

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr James Sullivan a prisoner at HMP Lowdham Grange on 24 March 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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

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

Mr James Sullivan was found hanged in his cell at HMP Lowdham Grange on 24 March 2016. He was 27 years old. I offer my condolences to Mr Sullivan's family and friends.

Although Mr Sullivan's death came after he received difficult news about his partner, it was not unreasonable given the range of their interactions for staff to have concluded that Mr Sullivan was not at risk of suicide or self-harm.

A prisoner found Mr Sullivan hanged in his cell. Although it would not necessarily have changed the outcome, staff missed four opportunities (during the morning roll count and at unlock) to find Mr Sullivan on the day he died. This was unacceptable, and Lowdham Grange must ensure their staff satisfy themselves of prisoners' safety during roll counts and when unlocking and relocking cells.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**December 2016**

**Contents**

Summary ..... 1  
The Investigation Process ..... 3  
Background Information ..... 4  
Key Events ..... 5  
Findings..... 13

# Summary

## Events

1. In October 2010, Mr James Sullivan was remanded to HMP Nottingham, charged with the murder of his ex-partner and received a life sentence, with a minimum term of 20 years. Prison staff monitored him under ACCT procedures until January 2011.
2. Mr Sullivan was moved to HMP Lowdham Grange in December 2011 and settled into prison life. In 2014, he began a relationship and applied to get married.
3. Mr Sullivan's partner stopped visiting him from late February 2016. On 11 March, she told him by telephone that she had been raped. Mr Sullivan was upset but supportive. He told an officer and his offender supervisor what had happened. Neither felt he was at risk of suicide or self-harm, but his offender supervisor asked staff to monitor his risk to others. Her view was that Mr Sullivan's tendency to make rash decisions might be directed towards another prisoner.
4. On 21 March, Mr Sullivan's partner told him she was pregnant and wanted to keep the baby. Mr Sullivan was upset and told her that he would end their relationship if she kept the baby. He worked in the kitchens and went to work the next day but the chef took him back to his wing and asked his offender supervisor to see him because he was upset. Mr Sullivan told her what happened but said he would not harm himself. That evening, Mr Sullivan told his partner by telephone that he did not want to lose her and would do everything he could to make their relationship work.
5. On Wednesday 23 March, Mr Sullivan did not go to work or to his usual art class. That afternoon, he told his offender supervisor that he had had a bad day, but had sorted himself out. He spoke to his partner a few times between 7.45pm and 9.07pm. In some of the calls, Mr Sullivan talked about not being there if she visited at the weekend. (The prison was not monitoring Mr Sullivan's calls and would not have known that he said this.)
6. On 24 March, staff counted and checked all prisoners at 6.00am and unlocked them for breakfast at 7.30am before locking them up for a short time. They then unlocked them for work at 8.10am. Staff raised no concerns about Mr Sullivan. A prisoner found him hanging from a window vent at 8.13am and raised the alarm. An officer went into his cell within seconds, cut Mr Sullivan down and with help, laid him on his bed. Rigor mortis was present. Officers did not try to resuscitate Mr Sullivan. When a nurse arrived a few minutes later, she began chest compressions and continued until paramedics arrived and recorded that he had died.

## Findings

7. Mr Sullivan's personal officer knew him well but, when he left to work elsewhere in the prison in October 2015, Mr Sullivan was not given a new personal officer.
8. While we know in hindsight that Mr Sullivan was at risk of suicide, he gave staff no indication that he might harm himself. It was not unreasonable that his

offender supervisor did not conclude on 23 March that he was at risk. She said that she would have started ACCT procedures if she had been concerned.

9. Although it would not have changed the outcome for Mr Sullivan, we are concerned that the morning roll check at 6.00am was not carried out as it should have been and that staff unlocking cells later that morning did not satisfy themselves that the prisoner inside was safe.
10. Mr Sullivan had clearly been dead for some time when he was found. Nursing staff should not have tried to resuscitate him.

