Investigation into the circumstances of the Death of a man, whilst a prisoner at HMP Littlehey, in September 2006

Report by the Prisons and Probation Ombudsman for England and Wales

October 2007

This is the report of an investigation into the death of a man who was found hanging in his cell in the Care and Separation Unit at HMP Littlehey in September 2006. The man was taken to Hinchingbrooke Hospital in Huntingdon where he died on 18 September, without having regained consciousness. He had been at Littlehey for just two days. He was 34 years of age.

I would like to extend my condolences to the family and friends of the man for their loss. His family, who believed the man had mental health problems, have been in contact with both Littlehey, and with one my Family Liaison Officers. A key part of the investigation was to ensure the family had the opportunity to raise any concerns. In this report, we have done all we can to answer their questions.

One of my investigators, conducted this investigation. In addition, the Cambridge Primary Care Trust conducted a clinical review into the man's care and treatment whilst in prison. I would like to thank, the Governor of HMP Littlehey, and his staff for their help and co-operation during this investigation. I am also grateful to the Cambridge Police for their ready assistance.

On this sentence, the man had been in prison for a year. During that time, he had been transferred between five different jails including Littlehey. He had been assessed as at risk of harming himself, and was on an Assessment, Care in Custody and Teamwork (ACCT) plan which monitors and supports prisoners at risk. The man was initially located on a standard wing at Littehey, but within 24 hours had smashed his sink in frustration about his medication and been moved to the Care and Separation Unit. On a check on the day of his allocation to the Unit, an officer found him hanging from a bed sheet attached to the cell's perspex window.

At time of writing, 12 per cent of the self-inflicted deaths in prisons I have investigated during 2006-07 have occurred in segregation units

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2007**

CONTENTS

SUMMARY

The man had been in continuous custody since 15 September 2005. On 21 September 2005, he had been sentenced to three years imprisonment for breaching his Drug Treatment and Testing Order (DTTO). On 29 November 2005, he received a further six months imprisonment to run consecutively.

The man had a history of drug and alcohol dependence. Whilst in prison he had been prescribed a variety of medication to help him overcome these difficulties, together with the associated problems of anxiety and depression.

After a period on remand and following sentence at HMP Norwich, the man was transferred to HMP Stocken in January 2006. However, while there he became frustrated about his medication and smashed up his cell. The man said that his reason was the pharmacy's problem in supplying the precise dose of his medication. He was taken to the segregation unit, but subsequently returned to the wing. The man was getting panic attacks, but was unwilling to engage with psychiatrists or counsellors and his anxiety and paranoia were increasing.

In July 2006, the man's cell was searched. A knife made from a razor blade and a toothbrush, and three containers believed to contain illicitly brewed alcohol, were found. On the same day, the man barricaded himself in a cell with another prisoner. He was persuaded out by officers and was moved into the segregation unit before being transferred to HMP Wellingborough

Later that month, the man again smashed up his cell as a protest for not having his medication. On 25 and 26 July, he barricaded himself in his cell and started to smash things as a further protest about being taken off his medication. The man was moved to Wellingborough's segregation unit where he was informed that he would be transferred to HMP Highpoint the following day.

When the man arrived at Highpoint, he was placed in a cell on normal location. However, once more he became very anxious about his medication, and was again described as paranoid. Yet again he barricaded himself in his cell, and said that others wanted to hurt him. Three days later, the man complained that he had heard whispers from other prisoners saying that they wanted to kill him or beat him up, and he believed there was a rumour saying he was a child abuser. The man agreed to go into segregation for his own safety. There he was seen by staff from healthcare and the Mental Health In Reach Team, and put on a self harm watch (ACCT). Staff worked hard to engage with the man and, with the aim of reducing his distress, arranged a further transfer to HMP Littlehey.

When the man arrived at Littlehey on 12 September, he was again placed on an ACCT form. But once more he became distressed about his medication, and on 13 September smashed his cell sink which flooded his cell. He was taken to the prison's Care and Separation Unit (segregation unit). Later that day, he was found hanging from a bed sheet threaded through a perspex window in his cell. Officers acted promptly, cut the ligature and administered first aid. Sadly, the man did not regain consciousness and died in hospital four days later.

THE INVESTIGATION PROCESS

1. The investigation was formally opened at Littlehey on 20 September 2006 by one of my investigators. The Governor and his staff produced the man's core record and a number of other documents for examination. Notices were issued to staff and prisoners telling them of the investigation, and inviting anyone with relevant information to make themself known. The investigator was given unrestricted access to the prison, staff and documentation relating to the man. He spoke to a member of the Independent Monitoring Board (IMB), a representative of the local branch of the Prison Officers' Association (POA), and to a member of the chaplaincy. He was also able to speak with Cambridge Police in relation to issues of common interest.

2. Cambridge Primary Care Trust conducted a clinical review of the man's care and treatment since his imprisonment in September 2005. He also took the opportunity of visiting Littlehey.

Family Concerns

3. A Family Liaison Officer from my office contacted the man's sister. My investigation has attempted to answer the questions posed by the man's family.

4. The man's sister requested that my investigation consider the following questions:

   - What happened to the man in previous prisons, as he had been at Littlehey for such a short time? In particular, the man had been very distressed at Highpoint. Whilst there, he had telephoned his sister and told her that the officers were telling prisoners that he was a 'nonce' (a sex offender) and a grass (an informer). She had telephoned the Governor to express her concerns. She had been told that the man was safe, and she believed that the man had told staff at Littlehey of this.

   - The man's sister has read his prison medical record and is aware that on 29 August, at Highpoint, the man had been identified as having suicidal thoughts and had told staff that he would kill himself. The man was placed on a constant watch and moved to the segregation unit for his own safety. Highpoint were trying to arrange for the man to be seen by a psychiatrist. The man's sister wants to know if he was seen by a psychiatrist.

