A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the circumstances surrounding the death of a man at HMP Littlehey in August 2012

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report of an investigation into the circumstances of the death of a man at HMP &YOI Littlehey in August 2012. He was found hanging in his cell. He was 45 years old. I offer my condolences to those affected by his death.

The investigation was led by an investigator. A clinical reviewer carried out a clinical review of the man's healthcare at Littlehey. The prison cooperated fully with the investigation.

The man's partner killed herself in September 2010, a few days after his arrest for offences against her 11 year old daughter. He attempted suicide on the day he learned of his partner's death. During his time in custody he frequently expressed suicidal thoughts out of guilt at his actions and because of his partner's death. In March 2012, he attempted suicide again and was assessed as at serious risk of killing himself at some point. He transferred to Littlehey in June 2012. In July, he was given a single cell, although it had previously been recognised that sharing a cell was a protective factor. He managed to find a ligature point in the cell, although it was regarded as a 'safer cell'. After his death a note was found in which he said that he could not live with the knowledge of what he had done and the effect this had had on his partner and children.

He was assessed by the mental health in-reach team at Littlehey and referred for a low intensity programme for treating people with depression and anxiety. The clinical review is critical of this decision and raises a concern about suicide and self-harm risk assessment and planning in the mental health team. However, it is not possible to say whether earlier, higher level intervention from the mental health team might have changed the outcome. At the time of his death, he was managed and supported under suicide and self-harm prevention procedures. While I am critical of the decision to allocate him a single cell, ultimately it is very difficult to prevent someone who makes a determined decision to kill himself from carrying out that plan, without making living conditions so restrictive as to be inhumane.

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 **March 2013**

CONTENTS

Summary

The investigation process

HMP&YOI Littlehey

Key events

Issues

Recommendations

SUMMARY

1. The man was arrested and charged with the rape of his 11 year old stepdaughter in September 2010. His partner, the victim's mother and the mother of his own children, died by suicide in the family home three days later. The children and stepchildren were taken into care. He was sentenced to 11 years six months imprisonment.

2. On 27 September 2010, while on an open ACCT (Prison Service suicide and self-harm prevention procedures), the man attempted suicide by hanging but was stopped by watching staff. He frequently told prison staff that he felt suicidal because of his guilt over his partner's death. In March 2011, another ACCT was opened when he said he felt suicidal at the six month anniversary of his partner's death. He said that every time he moved cell his first thought was how he would kill himself in it.

3. In January 2012, he told a psychiatrist in Brixton he had tested three ligature points in his cell. On 17 March, in a single cell in the healthcare centre in Brixton, he attempted to hang himself from shoelaces attached to an air vent above his cell toilet. On 22 March, a consultant forensic psychiatrist concluded that he was at serious risk of suicide.

4. In May 2012, he was arrested and interviewed about new evidence that he had also raped his younger stepchild and his own children. On 12 June 2012, he was transferred to Littlehey prison. An ACCT was opened on 24 July, when he said he continued to have suicidal thoughts. He was moved from a shared cell to a single 'safer' cell the same day.

5. The man continued to voice thoughts of suicide and told staff he carried a noose with him most of the time. At the time, he worked in the carpentry workshop (he was a carpenter by trade) and expressed an interest in working on a future building project in the prison.

6. In August, at about 6.20am, the night patrol officer was unable to get a response when he checked the man. He alerted the orderly officer and together they opened his cell and found him hanging from a sheet attached to a nail stuck in the air vent above his toilet. Staff and paramedics attempted to resuscitate him, but he was pronounced dead at 7.15am.

7. He left a note saying he could not bear the guilt he felt over his partner's death and what he had done to his children. He said he deserved to die and that the staff could not have done any more for him. We make four recommendations about risk assessment for suicide and self-harm, local guidance on prisoners at risk sharing cells, ACCT case managers and regular checks of designated safer cells.

THE INVESTIGATION PROCESS

8. We were notified of the man's death on 9 August 2012. The investigator issued notices to staff and prisoners at Littlehey informing them of the investigation and inviting anyone with information to contact her. Eight prisoners contacted her in response, but one later chose not to be interviewed.

9. The investigator visited Littlehey on 15 August and met the Governor. She visited the cell where the man died and collected copies of his prison records and other relevant documents. She spoke to the prison family liaison officer and met the prison's safer custody team. She also spoke to a member of the Independent Monitoring Board.

10. The local PCT commissioned a clinical reviewer to carry out a clinical review of the man's medical care at Littlehey. The investigator and clinical reviewer interviewed four members of staff together. We received the final report on 17 December.

11. The investigator visited Littlehey three times between 19 September and 22 October and interviewed 13 members of staff and seven prisoners. At the end of each day of interviews, she met the Governor or Deputy Governor and afterwards sent written feedback about the progress of the investigation and emerging issues. She also spoke to one member of staff by telephone in December 2012.