## **Recommendations**

- The Director should ensure that prisoners are assigned a new personal officer if their current one leaves, and that in line with the personal officer protocol, personal officers understand their responsibilities.
- The Director should ensure that when conducting roll counts or unlocking or locking a cell door, staff check that prisoners are safe and that there are no immediate issues that need attention.
- The Director should ensure that all staff receive guidance about the circumstances in which resuscitation is inappropriate.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Lowdham Grange informing them of the investigation and asking anyone with relevant information to contact her. No one came forward.
12. NHS England commissioned a clinical reviewer to review Mr Sullivan's clinical care at the prison.
13. The investigator visited Lowdham Grange on 4 April 2016. She obtained copies of relevant extracts from Mr Sullivan's prison and medical records.
14. The investigator interviewed 12 members of staff and two prisoners at Lowdham Grange in April.
15. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Sullivan's mother, to explain the investigation. She said that Mr Sullivan had been happy at Lowdham Grange. Mr Sullivan's mother believed Mr Sullivan's partner had a relationship with a man outside of prison and had become pregnant by him. Mr Sullivan's mother asked whether Mr Sullivan's telephone conversations with his partner shed light on why he had taken his life. She said prison staff had been very good, especially the family liaison officer.
17. Mr Sullivan's family received a copy of the initial report. They had no further comments or questions about the report.

# Background Information

## HM Prison

18. HMP Lowdham Grange is a medium secure prison, privately managed by Serco, which holds around 900 men. There are five houseblocks, which typically hold 120-130 men. It holds long term prisoners, many of whom are serving life sentences or indeterminate sentences.
19. Nottinghamshire Healthcare NHS Foundation Trust provide general healthcare and GP services at the prison, including 24-hour nursing cover, and an out of hours GP service.

## HM Inspectorate of Prisons

20. The most recent inspection of HMP Lowdham Grange was in June 2015. Inspectors reported good relationships between staff and prisoners. They said that despite the settled population, the quality of personal officer work was limited and disappointing. Overall, inspectors felt the prison had many positive and encouraging features. However, they were concerned about the number of prisoners who said they felt unsafe and that levels of violence between prisoners and towards staff were high.

## Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to January 2016, the IMB was concerned about low staffing levels and reported that the dedicated safer custody team was being disbanded.

## Previous deaths at HMP Lowdham Grange

22. Mr Sullivan was the fourth prisoner to die at Lowdham Grange since March 2013. One of these deaths was from natural causes and the other two were linked to drug use. There were no notable similarities with the circumstances of the other deaths or the recommendations we made.

## Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process 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 supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction 64/2011.

## Key Events

24. On 9 October 2010, Mr James Sullivan was remanded to HMP Nottingham, charged with the murder of his ex-partner. It was his first time in prison. He arrived with a suicide and self-harm warning form because he had self-harmed in police custody, had depression and because of his offence. At his initial health screen, Mr Sullivan told a nurse he would kill himself for what he had done. He said he had tried to take his life before. Staff started ACCT monitoring.
25. Mr Sullivan saw the mental health team regularly between October 2010 and August 2011. He spoke to them about childhood sexual abuse, his offence and concern about who would get custody of his baby son. He said he had self-harmed when he first came to prison.
26. Mr Sullivan settled into prison life and staff stopped ACCT monitoring in November 2010. They monitored him again between December and January 2011 because of concerns about his mood. In January 2011, a psychiatrist diagnosed Mr Sullivan with emotionally unstable personality disorder, which can cause people to act unexpectedly without considering the consequences, self-harm, have mood swings and have outbursts of anger or violence.
27. On 27 January, Mr Sullivan pleaded guilty to murder and was given a life sentence, with a minimum term to serve of 20 years. Afterwards, Nottingham briefly monitored him under ACCT procedures.
28. On 7 December 2011, Mr Sullivan was moved to Lowdham Grange.
29. On 4 December 2013, staff started ACCT procedures after Mr Sullivan said he would take his own life if he was not moved from his wing, where he had issues with another prisoner. He had written a suicide letter to his mother and had some homemade weapons with which he wanted to harm himself. Mr Sullivan was moved to another wing and staff stopped ACCT monitoring on 16 December.
30. On 8 July 2014, Mr Sullivan progressed to a settled wing, where prisoners are given more responsibility, such as to get to work on time.
31. Mr Sullivan's personal officer usually made weekly entries in Mr Sullivan's case notes about his work, family visits and his progress towards his sentence plan objectives. In October 2015, he left his role but was not replaced.
32. Mr Sullivan and an ex-partner began a relationship in the summer of 2014 and she visited him regularly from 24 September. She told Mr Sullivan that her eldest child was his. Mr Sullivan made an application on 29 December 2014 to marry her. He suggested two possible dates in April and May 2015. One of the chaplains explained to Mr Sullivan that marriage applications usually took around a year to process. The personal officer thought Mr Sullivan had come to terms with his life sentence and that Mr Sullivan's relationship with his partner meant a huge amount to him.
33. A prisoner said he had got on well with Mr Sullivan. He said Mr Sullivan would 'do anything for anyone' and did art work and made paper decorations for his