   - The man's sister wanted to know what information was transferred about the man from Highpoint to Littlehey, and why Littlehey did not keep the man on the watch for his own safety.

   - She considered that the number of times the man moved prisons did not allow him time to settle. The family felt as though he was being passed around, rather than one prison taking the time to try and deal with his problems.

- The family feel that moving prisons adversely affected the man's medication. Every time he was moved, his medication (Valium) was stopped. The man found this difficult as this was something he had been prescribed by an external doctor.

- The family is aware that on the night the man was found he had refused his medication. This led to him kicking things in his cell and being sent to the segregation unit. Although he saw a doctor, the man did not get the medication he wanted.

- The family believe that the man had mental health problems, as he would talk of hearing voices and people following him. His friends had urged him to sort these problems out. The Governor at Highpoint had told the family that the man would be medically assessed, and the family wanted to know whether his mental health was assessed adequately within the prison system.

- The family want to know why, after the man was transferred to the segregation unit, he was not checked between 8.30pm and 9.40pm. They would also like to know the minimum requirements for checking prisoners in the care and separation unit, and if these were adhered to.

- The family were told that the man had used a cigarette lighter to burn a hole in the ceiling and put the sheet through. The family would like details of exactly what he did and how. The family were unaware that the man had been moved to Littlehey. They wondered whether he was given the opportunity to contact family members.

- The family are concerned that the man was often put in the segregation unit and that this did not help him to deal with the problems he had. It also meant he did not have much contact with other prisoners.

- The family have concerns about the way a governor addressed them at the hospital.

- The family wanted the investigator to check whether there were any remaining possessions at the prison as the man's rosary beads and bible were missing. There were also very few items of clothing and no shoes.

Littlehey IMB concerns

5. The chair of the IMB at Littlehey, raised the following concerns:

- The reason for the man's transfer to Littlehey when he was the subject of an ACCT/Self Harm document at Highpoint. It appears that he was in a mentally unstable state at Highpoint, which was noted by the IMB at Highpoint. Was this a 'behind the scenes deal' by the two prisons to transfer the man that suited the establishments but not his short term welfare?

- Despite the man's state of mind, he was placed initially on E Wing which is the induction wing at Littlehey and a busy, potentially volatile environment not conducive to receiving a prisoner on an open ACCT.

- What medication was the man receiving at Highpoint and was it changed at Littlehey? If it was changed, why was this done given that he was on an open ACCT? It appears something happened or was said to the man after a visit to Littlehey Healthcare that triggered in him an adverse reaction.

6. My investigator wrote to the Chair of the IMB at Highdown to request his views of the man's care whilst at Highpoint.

7. My investigator wrote to HM Coroner, to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist him in his enquiries into the man's death.

BACKGROUND

8. The following medication was prescribed for the man at different times:

- Diazepam, marketed under the brand name Valium, which is used for treating anxiety, insomnia, seizures, alcohol withdrawal, and muscle spasms.

- Nitrazepam, which is a powerful hypnotic drug. It is a benzodiazepine derivative which shortens the time required to fall asleep and lengthens the duration of sleep.

- Seroxat, which is used for treating depression as well as anxiety disorders ranging from panic attacks to phobias.

- Mirtazapine, which is an antidepressant used for the treatment of mild to severe depression. It is also traded under the name Zispan.

- Risperidone, which is an antidepressant usually used to help treat illnesses or conditions such as psychosis, schizophrenia and hypomania.

- Trazadone, which is a psychoactive compound with sedative and antidepressant properties.

HMP Littlehey

9. HMP Littlehey is a purpose built category C training prison for men. The certified normal accommodation is 664. The operational capacity (maximum crowded capacity) is 706, with a typical occupancy of around 690. The prison was opened in 1988. It has been extended by the addition of two 'ready to use' units, one in 1997 and one in 2003.

10. Approximately 10 per cent of the population are serving life sentences. A small proportion of the prisoners are category D which enables them to work outside the prison. The prison offers a sex offender treatment programme, as well as extensive industrial work and education opportunities.

11. The prison's segregation unit is known as the Care and Separation Unit. The Unit is an L-shaped, single storey building. My investigator found it clean and in good decorative order. Prisoners held in the Unit were regularly monitored and entries in each prisoner's daily record painted a clear picture of their behaviour. The Unit consists of nine cells (two of which are safer custody cells), an adjudication room, an office, a servery and showering facilities. The Unit has its own exercise yard. Some of the cells in the Unit have perspex that covers the windows.

12. The minimum day time staffing level for the Unit is two prison officers, and one officer when the prison is in patrol state and prisoners are locked in their cells. The Unit is in patrol state from 5:30pm until the following morning.

The prison was inspected by Her Majesty's Chief Inspector of Prisons (HMCIP) on an unannounced visit between 5 and 7 December 2005. In her report the Chief Inspector commented:

> "Littlehey is to be commended for further improvements that it has made since our last inspection. It remains a safe and respectful prison, which has successfully integrated a large population of sex offenders and other vulnerable prisoners into the general population. The prison has expanded access to purposeful activity and begun to focus on the national resettlement agenda.
>
> "Staff and managers had worked hard to deliver an effective safer custody strategy. We were pleased to find our previous recommendations for improved reception arrangements had been achieved with refurbished reception building and improved processes. First night procedures had improved, as had efforts to prevent suicide, self harm, and bullying.
>
> "Littlehey had maintained a generally respectful, clean and tidy environment, and had now introduced electricity into all cells.
>
> "Healthcare was generally good, but the prison continued to cope with prisoners with mental health problems. The mental health in reach team was stretched and under resourced and some mentally ill prisoners were still confined to segregation units pending transfer to a prison with adequate hospital facilities.
>
> "Littlehey is an impressive and improving prison, working with some very high risk prisoners. Staff are to be commended for establishing a fundamentally safe and respectful environment, but further expansion of purposeful activity is required, together with strengthened sentence planning work.
>
> "Following our full inspection in December 2002, we concluded that the prison was performing reasonably well against this healthy prison test. Considerable improvements had since been made to the reception building structure, and the reception process was focussing on the needs of prisoners.
>
> "First night and induction procedures were sound, with good use of well thought out material. We found a high awareness of and commitment to the safer custody agenda, which was part of the safer prison strategy at the time of inspection."