12. Despite extensive efforts by the prison and police to contact the man's relatives, no member of his family was traced and therefore they took no part in this investigation.

13. The Coroner asked for an early sight of the key events section of this report in order to compile a list of witnesses for the man's inquest. A copy of the key events and two clinical reviews were sent to the Coroner and HMP Littlehey on 19 December 2012.

HMP&YOI LITTLEHEY

14. HMP&YOI Littlehey is a category C prison in Cambridgeshire holding up to 726 adult male prisoners and 480 young adults in an adjoining site. The NHS provides GP services, Monday – Friday. A GP service and local out of hours medical service covers periods when doctors and nurses are not on duty. Primary mental health and mental health in-reach services are provided by the NHS. The mental health team is supported by the NHS scheme, Improving Access to Psychological Therapies (IAPT) and two workers from the mental health charity MIND.

HM Inspectorate of Prisons

15. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Littlehey in October/November 2011. HMIP described a generally safe, stable and, in some areas, very effective prison with a strong commitment to learning and skills. The quality of ACCT documentation was variable with a lack of multi-disciplinary reviews and some poor care planning. However, vulnerable prisoners told HMIP that they felt well cared for. Death in custody reports were discussed at monthly safer custody meetings and action plans had been implemented. A full Listener team operated on the adult site. (Listeners are prisoners trained by the Samaritans to provide confidential support to other prisoners in distress.) Prisoners were positive about relationships between staff and prisoners and thought highly of the personal officer scheme.

The Independent Monitoring Board (IMB)

16. Every prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who monitor standards to help ensure that prisoners are treated fairly and humanely. The IMB report for 2011-2012 (the latest available) commented that 88.5% of the adult population were sex offenders, many of whom denied their offences which meant that they were unable to participate in group therapy sessions. The Board was also concerned about the delivery of health services and reported that waiting times for dental and optician appointments had increased, the provision of locum doctors was inappropriate and the pharmacy contract was inadequate. The Board commented favourably on the safety of prisoners at Littlehey and an improvement in staff prisoner relationships.

Previous self-inflicted deaths at Littlehey

17. The man's death is only the second apparently self-inflicted death at Littlehey since April 2008. In his review, the clinical reviewer repeats a recommendation about the implementation of the Care Programme Approach and clinical risk assessment policies from his clinical review of the previous one in June 2011.

ACCT (Assessment Care in Custody and Teamwork)

18. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations and interactions are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed. Other checks should be irregular to prevent the prisoner anticipating when they will occur.

19. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent and pressing issues, set achievable goals to help resolve the issues and identify who is responsible for achieving each goal. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

Safer cells

20. The definition of a safer cell is contained in Prison Service Instruction 17/2012 Certified Prisoner Accommodation. Annex B paragraph 12 states:

> "The design of safer cells has several features which can assist staff in the task of managing those at risk from suicide or self harm by ligaturing, such as specially designed furniture and fixtures which are manufactured and installed to make the attachment of ligatures very difficult, and prevent access to window bars via specialist approved window design. Safer cells are designed not only to minimise ligature points, but also to create a more normalising environment. They have been found to be more durable, easier to maintain and easier to search.
>
> "Safer cell designs are not intended to remove the need for appropriate operational processes. They do not deal with the problems underlying a prisoner's self-harming or suicidal behaviours, and so safer cells can only complement (i.e. not replace) a regime providing individualised and multi-disciplinary care for at-risk prisoners."

Care Programme Approach (CPA)

21. The Care Programme Approach is the process of identifying the care needs of people with a mental illness and is for anyone in touch with secondary mental health services. It provides an organised way of assessing all of a person's needs and developing a single care plan to ensure those needs are met.

Improving Access to Psychological Therapies (IAPT)

22. IAPT is an NHS programme offering interventions for treating people with depression and anxiety disorders. It provides psychological assessment to the point of referral and grants access to an individual therapy programme.

KEY EVENTS

23. The man was born in the UK but grew up in South Africa. He moved to the UK permanently aged 22 and worked as a carpenter. He met his partner in 2005 and they had two children together. His partner had two daughters from a previous relationship. On 16 September 2010, he was arrested after his partner contacted the police. He was subsequently charged with three counts of rape against his eldest stepdaughter who was 11 years old. He was remanded to HMP Pentonville. On 19 September, his partner killed herself at their home and their other children were taken into care.