partner, family and other prisoners. He described Mr Sullivan as cheeky and sociable.

34. On 30 September 2015, Mr Sullivan's offender supervisor applied for Mr Sullivan to take part in the Healthy Relationships Programme at HMP Holme House as part of his sentence plan objectives. The plan was for Mr Sullivan to transfer to Holme House for the course in June 2016 and then return to Lowdham Grange. She described Mr Sullivan as sociable and happy to talk to staff. She said he had settled well and, in the last 12 months, had accepted his sentence. An officer described Mr Sullivan as open and talkative. He said Mr Sullivan talked to officers, and, if he had issues, would ask for their help.
35. On 10 October, the personal officer noted that he had spoken to Mr Sullivan a lot that week because he was struggling with the anniversary of his offence. He offered him counselling, but Mr Sullivan declined.
36. On 12 November, the offender supervisor and Mr Sullivan met his new offender manager (probation officer in the community).
37. At the beginning of 2016, the offender supervisor spoke to the person managing the Healthy Relationships Programme at Holme House. They had decided the course in 2016 would be for vulnerable prisoners, so Mr Sullivan would not be eligible. She spoke to Mr Sullivan about this and said he did not mind waiting for the next course, because he hoped to get married in 2016.
38. From January 2016, Mr Sullivan worked in the kitchens from 8.30am to 12.00pm on weekdays and from 6.30am to 12.00pm at weekends. He worked with three other prisoners. Mr Sullivan took art classes four afternoons a week and went to chess club once a week.
39. Mr Sullivan's mother and other family members visited him regularly, usually monthly. They visited in January, February and March 2016, most recently on 12 March when his mother said Mr Sullivan appeared fine. In general, she thought he was happy, had friends in the prison and kept busy with work and art.
40. Mr Sullivan's partner visited him regularly until December 2015. She did not attend a booked visit on 29 January 2016, but visited on 12 February. Visits were arranged for 25 February, 10 March, 11 March and 18 March but she did not see him.
41. We listened to some of the telephone calls Mr Sullivan made. Prisoners at Lowdham Grange have the use of in cell telephones, which enable them to make calls whenever they wish, day or night. The records show that Mr Sullivan called his partner often, sometimes 30 times a day. (She did not answer all his calls.)
42. On the afternoon of 11 March, Mr Sullivan's partner told Mr Sullivan that she had been raped a few weeks earlier and the police had caught the perpetrator. Mr Sullivan was annoyed she had not told him sooner, but said he would support her.
43. Mr Sullivan went to the treatment hatch during the afternoon medication round and asked a nurse for ibuprofen gel for pain in his knuckles from punching the wall. He told her he had received some bad news, but she did not explore this further. She said treatment times were busy.