ACCT Suicide and self harm monitoring

13. Assessment, Care in Custody and Teamwork (ACCT) has been introduced at Littlehey to monitor and support prisoners assessed to be at risk of suicide or self harm. (The previous system was known as the F2052SH procedure; it was

still in use at Highpoint when the man was there.) Once placed on ACCT, the prisoner is observed at pre-determined intervals according to the perceived level of risk.

14. Each prisoner must be assessed within 24 hours and then reviewed at intervals decided upon on an individual basis. The ACCT guidance says that, to be effective, the review should involve the people who know the person at risk or who are involved in their care. The key questions for each review are listed as:

- have the problems that caused the ACCT plan to be opened now been resolved?
- if not, what needs to be done to resolve them?
- have any further problems arisen that are now causing distress and more risk?
- if so, what action can be taken to address these?
- is the person at risk now in contact with friends, family or other support?
- does the person at risk now have something in their life that they feel good about?
- if not, how can this be improved?

15. Over time, the reviews should also consider such other factors as:

- distress – has anything changed to make the person at risk more or less desperate?
- resources – has anything changed that makes the person at risk now feel more or less alone?
- previous suicidal behaviour – has anything changed that makes suicide more familiar or more acceptable to the person at risk?
- suicide intention or plan – has anything changed to show that the person at risk is more or less prepared to kill themselves?
- pattern of self harm – is self harm becoming more or less frequent?

16. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment and it is for the Case Review team to decide the most appropriate place to locate an individual prisoner.

KEY EVENTS

17. The man was remanded to HMP Norwich on 15 September 2005. The charges he faced were heard on 21 September and 29 November 2005, and he received a total of three years six months imprisonment.

18. On 10 January 2006, the man was transferred to HMP Stocken. His medical record noted that he had been prescribed diazepam and nitrazepam for two and a half years, and that he had hepatitis C. On 13 January, he complained of increasing anxiety as his dosage of diazepam was being reduced. The original dose was therefore restarted with a plan to start reducing again at a later date.

19. Towards the end of January, the man smashed up his cell which he said was because the pharmacy had a problem with supplying his precise dose of diazepam. The man had also been asking for additional nitrazepam. He was taken to the segregation unit, but was subsequently returned to the wing.

20. Four months later on 20 May, the man was still undergoing detoxification and was experiencing panic attacks. However, he was unwilling to engage with psychiatrists or counsellors. His anxiety and paranoia were growing, and his dose of diazepam was increased. He was also started on the antidepressant seroxat, and was advised to exercise in the gym.

21. On 27 June, the man underwent a liver function test which showed that he had mild liver damage. The following week, he complained of being unable to sleep and of being anxious. His antidepressant was changed from seroxat to mirtazapine.

22. On 4 July, the man's cell was searched and a knife (made from a razor blade and a toothbrush), and containers containing what was believed to be illicitly brewed alcohol, were found. Later that day, he barricaded himself in a cell with another prisoner but was persuaded by officers to come out. He was moved to the segregation unit before being transferred to HMP Wellingborough on 13 July.

23. A week after arriving at Wellingborough, the man asked for some more diazepam, but the reducing regime had finished and there was no current prescription. He became agitated when his request was refused. On 21 July, after three days without diazepam, the man smashed up his cell in protest. Four days later, he barricaded himself in his cell and again started to smash things. He requested mirtazapine, which was agreed, and resolved his immediate situation. However, the following day the man barricaded himself in again as a further protest about his medication. He was moved to the segregation unit where he remained until 8 August when he was told that he would be transferred to Highpoint the following day.

24. The transfer to Highpoint took place as planned on 9 August, and the man moved into cell G:23. Two days later, his anxieties about his medication increased. He became paranoid that others wanted to hurt him, and was again asking for diazepam. He barricaded himself in his cell once more.

25. The following day (12 August), the man complained that he had heard whispers from other prisoners that they wanted to kill him or beat him up. He believed there was a rumour going around that he was a child abuser. The man agreed to go to the segregation unit for his own safety. His medication was changed once again, and he started a course of respiridone. It was stopped the next day as it made him tired.

26. On 14 August, the Governor spoke to the man during her rounds of the segregation unit. He said he was fine and did not need anything. The Governor thought that the man seemed to be making reasonable progress. He was assessed the next day by the Mental Health in Reach Team who noted his history of significant anxiety problems and panic disorders. It was established that the man was not psychotic, but might lapse into psychosis under extreme stress. His medication was once more altered, with trazadone added to the prescription for mirtazapine. The man was to be reviewed later by the doctor. An entry was made in his medical records on 17 August that he was hearing voices and asked for extra medication.

27. On 20 August, the man refused to take his medication, but he did agree to take it on 22 August. He was seen by the Mental Health In Reach Team the following day and said he had no more paranoid feelings, was able to cope with panic, and might be able to be transferred back to normal location at some point.