24. He was told the news of his partner's death the same day and an ACCT document was opened after he made small cuts to his arm and told staff he felt suicidal. He was placed on constant supervision (when the prisoner is watched at all times in his cell by staff). On 27 September, witnessed by the member of staff watching him, he tried to hang himself. The member of staff intervened and he sustained no injury. In late October, a consultant forensic psychiatrist at Pentonville prescribed him the anti-depressant drug mirtazapine. The ACCT document was closed on 20 November 2010 as his mood was judged to have improved, he was under the care of the mental health team and he was working full time.

25. On 20 December 2010, the man was sentenced to 11 years six months imprisonment. He transferred to HMP Wandsworth on 7 March 2011, to complete the sex offender treatment programme (SOTP). On 16 March 2011, another ACCT document was opened after he told staff he was feeling depressed and suicidal because it was six months since his partner's death. He said he felt guilty about her death and depressed that he had no contact with his children. He said he frequently thought about hanging himself and when he moved to a new cell his first thought was how he could kill himself. The ACCT was closed on 31 May because his mood had improved and his caremap was complete. He had instructed a solicitor to try to re-establish contact with his children and was feeling positive about this. He remained under the care of the mental health in-reach team (MHIRT – a specialist secondary care team employed to provide mental health care in prisons or prisoners with a severe and enduring mental illness).

26. On 8 December 2011, another ACCT document was opened at Wandsworth after he said that he felt very low after receiving news that his children might be adopted. He transferred to HMP Brixton in January 2012. On 23 January, he told a psychiatrist that he continued to have suicidal thoughts and had tested three ligature points in his cell to see if they would take his weight. He told her he was confident he could not be stopped if he wanted to kill himself. He was placed on constant supervision in a gated cell (a special cell without a normal door allowing staff to watch the prisoner at all times) for a crisis period of 24 hours. He was then moved to a standard cell in the healthcare centre and observed intermittently.

27. At 3.45am on 17 March, the man was found attempting to hang himself with a noose made from shoelaces and attached to an air vent above his toilet. He

said he was planning to hang himself as it was the 18 month anniversary of his partner's death. He was constantly supervised again. On 22 March, a consultant forensic psychiatrist concluded that he was at serious risk of self-harm and suicide. She agreed to support his transfer to a medium secure hospital for assessment and treatment.

28. The man moved to HMP Wandsworth on 23 March, as Brixton had six prisoners requiring constant supervision but facilities for only five. The ACCT opened in Brixton in December continued. On 13 April, a prison doctor reviewed him because a medium secure hospital bed had become available. The doctor found that he was not depressed and the man said he did not want to transfer to hospital. He had settled at Wandsworth in a shared cell and had regular employment in one of the workshops. His ACCT was closed on 17 April. He was described as being in a positive frame of mind and enjoying his job in the workshop.

29. A categorisation review board reviewed the man's security category on 27 April. The board noted he had successfully completed SOTP and had demonstrated a continued willingness to engage with offence related courses. They decided to re-categorise him as a category C prisoner and recommended that he transfer to a category C training prison.

30. On 17 May, he was taken to a police station at the request of a police child protection team. He was arrested and interviewed about new evidence that he had raped his younger step-child and his own children.

31. The man moved to Littlehey on 12 June. His person escort record (PER – a form highlighting risk factors that travels with every prisoner when they move between prisons or go to court) noted that an ACCT document had been closed in April.

32. He completed his induction at Littlehey on 12 June. He gave no next of kin details, said he was not in contact with his family and declined the offer of a telephone call in reception. His induction interview sheet shows he indicated that he had a history of self-harm and had current thoughts of self-harm. He was allocated a cell on E wing.

33. On 13 June, a community psychiatric nurse at Wandsworth telephoned Littlehey and gave a verbal handover of the man's history of care, treatment and risk of suicide and self-harm. This information was passed immediately to the mental health in-reach team and they decided to assess him in due course. A Healthcare Assistant (HCA) visited him on his wing the same morning to tell him that the MHIRT were aware of him and would assess him. He told her he was unhappy as he had not received his medication and he wanted to be in a single cell. She ascertained that he would be receiving his medication that lunchtime. She contacted the psychiatric nurse, who told her that he had shared a cell in Wandsworth because they believed this reduced his risk of suicide and self-harm.

34. On 18 June, the man saw the HCA for his mental health triage assessment. He told her that he was not sleeping well and rated his mood as two out of ten. He said he heard voices and said he was very anxious. He did not like sharing a cell or being in a crowd and rocked himself for comfort. He said he had lost a stone in weight while in prison. His thoughts of suicide got worse from the middle of each month. He said he had made plans to kill himself before and frequently made nooses.

35. On 19 June, he told a locum prison doctor that although he was happy at Littlehey he had thoughts of hanging himself. The doctor thought that his statement was belied by his manner as he appeared in good humour. The doctor therefore raised what he regarded as minor concerns about his statement with the MHIRT who told him they planned to see him on 10 July. The doctor was satisfied that this was sufficiently timely.