44. An officer said he was aware that Mr Sullivan's partner had allegedly been raped. He said Mr Sullivan had asked him that afternoon if he could transfer some money for him to call his partner at the weekend. He checked Mr Sullivan's account, but said Mr Sullivan had already transferred his weekly money allowance. (This meant he did not have much telephone credit left.) He said he knew this might be a problem, so he arranged for Mr Sullivan to make an extra telephone call home on Saturday afternoon. He said that, when Mr Sullivan rang his partner the next day, everything seemed okay.
45. A chef remembered Mr Sullivan going to work in the kitchen most likely on 12 or 13 March, and that he said his partner had been raped. She said she asked him if he wanted to go back to the wing. Mr Sullivan called his partner at lunchtime and then returned to work.
46. On 14 March, the offender supervisor spoke to Mr Sullivan after the chef told her about his partner's alleged rape. He spoke to her about it. He said his head was "messed up" and that his partner had said she had not visited because she had not wanted him to see the bruising and cuts caused by her attacker. Mr Sullivan told her that his partner had taken emergency contraception. She thought Mr Sullivan was concerned for his partner and confused by what she told him. She said he seemed unsure whether it was truthful. She said in her intelligence report that if Mr Sullivan's relationship with his partner ended, it would have a negative effect on Mr Sullivan's behaviour. She worked part time, but said she checked on Mr Sullivan most days that she worked.
47. On 17 March, Mr Sullivan told the offender supervisor that his partner had contacted the police because her two year old son had been touched inappropriately. Mr Sullivan had not told his mother about this because his partner had asked him not to. She asked wing staff to keep an eye on him. An officer remembered her telling staff that things were going on in Mr Sullivan's life and that he might react badly towards another prisoner or a member of staff. (The officer said he was not told about the alleged rape.)
48. Just before 8.00pm on Monday 21 March, Mr Sullivan spoke briefly to his partner. She told him she had taken a pregnancy test which indicated that she may be pregnant. Mr Sullivan was quiet and told her he would call her back.
49. At 8.10pm, Mr Sullivan and his partner talked for about 25 minutes. He wanted to know what she would do about the pregnancy. Mr Sullivan said he could not stay with her if she kept the baby because he could not bring up a rapist's child. His partner said she did not know how she felt.
50. That night, Mr Sullivan tried to ring his partner many times, often several times an hour. She answered the phone a little after 6.00am on 22 March. Mr Sullivan told her he had been awake all night and that some things did not make sense. They talked for 40 minutes about emergency contraception, her possible pregnancy and whether she would keep the baby.
51. Mr Sullivan went to work in the kitchens but the chef took him back to his wing because he was upset. He told her that his partner had said she was pregnant. Mr Sullivan said he did not understand why his partner would want to continue

with a pregnancy resulting from a rape. He talked about ending their relationship. The chef asked the offender supervisor to see him.

52. Mr Sullivan was upset when he spoke to the offender supervisor. She suggested that Mr Sullivan should try to remain a friend to his partner and encourage her to contact her police support worker. She suggested he call his mother, but he said that she did not know about the rape. She wrote an intelligence report about their conversation and said she asked wing staff to keep an eye on Mr Sullivan. (It is not clear who she spoke to.) She said Mr Sullivan was not good at dealing with stressful situations and had become quiet. She felt his risk level had increased, but she did not think he would harm himself.
53. At 11.47am, Mr Sullivan spoke to his partner and suggested she contact her police support worker. He asked her to 'do the right thing' and end the pregnancy. His partner said there was no way she could get rid of the baby.
54. Mr Sullivan told a prisoner that his partner had been raped and was pregnant. Mr Sullivan said he could not deal with her decision to keep the baby. He did not go to his art class that afternoon. Just before 8.00pm that evening, Mr Sullivan spoke to his partner for 20 minutes. He told her he still loved her. He said, "If I didn't want to lose you, I'd be in a mortuary now. I've contemplated that twice already today". Mr Sullivan added that he felt they could get through the situation. He told her that what had happened was not her fault. They talked about how he might explain things to his family. Just before midnight, they spoke again and Mr Sullivan said if she wanted him to stay, he would do everything he could to make it work. He said he loved her too much to lose her.
55. The next day, Wednesday 23 March, Mr Sullivan did not go to work. The chef was not working that morning but said if she had been she would have gone to Mr Sullivan's wing to ask him why he was not at work. He did not go to his art class that afternoon. If prisoners refuse to work, they are usually given a warning (which can affect their entitlements) but Mr Sullivan did not receive one. An officer said that if staff were aware of issues, they would probably not give a warning. We are not certain which officer unlocked Mr Sullivan for work on 23 March – three officers were on duty but none could remember doing so.
56. On 23 March, the offender supervisor noted in Mr Sullivan's case notes that she had seen him several times that week about relationship issues. She noted that she had asked wing staff to keep an eye on him but had not felt there were real concerns.
57. A prisoner who worked with Mr Sullivan said Mr Sullivan had had a bad couple of weeks. He said he had told Mr Sullivan not to do anything silly and that he could talk to him about his feelings. He said he was worried that Mr Sullivan would hurt someone else, not that he might hurt himself. He told him to keep calm. He said Mr Sullivan's temper was shorter than usual and that he was not coping well with the banter from other prisoners about his partner. (Some prisoners said his partner had not been raped.) Mr Sullivan told him that he had told his partner he would end their relationship if she kept the baby. He said he needed the day off, but would work the next day.