28. The man was assessed by healthcare staff on 29 August. He described having had bad thoughts about hanging himself the previous day, but instead had cut his arms. He was placed on a self harm watch (F2052SH), to be checked frequently and intermittently, and an urgent referral was made to the Mental Health In Reach Team. The man was given extra tobacco, and encouraged to use the prison's Listener scheme. (Listeners are prisons trained by the Samaritans to offer care and support to fellow prisoners.) Staff were also asked to engage in conversation with him. The next day (30 August), it was recorded in the man's medical record that he had a very gloomy outlook, and was saying that officers were talking and wanting to get him into trouble. The F2052SH document was reviewed, and the man was re-assessed as 'high risk of self harm' and placed on a constant watch.

29. At 5.35pm, a Principal Officer (PO) had a long chat with the man. He reported that his eye contact was good, and he was responsive to staff. The PO said that the man was apprehensive that rumours about being an informer and a sex offender would follow him, which the PO explained was unlikely. He said that the man thanked him for their chat and told him he would see him later.

30. On 31 August, the man attended the F2052SH case review. He said he found being on a constant watch was difficult, although his mood improved slightly. He was seen by the In Reach Team who found no evidence of mental disorder, but did notice that he had delusional ideas about being persecuted. The plan was for the man to see the consultant psychiatrist as soon as possible for his medication to be reviewed. However, this did not happen as the man left the

prison before it could be arranged. On 1 September, the man's constant watch was reduced from constant to frequent but intermittent (which meant that he was not being observed all of the time), as it was noted that he was feeling happier. The review also questioned whether his abdominal pain could be due to Crohn's Disease, but it was judged otherwise.

31. Three days later, on 4 September, it was recorded that the man was quiet. The Mental Health In Reach team saw the man and thought that the segregation unit was inappropriate for him. It was recorded that the man was not taking diazepam, but was taking trazadone and it was planned that it should be increased. It was recommended that the man attend anxiety and stress management classes, and counselling was also suggested. It was also recommended that the man should have a key worker at his next prison.

32. The next day (5 September), the man attended another F2052SH self harm review. He appeared down beat and made little eye contact throughout the meeting. The assistance he was getting from the In Reach Team was discussed, but he felt that his medication was not having an impact on his condition. The man was told that attempts to transfer him to another prison would start following the review. The man said that he had no thought of self harm, and it was agreed that the level of observations could be reduced. The support plan was:

- continue support from Healthcare
- provide access to Listeners and Samaritans phone
- remain on frequent and intermittent watch
- have constructive interaction with segregation staff
- The man was to be kept informed about transfer progress.

33. A further review took place two days later on 7 September, and the man attended. He said that he was content to transfer to HMP Edmunds Hill, and said that he was fine and appreciated the extra tobacco. However, he made little eye contact during the review, and said he believed staff and prisoners were plotting against him to kill him because they believed he was a sex offender. He asked about his medication and was told that it was ready for him. The support plan was:

- continue to receive his medication
- Mental Health In reach team to be alerted when the man was moving on to Edmunds Hill
- To bring the review to the immediate attention of staff at Edmunds Hill
- Continue on a frequent intermittent watch.

34. A further review took place at 6:00pm the same day, as Edmunds Hill had refused to accept the man the review noted that the man was very low in mood, and disappointed that the transfer had been cancelled. The man questioned why he was now on a constant watch, and it was explained that it was due to his behaviour and his low mood. He was told that the constant watch was not a punishment but to keep him safe. His support plan was:

- heightened awareness of the need for additional support
- Healthcare to see the man and observe him take his medication
- Listeners and Samaritans to be contacted as required
- place on constant watch with the next review scheduled for 9:30am on 8 September.

35. The next F2052SH review took place as scheduled, and the man again attended. He again said that he was disappointed that the move to Edmunds Hill did not take place, and was described as low in mood. When he was asked whether he had thoughts of self harm, the man denied any. He asked for some tobacco. The review discussed the possibility of his transferring to Littlehey, with which the man was in agreement. His support plan following this review was:

    - remain on observed medication
    - remove constant watch
    - have access to Samaritans by phone and Listeners if requested.
    - explore a possible transfer to Littlehey
    - have constructive interaction with segregation staff.

36. The same day, the Governor spoke to the man again. She described him as quiet but cooperative and said that he appeared in better spirits than when she had last seen him. Governor Doolan spoke to segregation unit staff, enquiring about the plans to resolve the man's problems. She was told that, having been held at Littlehey (which primarily holds sex offenders) on a previous sentence, other prisoners had labelled the man as a sex offender and were teasing him. She asked if the man still wished to transfer to Littlehey, which the staff confirmed but said that one request had been made which was unsuccessful. The Governor recognised that it would be difficult to reintegrate the man back to an ordinary wing at Highpoint, and so decided to speak to the Governor at Littlehey directly.

37. The Governor spoke to Acting Governor at Littlehey and, with her consent, made transfer arrangements with the Senior Officer (SO). The SO confirmed that the man would initially share a cell on E wing, and would participate in drugs work. The man confirmed to the Governor that he was happy with the arrangements.

38. The Governor told the SO that the man was a low cell sharing risk, was a prolific offender, and had previously been on a constant watch. She said that the risk had reduced considerably, but he remained on F2052SH self harm monitoring. The Governor and SO agreed that the transfer would take place on Wednesday 13 September. The Governor recorded in the man's prison history sheet that he was a vulnerable drugs offender, and was being threatened at Highpoint where he had incorrectly been identified as a sex offender.

39. A final F2052SH review took place at Highpoint at 8:55am on 12 September. The man said that he was apprehensive about the transfer. He was described as having poor eye contact throughout the review, but he declared that he had no thoughts of harming himself. Those present attempted to persuade the man

to look forward to his move in a positive manner, and he accepted that he needed to try harder. He said that he had previously found Littlehey a positive experience. Those present felt that the man should remain on an intermittent watch for the transitional period. His support plan was:

- remain on intermittent watch
- talk to staff at Littlehey
- continue to take medication
- have access to Samaritans phone/ Listeners.