36. On 27 June, the man made an application to the Offender Management Unit (OMU) for two child contact application forms, which he completed and returned on 18 July.

37. On 6 July, his case was discussed by the MHIRT. They decided to refer him to IAPT (Improving access to psychological therapies – an NHS programme for people with depression and anxiety) step two (low intensity) for work on his low mood.

38. On 24 July, a visiting consultant forensic psychiatrist saw him for a review of his medication and noted his history of attempted suicide. The man told him that he continued to think about his offence and the death of his partner. He said that sharing a cell was a major cause of stress and, allied to his difficulty sleeping, this increased his risk of self-harm. The psychiatrist assessed his risk of suicide as "moderate". At interview the psychiatrist explained that he was not immediately worried that he was at imminent risk of attempting suicide. He recommended opening an ACCT and that the MHIRT complete a detailed suicide risk assessment and management plan under the care plan approach (CPA) before he reviewed him again in four to six weeks.

39. The psychiatrist opened the ACCT himself and completed the 'concern and keep safe' form. He wrote that the man had a history of suicide attempts in prison and continued to think about his offence, his guilt and about killing himself. He said that the man's ACCT reviews should have input from the mental health team. He recommended that he have a single cell on medical/psychiatric grounds and set the frequency of observations at twice an hour.

40. After speaking to the man, the psychiatrist and the Head of the mental health team went to C wing and told staff that he should be moved to a single cell as a matter of urgency, but there were no single cells available on C wing. A Senior Officer (SO) was on duty as the B wing SO that day. He said he received a phone call from the Head of the mental health unit at about 11.55am telling him that the man needed to be moved urgently to a single cell. He said that the only single cell available on B wing was the safer cell

B3-15. Just after midday the man was brought to B wing with his ACCT document. The SO showed him the safer cell and spoke to him on his own. He said that he seemed very calm and did not seem to be bothered which cell he was in.

41. After going to C wing, the psychiatrist reviewed the man's electronic medical record and read the entries made by the community psychiatric nurse and the HCA on 13 June. He said he then realised that he had been managed in a shared cell at Wandsworth because this was thought to reduce his risk of attempting suicide. He went straight to B wing and told the SO that he should not be in a cell on his own after all. The SO was unhappy about moving another prisoner in with him. He offered him the opportunity to have a Listener in the cell with him but he said he did not want one. As the wing was serving lunch at the time the SO decided to keep him on his own but on an increased number of observations (every ten minutes) until he could be properly reviewed by an ACCT assessor.

42. Further discussions between the psychiatrist, the Head of the mental health team, a doctor and the SO took place at 1.45pm. At interview the psychiatrist and the Head said that they had wanted the man to be put in a shared cell but the SO had told them that it was not possible. Eventually, after much discussion, they agreed that he could be kept in a cell on his own as long as he was in the safer cell and on an open ACCT. All three members of staff then went to his cell and explained the plan to him. They agreed that he would be observed twice every hour. The SO said he would arrange an ACCT assessment either that afternoon or the next day.

43. The SO told the investigator that he had been asked to move another prisoner in with the man to reduce his risk of suicide and self-harm, but he did not think another prisoner should be relied upon to prevent him harming himself. He did not think it was fair to put another prisoner in that position. He said he was concerned as well, that he would be putting that person in danger. He did not know him and said that one minute he was told it was urgent that he had a single cell and the next minute he was told he needed to put someone else in with him. He said he had offered to put a Listener in with him in the short term that day but he had not wanted one and he could not force one on him.

44. The SO spoke to him again later in the afternoon. He said he had a long chat with him and talked about his background. The man told him that 95% of the time he carried a noose with him. He said he did not have one then but could make one whenever he chose. He was offered the Samaritans phone (a cordless telephone with direct access to the Samaritans help line) but declined.

45. Officer A completed the man's assessment interview at 6.35pm. He told him he felt incredibly guilty about his partner's death and had constant thoughts of suicide by hanging. He said he had attempted suicide in the past, twice being discovered by staff and on another occasion the ligature broke. However, he said that the hope of seeing his children again gave him reason to live. He

also found being busy in the workshop helpful. He said the 16th of every month was a bad time for him as this was the date on which his partner killed herself.

46. The SO and officer completed an action following assessment review. The man told them he rated his thoughts of suicide or self-harm at three out of ten. Observations remained at twice every hour.

47. He had his second ACCT review the next day on 25 July. The B wing manager (and nominated ACCT case manager), the Head of the mental health team, the mental health key worker responsible for the man's CPA and the man all attended. He said he carried a noose around with him. When challenged he said he did this "occasionally". He agreed to be searched when he went to and from the wing to work and was told that his cell would also be searched. A caremap was drawn up. He was referred for further assessment by a psychiatrist and the MHIRT were tasked with arranging grief/bereavement counselling for him. He was given the task of continuing to engage with his carpentry course in workshop five. Wing staff were required to search him and his cell frequently for nooses.