58. The offender supervisor said the police had told her that Mr Sullivan's partner had not told them about her alleged rape. Around 5.15pm, she spoke to Mr Sullivan by telephone. (She said she did not yet want to tell Mr Sullivan this news and thought she would find it easier not to by telephone.) He told her he had had a bad day, but had sorted himself out. She thought he sounded brighter. She encouraged Mr Sullivan to ring his mother because she felt she was a positive influence on him. Mr Sullivan said he did not want to bother her and his partner did not want him to tell her.
59. An officer locked Mr Sullivan in his cell at 7.45pm, asked if everything was okay and said Mr Sullivan replied yes. Soon after lock up, Mr Sullivan called his partner. They had a few conversations, and Mr Sullivan said their relationship was "on its way out" if she kept the baby.
60. At 8.26pm, Mr Sullivan telephoned his partner and asked why she had not booked a visit. He told her that if she did visit at the weekend, he had a vase full of flowers for her (referring to the paper flowers he made in art class). She said he sounded as though he was not going to be there. Mr Sullivan said he would always love her. They talked about the fact that Mr Sullivan wanted her to end the pregnancy but she would not do this. He said he could not imagine 15 years in prison without her. He added that he could not change what he had said, but he could try to change his feelings. He said he loved her so much, he would learn to live with it and would still marry her. There were periods of quiet and Mr Sullivan tried to get his partner to talk to him. The call ended with him saying, "I'm just wondering when to make the last phone call. Of the night I mean". They agreed he would ring at 9.00pm.
61. At 9.00pm, he called again and told her she might get a phone call from probation the next day. He said he would always love her. Mr Sullivan said he took back any earlier implication that he might not be here. The conversation did not end well. At 9.06pm, Mr Sullivan rang again. This call lasted just 15 seconds. It was an angry conversation and Mr Sullivan said he had not finished speaking. She replied that if he was going to kill himself, he should just do it.
62. Mr Sullivan rang back a minute later and they spoke for just under two minutes. He asked if she had calmed down. He reassured her that he was not going to do anything. He asked what time he should call her in the morning and they agreed 7.30am. Mr Sullivan said he loved her. This was their last conversation.
63. During every weekday night shift, the night officer is required to make a 2.00am 'welfare check' of all prisoners on the wing. CCTV shows that this check was done by the night member of staff. She said she remembered seeing what looked to be Mr Sullivan sleeping in bed under his covers. A prisoner said he heard no strange sounds from Mr Sullivan's cell that night.
64. At 6.00am, an officer started work and did a roll count and check of all prisoners, although he said he did not remember checking Mr Sullivan's cell. He said he would have seen someone lying on the bed before continuing to the next cell.
65. Two officers began work at 7.15am. They are not required to do a count or well being check of prisoners. Officer A put milk outside everyone's cell. At 7.30am,

all cells were unlocked so that prisoners could collect breakfast from the servery if they wished.