40. Later that day, and a day earlier than planned, the man was transferred to Littlehey where he went through the reception process. The reception staff were aware that he was on an open F2052SH. The man was interviewed by an Officer who recalled that the man was quite happy to be back at Littlehey, and was looking forward to making a fresh start.

41. Unlike Highpoint, Littlehey uses the Assessment, Care in Custody and Teamwork (ACCT) framework for monitoring and supporting prisoners at risk of suicide or self harm. As part of the man's continued self harm assessment, an ACCT review was held. The man presented at the review as a little apprehensive, which he said was because of harassment by others. He said he did not feel like harming himself, but felt threatened by what he described as a near nervous breakdown.

42. The man was tearful, and was upset about being at Littlehey as he said he was afraid that prisoners might call him names. He was asked about the name calling, and he said that he had been called a 'nonce' at Highpoint. He was afraid that he might receive more name calling at Littlehey, but was told that the prison did not tolerate bullying. The review lasted approximately 40 minutes, and at the end it was felt that the man was more cheerful and was willing to stay at the prison. The man told those present that he had been to Stocken, Wellingborough and Highpoint where things kept going wrong, and that he would make his best attempt to survive at Littlehey.

43. The review decided that the man's ACCT plan would include being seen by a member of the mental health team and that listeners would be used when necessary. It was decided that staff should have a conversation with the man every two hours, with observations every one and half hours during periods, such as patrol state, when he was locked in his cell.

44. The man was taken to E wing which has three landings accommodating 99 prisoners. He was placed in cell 2-10. The wing is managed by a senior officer and four other officers. The man was regularly observed according to the ACCT plan, and the observations were recorded on the ACCT form.

45. At 10:20am the next day (13 September), the man was visited by the Duty Governor who spoke to him at length. The man then saw a doctor and other healthcare staff at the morning surgery. The man told the doctor that he took Zispan (mirtazapine) and trazadone daily at night. The doctor explained to the man that two antidepressants are not routinely prescribed at the same time and

said that he would prescribe Zispan. The doctor said that if the man wanted to continue with the trazadone, he would have to have a psychiatric assessment. The man was unhappy about the doctor's decision, and replied that he would not take any medication and walked out of the consultation.

46. Staff from E wing staff contacted healthcare to ask why the man's medication had been stopped by the doctor. The pharmacist said that he would ask the doctor to prescribe mirtazapine again the following morning, but that the man would need a psychiatric review in order to have trazadone or any other alternatives. The doctor offered to continue the mirtazapine tablets, but the man refused this too.

47. At midday, the man had his lunch and told an officer that he wanted to go to the 'block' (the name commonly given to a segregation unit). Two and a half hours later, the officer recorded that the man was packed and wanting to know when he was going to be moved. At 4:10pm, he was seen by another officer who noted on the ACCT form that he had spoken to the man at length about his medication and that he did not want to be at the prison. The man agreed to see healthcare staff the following day.

EVENTS OF 14 SEPTEMBER 2006

48. On the morning of 14 September, the man had his breakfast at 8:15am and then went to healthcare where he was seen by the doctor who told the man that he would not prescribe trazadone, but would prescribe mirtazapine which the man accepted. Later that morning, at 12.15pm, an entry was made in the man's ACCT record that he had returned from healthcare in a solemn mood and would not talk to officers. Another entry was made five minutes later. It noted information from Governor Way that, as the man had been refused his normal medication, he might behave adversely.

49. At 3:15pm, an officer was in the E wing office on the ground floor when the bell in the man's cell was activated. This caused a light to be illuminated on a panel in the office and a buzzer to sound. An officer responded to the buzzer, went to the man's cell and spoke to him through the door viewing panel. The officer described the man as "jumpy". He said that he was shouting that he had not got his medication from healthcare, and that the Principal Officer had said he could go to the block if this did not happen. The officer told him not to shout, to which the man replied that he was going to smash the sink. The man picked up his wooden chair, smashed it in the middle of the cell, and then started to smash the sink.

50. The officer shut the viewing panel and called for assistance. Water poured through the bottom of the cell door and down on to the landings below. The PO on duty spoke to the man. The man was sitting on the top bunk, smoking a cigarette. The PO asked the man if he would speak to him, and he agreed.

51. To break the ice, the PO made breast stroke motions as he went into the cell which was an inch deep in water. The man smiled at this, and told the PO that he was not getting the medication he felt he should have. The PO asked if the man thought that smashing up his cell would get him the medication, to which he replied that he knew it would not. The man told the PO that the medication was because he was prone to panic attacks when with lots of other people on normal wings. He said that he felt safer when in the segregation unit, where he only had to deal with two members of staff. The man said that the panic attacks would subside if he was taken to the Care and Separation Unit (CSU - the segregation unit). He then walked unaided to the CSU, accompanied by the and another member of staff.

52. The PO described the man as talkative, saying that he would be fine in the CSU which would alleviate the stress of being with other prisoners. En route, the PO explained what would happen next. He said that the man was concerned about his tobacco and lighter, and the PO thought that it was safe for him to have them. When the PO gave the man his tobacco, cigarette papers and lighter, he commented that perhaps The man thought he was going to be in the CSU for some time. The man replied that he might as well be prepared for a wait. The PO told the man that he would ensure that he got the rest of his property the following morning when he saw him next.