48. Between 25 and 28 July, no concerns were raised on the man's ACCT record. His personal officer spoke to him on several occasions. On 29 July, he told an officer that he had had disturbing dreams after which he found it hard to get back to sleep. The officer said he appeared upbeat and told him that he had just borrowed a lot of books from the prison library.

49. The man attended a third ACCT review on 31 July with a SO, officer and the mental health key worker. The record shows that his situation had not changed. He said he continued to have thoughts of suicide by hanging and agreed to interact with staff about this. Despite this his on-going record described him as reasonably cheerful. The mental health key worker wrote on his medical record that he was being searched for nooses every time he left or returned to the wing. He told them in his review that he had a noose with him that he had brought from a previous prison. He was asked to hand this to staff but refused and said that if he did he would simply make another. He said that the court case about his access to his children was expected in November and that if he was denied access to his children, he would have nothing to live for.

50. The mental health key worker saw the man the next day on 1 August to discuss his CPA mental health assessment. He told her that the only things keeping him safe were the prospect of gaining access to his children and going to work to keep busy. He said he would like his continual suicidal thoughts to "go away".

51. The same day the mental health key worker spoke to the community psychiatric nurse at Wandsworth. The nurse told her that the man was on the MHIRT caseload there because of his suicidal ideation and the complexity surrounding it. He was in a shared cell of up to three people at Wandsworth because he had attempted suicide in a single cell. At Wandsworth he had

been monitored through the ACCT process and the nurse saw him fortnightly. He did not have a severe and enduring mental illness, which was the usual criteria for MHIRT cases, but because of his suicidal thoughts the MHIRT monitored him to support the prison in managing him.

52. On 2 August, the man had a long chat with his personal officer Walsh. He told the officer that he was trying, through his solicitor, to get contact with his children. He said he had low times when he thought about his partner and the reason for her death. The officer reminded him of the support available and that he was ready to talk whenever he was on duty. Later that day, he had a visit with his solicitor. The officer checked on him when he returned to the wing and he said he was fine. The next day, an officer told him that the Governor was asking for prisoners with carpentry and bricklaying experience for a prison project. He told the officer that he was very interested and seemed "buoyant" at the prospect. He put in an application form expressing his interest the same day.

53. On 6 August, he attended another ACCT review with a SO, an officer and the mental health key worker. He told the review that he still had suicidal thoughts and knew about the support available to him. His level of risk was described as raised but his observations were reduced to one an hour. The key worker wrote on his medical record that he told the review he was keeping himself busy working in the carpentry workshop and had read a lot over the weekend. He asked about the prospect of moving to a single cell on a different spur of B wing. After the review the key worker asked the officers whether it was likely he would be moved to a standard single cell on B wing. They told her that it was not because he was a C wing prisoner and was only on B wing because he was in the safer cell. She explained to them that he had previously attempted suicide in a single cell.

54. The key worker saw him after his review and showed him the CPA mental health assessment she had written. He read through it and agreed it and said he was happy for the officers to have a copy on the wing. The plan provided that he be closely monitored by the MHIRT and reviewed by a psychiatrist every four to six weeks. In addition he would be managed under ACCT with multi-disciplinary reviews. His crisis plan identified the warning signs that his risk was increasing. These were isolating himself, not eating, poor sleep and neglecting his personal hygiene. The CPA noted that his mood might drop and his risk might increase around the 16th of each month because this was the date on which his partner had died.

55. On 8 August, the man had an altercation with another prisoner in the workshop. According to other prisoners he asked a prisoner to repay a tobacco debt. When the other prisoner could not pay him, he took a box the man had made from him. The other prisoner then threatened him with a Stanley knife and words were exchanged. Neither of the workshop instructors witnessed the incident with the knife. The Security Department was informed and an officer was stationed at the door when the prisoners went back to their wings for lunch. The other prisoner was kept on his wing for the afternoon session. Later that afternoon, the other prisoner confronted him when he was

walking back to his wing and told him they would ‘sort it out’ during the exercise period (when prisoners are allowed to spend time in the open air) that evening. After work he returned to B wing but did not go outside during the exercise period.

56. An officer spoke to him and wrote an entry in the wing observation book. He said the man had told him that the altercation in workshop 5 was over tobacco owed to him. He said he did not feel that the situation would escalate but would tell staff if it did. The officer wrote that the security department were aware of the incident.

Day of the incident

57. An Operational Support Grade (OSG) was on duty as night patrol officer on B wing on 9 August. At 5.18am, he made his hourly ACCT check and saw the man asleep in bed. He was satisfied that he was breathing and observed movement. At 6.22am he checked him again but this time he could not see him in bed. He said he saw him apparently standing over his toilet leaning on the wall.

