and that offender supervisors provided insufficient one-to-one structured offending behaviour work to motivate and progress these prisoners through their sentence or reduce their risk.

134. The prison responded to HMIP's recommendations on this subject by setting out a plan of action to be completed by December 2020. We have not, therefore, made a recommendation of our own.

Clinical care

135. The clinical reviewer considered that the physical care that Mr Briant received was of a good standard and that the mental health care he received was of a reasonable standard. She found that both aspects were at least equivalent to that which Mr Briant could have expected to receive in the community. However, the clinical reviewer made a number of recommendations in her review which the Governor and Head of Healthcare will need to address.

Inquest verdict

136. The inquest hearing into the death of Mr Briant concluded on 8 November 2024. It confirmed the medical cause of Mr Briant's death as hanging by ligature. The inquest concluded that Mr Briant died by suicide.

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