53. An officer was working in the CSU that afternoon when the man arrived. He recalled that the man had a problem with the doctor about his medication, but did not think that he was particularly angry or anxious. One of the governor grades was in the CSU on other business when the man arrived. In correspondence, he described the man was calm and cooperative with staff. The governor grade was not aware at that time that the man was on an ACCT document. The man was initially placed on five observations per hour pending being seen by a nurse for fitness to be detained.

54. The man was then assessed by a nursing sister, who had been verbally briefed that he had smashed up his cell because he was unhappy about medication and had seen a doctor that day. She did not read any records, and told my investigator that she did not know that the man was on ACCT. It would appear that, when nursing sister saw the man, the ACCT plan was being retrieved from the wing and had not been taken to the CSU.

55. The nursing sister went into the cell and introduced herself to the man. She said that he was lying on his bed facing her, and muttered something under his breath which she took to be a swear word. He then turned his back on her and faced the wall. The nursing sister signed the CSU safety algorithm, which confirms a Prisoner's fitness to be detained in the unit.

56. The nursing sister said that if she had known that the man was on an ACCT plan, she would have tried to have got more of a conversation to find out why he was in that mood, and why he had smashed up his room. When the man, arrived in the CSU, the CSU governor and an officer were there. The CSU governor said that he too was unaware that the man was on an ACCT document. He signed off the segregation safety algorithm authorising the man's segregation.

57. After the man was recorded by the nurse as fit for detention, 90 minute conversations with the man and two hour observations were deemed appropriate by the PO in his capacity as the safer custody manager.

58. An officer arrived at the CSU at approximately 8:15pm to start his night shift. The outgoing officer briefed him about the man and told him that he was on an open ACCT form, had smashed up his cell but was happy being in the CSU as he wanted to be away from other prisoners. The night duty officer was told that the man was to be checked every one and a half hours.

59. After being briefed, the night duty officer went round the CSU cells and spoke to all the prisoners to check that they were well. The Night Orderly Officer (the person in charge of the prison at night), visited the CSU at around 9:00pm and spoke to the night duty officer. Orderly Officers are issued with an electronic pegging wand which they press against a static disc in the CSU to prove they have visited. The PO and night duty CSU officer discussed the man as he was a new arrival and on an open ACCT form. The night duty officer was concerned that he would have to wake the man up through the night to check on him, and they agreed that he should be woken to check that he was alright.

60. The night duty officer next visited the man's cell at 9:40pm when he found the cell in darkness. The night duty officer opened the cell viewing panel, called the man's name twice, and switched on the cell light. He saw the man suspended at the rear of the cell hanging from a ligature. The night duty officer was not carrying his radio or anti ligature knife. He said that using the radio would have been audible to other prisoners, and it was preferable to go to the office to use the telephone, and collect the knife.

61. The night duty officer ran to the office, which was a short distance away, and telephoned the control room for assistance. He collected the knife and began to return to the cell when the telephone rang again. He answered the call, and asked for permission to enter the cell. He then returned to the cell, joined by officers. They entered the cell together, and saw that the man had torn part of his bed sheet to make a ligature which he had threaded through a hole he appeared to have burnt through the perspex window. He had hung himself from the windows, and his feet were not touching the ground.

62. The officers supported the man's weight by holding him, and cut the ligature which fell away when it was cut. The officers moved the man on to his bed. They saw that the man had a pulse in his neck, but could not see that he was breathing. The PO radioed the control room to ask for an ambulance, and then placed a resuscitation mask over the man's face and attempted mouth to mouth resuscitation. The ambulance crew arrived approximately ten minutes later. They took the man off his bed and placed him on the floor outside his cell, where they took over resuscitation before taking him to Hinchingbrooke Hospital at 10:31pm with a prison officer escort. Officers remained at the man's bedside whilst he was in hospital.

63. The cell was then sealed and treated as a potential crime scene. Cambridgeshire Police have concluded that there was no third party involvement.

AFTER THE MAN WAS FOUND

64. The man's sister was contacted by the police as soon as practicable, and they confirm that she was told at 1:01am on 15 September that her brother had hanged himself and was unconscious at hospital. The man's sister was given the contact details of the Deputy Governor who acted as the prison's family liaison officer.

65. One of the duty governors who visited the hospital to check on the bed watch arrangements spoke to the man's mother who was very angry that the officers were at the hospital in the same room as her son, especially as they ate their refreshments in the same place. The duty governor subsequently arranged for the officers to remove their epaulettes, and moved their seats so that they were more discreet.

66. On the morning of 18 September, the duty governor went again to the hospital and saw the man's family who were sitting together in a room. She described them as understandably emotional, and they asked a number of questions. The governor said that she felt uncomfortable and unable to address all of the family. Instead, she offered to speak to individual members outside the room and went out to await them. She said that no one came out, and so she left the hospital. The man did not regain consciousness, and died later that day at 4:50pm on 18 September.

67. The man's post mortem was carried out next day. Death was due to asphyxia by hanging. There were no significant toxicological findings. There were insufficient samples for further analysis, particularly for trazadone.

68. Staff and prisoners said that they generally felt well supported by the senior management team and by the staff care and welfare team.

ISSUES CONSIDERED IN THE INVESTIGATION

Clinical care

69. It is the opinion of the clinical reviewer, that the man had serious problems which officers and healthcare made conscientious efforts to deal with. The review concludes that the man received a similar standard of care to that which he would have received had he been in the community. His initial problems related to his drug and alcohol dependence which were effectively dealt with by reducing courses of opiates (dihydrocodeine) and benzodiazepine tranquillisers (diazepam and nitrazepam). In addition, the man suffered from depression and anxiety. He was prescribed drugs to improve the symptoms of depression (seroxat, mirtazapine and trazadone), and other drugs to settle paranoid feelings (risperidone).