58. The OSG said he knocked on the cell door and called out to him, but could not get a response. He went to the office and telephoned the gate to speak to the night orderly officers. He asked someone to come over as soon as possible because he could not get a response from the man.

59. A SO was on duty as night orderly officer and went straight to B wing, about two minutes walk away. He could not get a response from the man and then he and the OSG went into the cell. They found that he had tied a noose around his neck and attached it to the vent above his toilet. Together they cut the noose and laid him on the floor. The OSG radioed for emergency assistance and officers responded. The SO radioed for an emergency ambulance to be called.

60. The SO, an officer and the OSG gave the man cardiopulmonary resuscitation (CPR). Three officers were deployed to make sure that there was no delay with the ambulance getting into the prison. A defibrillator was attached to the man, but it did not advise a shock. The control room log shows that the first emergency call was made at 6.27am and the ambulance was requested at 6.30am. The ambulance arrived at the gate at 6.43am and paramedics reached the cell at 6.48am. They took over CPR but pronounced the man dead at 7.14am.

Prisoner support

61. All prisoners with open ACCT forms, or had recently had them closed, were reviewed the same day. Listeners were sent to B wing to support any prisoners who were affected by the man’s death. The safer custody team visited prisoners who were known to have been adversely affected by other deaths at Littlehey. Prisoners were informed of the man’s death by notices throughout the prison. The prisoners in workshop five were told during class

the same morning. A number of them were very upset, because of the altercation involving him the previous day. A Listener on the carpentry course spoke to a number of them and got the support of other Listeners. A memorial service for the man was held later in August.

Staff support

62. A hot debrief for all staff involved in the emergency incident was held later that morning. The prison's care and welfare team attended and offered their support. The Governor provided sandwiches and offered to organise and pay for taxis home for anyone who needed one.

Other actions

63. After the man's death, the prison's safer custody team reviewed the designation of B3-15 as a safer cell. They found that since the cell had been passed as a safer cell, a new smoke detector had fixed to the wall, next to the door. This was removed as an obvious ligature point and cell B3-15 was not used as a safer cell until this was done.

64. The safer custody team also reviewed the location and make up of the emergency response equipment. This was found to be complete. All staff involved had cut down tools and protective face masks with non-return valves.

Documents in the man's cell

65. The man left a letter for staff, his will and a letter and matchstick models for his children in his cell. In his letter for staff he said that he felt he did not deserve to live. He said he could not live with what had happened to his partner and his children and could not accept what he had done. He said the incident in the workshop had made him realise how desperately he wanted to die because he had been disappointed that the other prisoner had not stabbed him. He added that his death was no fault of the officers – they had been "exceptional" and had bent over backwards to help him and ensure he was all right. He thanked them all.

66. The man had made an entry of "police station" on his calendar for 9 August.

Family liaison

67. A prison family liaison officer (FLO) was appointed. The man did not give the name of his next of kin when he arrived at Littlehey. His father was thought to be in South Africa, his mother in Canada and a brother was possibly in Thailand, but no one knew their names or even the towns they lived in. The police tried to contact a sister believed to be living in London but without success. The FLO contacted the social worker for the man's children and stepchildren. His letter and matchstick models for his children and his Will were sent to his solicitor.

68. In the absence of any family the prison organised and paid for the man's funeral. Staff attended the service. The prison paid for a plaque at the crematorium so that there would be a memorial for family if they were found in the future.

ISSUES

Clinical review

69. In addition to reviewing the man's prison medical record and conducting joint interviews with the investigator, the clinical reviewer was able to refer to a clinical review into his mental health at Littlehey. This was conducted by another clinical reviewer on behalf of the local PCT, the providers of mental health services at Littlehey.

70. The second clinical reviewer found that the man was a high risk prisoner who had attempted to take his own life by hanging on at least two occasions. His prison medical recorded the assessment by several doctors at previous prisons that he was at high risk of killing himself. All this information was available to the MHIRT at Littlehey. She found that the mental health team at Littlehey identified some of the risks presented by him and a need to review the risk information, but no named healthcare lead was assigned this task and no timescales were set. This meant that there was no formal initial healthcare risk management plan to communicate key risk issues to the prison staff.

71. The clinical reviewer found that the decision by the MHIRT on 6 July to refer the man to IAPT was inappropriate in the light of the information gathered by the HCA on 18 June at his mental health triage assessment. This further delayed MHIRT assessment and intervention. The MHIRT did not become involved until the psychiatrist reviewed his medication on 24 July and recommended that he be managed by the MHIRT using the CPA and ACCT.

72. She found that the CPA risk management plan written by mental health key worker did not contain relevant information about the man's previous suicide attempts. She said this information should have been incorporated into the risk assessment. The detailed suicide and risk assessment asked for by the psychiatrist on 24 July had not been prioritised or completed despite the key worker's belief that the man would succeed in killing himself at some point in the future. The information that he had made a previous suicide attempt in March by attaching a ligature to a ventilation grill was contained in the medical record which was not directly passed on to wing staff. (We note it was available in his NOMIS record and previous ACCT document, both of which were accessible to wing staff.) The clinical reviewer made seven recommendations to the local PCT, which have been translated into an action plan.

73. The first clinical reviewer's opinion is that the man had exhibited past suicidal behaviour, had risk factors and intended to take his own life. There were delays in him seeing the MHIRT at Littlehey. When completing his CPA and crisis plan his key worker, the mental health key worker did not assess all the facts from his notes. A detailed suicide risk assessment was not completed. He agreed with the second clinical reviewer that, had there been a detailed suicide risk assessment and had that translated into better risk management planning, "then that may have helped to reduce both the opportunity and means for the man's suicide".

74. The clinical reviewer said that the man had received a considerable input from staff while in prison but his suicide risk assessment and care planning by the healthcare team had not been optimal. He was the clinical reviewer in a previous death at Littlehey in June 2011 and concluded in that case that the healthcare process for formally assessing and documenting suicide risk was not adequate and the translation of risk assessment into action plans was lacking. He noted that the local PCT have identified problems with the suicide risk assessment and care planning process with patients in the community and are reviewing their processes.

75. It is not possible to say whether earlier intervention from the MHIRT and a detailed suicide risk assessment would have changed the outcome in this case. The man killed himself at a time when he was on an open ACCT, in a safer cell and after considerable input from staff. The ACCT process is a multi-disciplinary procedure of which the input of healthcare staff where relevant is just one part. He did not kill himself during the period 12 June to 23 July when healthcare had not identified his risk, though we know from his assessment on 18 June that he had been finding it hard to sleep and rated his mood at only two out of ten. Eventually it was as a result of an assessment from the psychiatrist that an ACCT was opened.

76. Evidence from other prisoners who knew the man is that they were surprised and shocked by his death. They said he appeared to be his usual self and was looking forward to taking part in a planned building project in the prison. Nevertheless, we consider that the HCA's triage assessment of 18 June should have prompted swifter action. His case was not discussed for some two and a half weeks after this, and even then he was referred to IAPT for low intensity work on his low mood. We are also concerned that that this is the second case at Littlehey in which suicide risk assessment and planning by the healthcare team has been criticised as inadequate. In the light of the findings of both clinical reviews we recommend:

    The Head of Healthcare should ensure that the mental health team completes suicide risk assessments promptly, that risk decisions are made on all the available information from a prisoner's medical record and identified risks are properly documented and shared with staff working directly with the prisoner concerned.

The man's ACCT

77. At their last inspection in November/December 2011, HMIP found that the quality of ACCTs at Littlehey was variable. Specifically they found that reviews were not multi-disciplinary and care planning was poor. In the man's case the psychiatrist specified that his reviews should have input from the mental health team and the mental health key worker attended each one except the first one held on the day the ACCT was opened. The caremap was satisfactory, involving a CPA led by the key worker, and there were a number of very good quality entries on the on-going record. However, the man's four case reviews were each chaired by a different case manager.

Guidance for ACCT is that effective case reviews should have the same case manager present whenever possible. We consider that consistent case management is important to allow appropriate continuity of care.

The Governor should ensure that there is continuity of case management in ACCT case reviews,

The decision to move the man to a single cell

78. Until his appointment with the psychiatrist on 24 July, the man occupied a shared cell. When he arrived at Littlehey he told the HCA that he preferred to be in a single cell because he found sharing stressful. The HCA was told by the community psychiatric nurse that he had been in a shared cell at his previous prison because it was thought that this reduced his risk of suicide and self-harm. The HCA therefore did not take forward the man's request for a single cell and made an entry on the record accordingly.

79. At the time he saw the psychiatrist, the man was sharing a cell on C wing with another prisoner. The prisoner said at interview that the man had confided in him that he felt suicidal but told him that he would never commit suicide while sharing a cell because of the effect it would have on a cellmate. Wing staff were not aware of this conversation. The psychiatrist initially recommended that he be moved as a matter of urgency to a single cell only to change his mind after looking more closely at the medical record and reading the entries relating to the conversation between the HCA and the community psychiatric nurse. By this time a single cell had been identified on B wing and he had been moved there. A SO explained at interview that it was by chance that the only single cell that was available was the safer cell B3-15.