70. At times, the man felt that the dose was reduced too quickly. Sometimes the doctors agreed to his requests for increased medication, and at other times they did not. The reviewer concludes that there were some indications that The man was manipulative about his medication and, on more than one occasion, he smashed up his cell because he did not feel that doctors or the pharmacist were doing what he wanted.

71. The man's anxieties focussed on feelings that other prisoners and officers wanted to harm him. Healthcare staff did not consider his anxieties to be based on reality, but were paranoid feelings. On one occasion, the man was placed in segregation for his own protection, and on other occasions after disruptive behaviour

72. When the man arrived at Littlehey, he was prescribed two antidepressant medications simultaneously which the reviewer states are very unusual. Although the medications are not strictly contra-indicated, it is normal practice to prescribe only one antidepressant at a time. Both the antidepressants can have an adverse effect on the liver, and the man already had abnormal liver function caused by hepatitis C. The reviewer considers that the two drugs could possibly have a cumulative effect, and does not criticise the doctors for trying to stop one of the drugs. As prescribers, doctors are responsible for the quality of their prescribing. If the two medications had continued, they would have been liable to criticism.

73. The man's family consider that moving prisons adversely affected his medication and that, every time he moved, his medication was changed. The clinical reviewer has concluded that the man's medical care was consistent with what he would expect in the community. Individual doctors take responsibility for their own prescribing, and the reviewer finds no fault with any. The doctors at Littlehey attempted to eliminate the duplication of their predecessors at Highpoint, and the reviewer accepts that they were pressured by the man. He was moved because his behaviour was disruptive, and it was hoped that he would be less distressed and would settle in the new environment. Sadly, despite the best efforts of staff, the man was unable to settle in Stocken, Wellingborough, Highpoint or Littlehey.

74. The family believe the man had mental health problems, and he would talk of hearing voices and thought people were following him. They were told by the Governor at Highpoint that he would be medically assessed, and they want to know whether this was done adequately. I have found that the man was assessed on a number of occasions by the Mental Health In Reach Team, and was also referred to the psychiatrist's clinic. However, the man was transferred from Highpoint before he could be assessed by a psychiatrist. He was offered additional support, pending the transfer to Littlehey.

Suicide and self harm monitoring

75. In August, the man confessed to having gloomy thoughts about harming himself and then cut himself. Suicide and self harm monitoring procedures commenced and he was offered counselling and the services of Listeners.

76. The following month, it was thought that the man's mood had improved and he could be transferred to another prison. He was initially told that he was going to be transferred to Edmunds Hill, but unfortunately the offer was withdrawn at the last minute. Later that evening, his antidepressant medication and the level of monitoring were increased.

77. It was recorded that the man did not have any thoughts of self harm and that his mood had improved, and he seemed to be coping quite well. The level of monitoring was reduced and he was assessed as fit to transfer to Littlehey.

78. I judge that many aspects of the implementation of the F2052SH and ACCT procedures were commendable. It was decided promptly that the man should be placed on self harm monitoring at Highpoint, and this was continued through the ACCT procedures at Littlehey. A full assessment was carried out immediately after his transfer, and appropriate objectives were set. The observations took place as directed and were checked by the prison's managers. Records, including the observation records, were comprehensive, orderly and clear, and actions took place when they were supposed to. Other than to protect medical confidentiality, the records were multi disciplinary. The reviews took place at both prisons as required, led by trained reviewers and attended by the man and key staff. The reviews took appropriate decisions and the man appeared to have engaged with the process. The first review at Littlehey was convened immediately after the man's arrival, but it would also have been good practice for it to have been re-convened when he moved to the CSU.

I recommend that the ACCT guidance is amended to require that ACCT reviews are automatically held after an incident when a prisoner on ACCT is taken to the segregation unit.

79. There was one oversight in that the nurse assessing the man's suitability to be segregated was unaware that he was being monitored on ACCT. However, I am satisfied that there was no realistic alternative to moving the man to the CSU, which in any event was where he wanted to be.

80. The man's family have questioned why, after the man was transferred to the CSU at Littlehey, he was not checked between 8.30pm and 9.40pm. They wish to know what the minimum requirements for checking prisoners were and whether they were adhered to.

81. The plan drawn up at the man's self harm review said that he was to be spoken to every 90 minutes during the day and observed every two hours. The penultimate check was at 8:20pm and the last check, when he was found with the ligature, was 80 minutes later at 9:40pm. This was within the minimum standards in his plan.

82. There was a reasonably quick response when staff found the man. However, I note that the officer who discovered him was not carrying a cut down knife or a radio. Although CPR was begun when the man was on his bed rather than on a hard surface, in the circumstances this was understandable. I make no formal recommendations, but the Governor will wish to consider the implications.

The number of prison moves

83. The man's family have asked what happened to the man in his previous prisons, as he had been at Littlehey for such a short time before he took his life. In particular, they said that he had been very distressed at Highpoint and had told his sister that officers were telling prisoners that he was a sex offender and an informer. His sister telephoned the Governor to express her concerns, and was told that the manwas safe. The family believe that, because of the number of prison transfers, the man was unable to settle. They consider that the manwas passed around, instead of one prison taking the time to deal with his problems.

84. The man was initially remanded in custody to Norwich, and transferred to Stocken, a short time after conviction. It was at Stocken that the man first smashed up his cell which led to him being transferred to Wellingborough. He again smashed his cell and barricaded himself in with another prisoner, as he felt that he had not been given the correct medication. This second incident led to arrangements being made for him to transfer to Highpoint.