80. The SO, psychiatrist, Head of the mental health team and a doctor discussed the position. The SO was unwilling to put the man in a shared cell because of concerns about making a prisoner partly responsible for his safety. A compromise was reached whereby he remained in the safer cell with frequent ACCT observations.

81. Although we understand the SO's view, this view should not have prevailed. It is clear at that stage that the considered opinion was that the man would have been safer in a shared cell. This should have taken precedence over other concerns, yet the staff involved all accepted the arrangement that he should remain in the single cell. We make the following recommendation:

The Governor should ensure that prisoners are allocated to shared cells when this has been documented as a protective measure against suicide or self-harm.

The ligature point in cell B3-15

82. A safer cell is one in which there are as few ligature points as possible to make the attachment of ligatures very difficult and to prevent access to the window bars. In this case, the man fixed an object (which we were told was a

nail), into the vent and attached his noose to that. When he attempted to hang himself in Brixton in March, he tied shoelaces to a similar vent. Even if this information had been highlighted to wing staff it is difficult to see what could have been done about the ventilation point. All the cells in the category C adult site at Littlehey have a vent on the wall above the toilet and it is not possible to ensure that even cells known as 'safer cells' are entirely ligature free. Only extreme physical measures, such as placing him in strip conditions in a gated cell might have prevented him from making a noose and creating a point from which to suspend himself. Although he was regarded as a risk of suicide he was not considered to be in crisis and such conditions would not have been proportionate. Although we consider he should have remained in a shared cell, ultimately it is very difficult to prevent someone who makes a reasoned decision to kill himself from carrying out that plan, while at the same time providing humane living conditions

83. Although designated as a safer cell, the cell the man was in had subsequently had a smoke detector fitted, although it was an obvious additional ligature point. Cells regarded as safer cells should not be subject to retrospective adaptation which introduce additional ligature points. We make the following recommendation:

The Governor should ensure that all designated safer cells are free from obvious ligature points.

The emergency response

84. Littlehey's operating policy and procedures for entering cells during night state (i.e. before day staff come on duty) provide that cells should not usually be unlocked without the authority of the night orderly officer (NOO) who should normally be present. Where there appears to be an immediate danger to life cells may be unlocked without the NOO, however before doing so staff must make every effort to get a verbal response from the prisoner and take into account what they can see through the observation panel. The OSG tried repeatedly to get a verbal response from the man. He said it was difficult to see him clearly but he was apparently standing by his toilet leaning towards the cell wall. He therefore asked for a second opinion from the NOO and did not enter the cell on his own. As soon as the SO (the NOO) arrived, both men went into the cell, cut him down and began CPR. While it is usually preferable that staff enter cells immediately when a life appears to be in danger, we do not criticise the OSG's decision to seek advice. We are satisfied that there was not an unreasonable delay in entering the cell.

85. Other staff were quickly on the scene and CPR was continued at the correct ratio of breaths to compressions. Emergency equipment was also brought promptly and used correctly. An ambulance was called and the paramedics arrived at the man's cell within about 18 minutes. The SO made sure that there were staff on the gate and staff ready to escort the paramedics to the cell so that there was no unnecessary delay. Given the distance between the local accident and emergency department and the prison this represents a

swift response. We are satisfied that once he was found hanging, staff acted promptly and efficiently to try to resuscitate him.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that the mental health team completes suicide risk assessments promptly, that risk decisions are made on all the available information from a prisoner's medical record and identified risks are properly documented and shared with staff working directly with the prisoner concerned.

   This recommendation was accepted at draft report stage. The National Offender Management Service responded:

   The MHIRT carry out suicide risk assessments promptly and these are shared with appropriate stake holders and also discussed formally at the Complex Needs meeting.

   The management of risk is robustly managed and documented in both clinical and HMP IT systems.

2. The Governor should ensure that there is continuity of case management in ACCT case reviews.

   This recommendation was accepted at draft report stage. The National Offender Management Service responded:

   The Head of Safer Custody and Equalities to put measures in place for additional training to ensure that Custodial Managers chair reviews to provide greater continuity of case management. This will be reviewed by management checks and on going training by the safer custody team.

3. The Governor should ensure that prisoners are allocated to shared cells when this has been documented as a protective measure against suicide or self-harm.

   This recommendation was accepted at draft report stage. The National Offender Management Service responded:

   The Head of Safer Custody and Equalities to put measures in place to ensure those prisoners who are assessed as needing to share a cell as a protective measure against self-harm do so, providing the CSRA and the level of risk to the cell mate is deemed acceptable. Custodial managers to be given training to ensure consistency within this area.

4. The Governor should ensure that all designated safer cells are free from obvious ligature points.

   This recommendation was accepted at draft report stage. The National Offender Management Service responded:

   The Head of Equalities and Safer Custody to put a protocol in place for the use of safer cells in line with the national guidelines for checking of such cells.