85. Staff at Highpoint worked hard to engage with the man but, again after a dispute about medication, there was a third incident when he barricaded himself in his cell. The suicide and self harm procedures were started in an attempt to provide the man with increased support. He became increasingly withdrawn and was assessed by the prison's mental health team. A transfer to Edmunds Hill was considered, but the man felt that his worries would not change there. In the event, the place at Edmunds Hill was withdrawn. The man expressed an interest in moving to Littlehey where he had been for a previous sentence. The arrangements were made by the Governor of Highpoint with the Acting Governor in charge at Littlehey, and all the relevant information (including his medical record and the suicide and self harm monitoring) was exchanged between the two prisons.

86. The transfer to Littlehey took place as agreed, and the man was medically assessed and placed on the induction wing. The suicide and self harm monitoring transferred, and the observations continued as required. For reasons already described, the doctor at Littlehey then changed the man's prescription and a fourth incident followed. Again he smashed up his cell, and again was placed in segregation. However, as before, the man appeared to accept and even welcome being alone. Nevertheless, the observation cell in which he was placed was not one of the designated 'safer cells'. Although, it was furnished to 'safer cell' standards.

I recommend that prisoners who are on ACCT and who are located in the CSU should be placed in a safer cell.

87. It is not always appropriate or beneficial to move a prisoner from one prison to another when they present challenging behaviour. Frequent transfers can be interpreted as moving the problem on, rather then dealing with its cause. Moreover, the period immediately after a transfer is known to be one when prisoners are more at risk from suicide and self-harm. However, it is well documented that staff at each of the prisons where the man was held worked hard to engage with him. He was aware that a consequence of behaviour, such as smashing cells and barricading himself in, could be relocation to the segregation unit and possible transfer to another establishment.

I recommend that consideration be given to a protocol those prisoners with specific health or psychiatric needs should not be selected for transfer unless the receiving establishment's medical officer has agreed.

Other family concerns

88. The man's sister wanted to know what information was transferred about the man from Highpoint to Littlehey, and why Littlehey did not keep the man on the watch for his own safety.

89. Details of the man's imprisonment were personally communicated by the Governor at Highpoint prior to his arrival and he was transferred with his core record medical records and self harm form. In my view, Littlehey received all the available information about the man before and when he arrived.

90. The family were told that the man had used a cigarette lighter to burn a hole in the ceiling and put the sheet through to form a ligature.

91. As outlined in this report, the man had used his cigarette lighter to burn through the perspex cell window, creating a hole through which he threaded his bed sheet. It is believed he used a plastic utensil to accelerate the burning of the perspex.

92. The family were not aware the man had been moved to Littlehey, and asked whether he was allowed to telephone family members. I have established that the man was given the opportunity to make a telephone call, and that he was aware of the procedure for doing so.

93. The family are concerned that the man was often put in the segregation unit, which they consider did not help him deal with his problems and meant he did not have much contact with other prisoners. I understand this concern, as segregation is inevitably a stressful location. However, the man was taken to the segregation unit on each occasion as a consequence of his own actions. He also told staff that he preferred to be in segregation so that he could be on his own. Although he had little contact with other prisoners, he did receive the routine visits from governors, healthcare, the Independent Monitoring Board and the chaplaincy.

94. The family are dissatisfied with the way a governor spoke to them at the hospital. The governor concerned has been interviewed during this investigation and acknowledges that it was an extremely difficult and emotive time. I accept that there was no intention to treat the family discourteously.

95. The family have asked whether there are any remaining possessions at the prison as the man's rosary beads and bible were missing, and there were very few items of clothing and no shoes. My investigator has spoken to the Governor who has arranged for the return of the man's rosary beads and shoes.

CONCLUSIONS

96. The man had been imprisoned on a number of occasions. In the past, he had abused drugs and alcohol, and his family thought he was suffering from mental health problems. Since first being received into custody on this occasion, the man had been moved from Norwich to Stocken, then to Wellingborough, Highpoint, and finally to Littlehey. Each prison worked hard to engage with the man, but he was repeatedly concerned about his medication. His response included several acts of disruptive behaviour, damage to property and barricading himself in his cell. As a result, he was placed in segregation units and moved on to other establishments. I believe that each prison worked hard to engage with the man and help him to settle, but his anxieties went with him and the moves did not help.

97. The man left Highpoint having been identified as at risk of harming himself. The correct procedures were followed when he was at Littlehey. He had been there before and was met by staff who knew him. The reception doctor correctly decided to eliminate a duplicate medication, and the man showed his displeasure by smashing his cell. He was taken to the segregation unit by the Principal Officer who was the prison's safer custody officer and whom he knew previously. The man was seen by a nurse who, although she did not know he was on ACCT, deemed him fit to be segregated. The safer custody officer spoke to the man again in his cell and gave him his tobacco and a lighter. They exchanged pleasantries and the officer left, promising to see the man the following morning. The safer custody officer was involved in the review of the man's ACCT plan and was satisfied that 90 minute conversations and two hourly observations were still appropriate, and fully expected to see the man the following morning.

98. The man was found hanging in his cell at 9:40pm on 14 September, well within 90 minutes of the last documented check. Although I have made some passing comments both about the immediate response and subsequent events, in general I believe the prison handled all matters as well as could reasonably be expected.

RECOMMENDATIONS

National

I recommend that the ACCT guidance is amended to require that reviews are automatically convened after an incident when a prisoner on an ACCT form is taken to the segregation unit. (Accepted by the Prison Service revised Prison Service Order to be published)

I recommend that consideration be given to a protocol that prisoner with specific health or psychiatric needs should not be selected for transfer unless the receiving establishment's medical officer has agreed. (Not Accepted by the Prison Service)

Local

I recommend that prisoners who are on ACCT and who are located in the CSU should be placed in a safer cell. (Accepted by Littlehey, although the observation cell that the manwas in was of a safer cell standard)