66. Officer A unlocked the two's landing (where Mr Sullivan's cell was). He unlocked each cell and put the milk inside. He said that not all prisoners came out to collect their breakfast. He thought Mr Sullivan normally stayed in his cell until it was time to leave for work. He did not check on Mr Sullivan's wellbeing.
67. Prisoners have time to collect and eat their breakfast before being locked in their cells around 7.55am. Officer A thought that about a dozen prisoners were out of their cells on the two's landing at lock up time. He said that people knew the routine and that they had to return to their cells. He assumed Mr Sullivan was in his cell and did not make a visual check when he locked his cell.
68. The main moves for work and education take place at around 8.10am. Prisoners on Mr Sullivan's wing are trusted to go to their activity. Officer A unlocked Mr Sullivan's cell but did not go inside or check on his wellbeing. A short time later, he said a prisoner in another cell put his light on and he realised he had not unlocked that prisoner, who was due to go to an art class. He went back upstairs to unlock him.
69. A prisoner said his normal morning routine was that he would bang on the cell wall; Mr Sullivan would telephone his partner at 7.30am and then go into the prisoner's cell around 7.45am for a coffee. That morning, Mr Sullivan had not gone into his cell. After being unlocked for main moves, the prisoner went to check on Mr Sullivan because he had not heard from him. He got to Mr Sullivan's cell at 8.13am and looked through the door flap. He could not see clearly so he opened the door and went inside. He saw that Mr Sullivan was suspended from a window vent. He left the cell and shouted to Officer A something like, "He's strung up". The officer said the prisoner looked shocked. He went into Mr Sullivan's cell and radioed a medical emergency code blue (which indicates among other emergencies, that a prisoner is unconscious or not breathing). The communications room recorded the code blue at 8.13am.
70. Two other prisoners who were on the landing followed Officer A into the cell and helped him by holding up Mr Sullivan's body so that he could use his anti-ligature knife to cut through the ligature (a bed sheet plaited with sellotape).
71. Officer B arrived at the cell 30 seconds later. There were several prisoners around, but no other staff arrived for a further minute. Both officers thought Mr Sullivan was dead and said his body was stiff and seemed elongated. His tongue was swollen and a purple black colour. With the help of one of the prisoners, they put Mr Sullivan on his bed. The staff did not try to resuscitate Mr Sullivan (although Officer A said he was about to start chest compressions when the nurse arrived). Officer B said it was clear to him that Mr Sullivan had been dead for a long time. Officer A could not remember putting a sheet over Mr Sullivan, but Officer B said they did and the nurse remembered removing one when she got to the cell. An officer from N wing went to Mr Sullivan's cell when she heard the code blue.
72. At 8.16am, the communications room radioed another message to ask all officers who were not supervising prisoners to attend Mr Sullivan's wing. Officer C was

on his way and radioed to say he would collect the defibrillator from a central office area between Mr Sullivan's wing and another wing. The nurse arrived with a red emergency bag at 8.17am. Another nurse arrived just over a minute later.

73. The nurse removed the sheet from Mr Sullivan and started chest compressions. She said she had not been in this situation before and panicked. She did not assess Mr Sullivan's condition before starting chest compressions. She wrote in SystemOne that while delivering chest compressions, Mr Sullivan was cold to touch, his pupils were fixed and dilated and his tongue was swollen and purple. Her colleague tried to insert an airway, but could not.
74. Officer C arrived at Mr Sullivan's cell at 8.18am. Officer D had just arrived and took the defibrillator from him. It was applied, but did not detect any heart rhythm.
75. Officer D took over the chest compressions, but said Mr Sullivan was clearly dead and rigor mortis was present. Officer C, who also did chest compressions, described the same. The nurse was distressed and Officer C asked her to leave the cell. She left at 8.22am. A Sister arrived soon after and helped with the resuscitation efforts. She tried to insert an airway, but could not do so. Staff continued chest compressions and breaths until paramedics arrived.
76. East Midlands Ambulance Service recorded the call at 8.15am, and despatched an emergency ambulance at 8.18am. They arrived at Lowdham Grange at 8.29am. They were with Mr Sullivan by 8.31am and recorded his death at 8.32am. Their report indicates that Mr Sullivan had rigor mortis when they arrived and blood pooling in his feet, legs and hands.
77. Mr Sullivan left letters in his cell for several members of his family, staff and partner. In his letter to his partner, he said he could not live without her, but could not bring up a child conceived during a rape. In the letter to his mother, he said that things had been building up for weeks and he could not cope anymore.

### **Contact with Mr Sullivan's family**

78. The Director of Lowdham Grange and a prison chaplain left the prison at 9.25am to visit Mr Sullivan's mother and stepfather to tell them of his death and offer support. Later that day, an officer was appointed as the family liaison and telephoned the family. She maintained regular contact with Mr Sullivan's mother. Mr Sullivan's funeral was on 21 April 2016. The prison contributed to the costs, in line with national policy.

### **Support for prisoners and staff**

79. A senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. Some staff we interviewed did not feel that managers had offered them enough support. In particular, staff who knew Mr Sullivan well, but were not involved in the emergency response itself, felt overlooked.
80. The prison posted notices informing staff and prisoners of Mr Sullivan's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Sullivan's death.

## Post-mortem report

81. A post-mortem examination found Mr Sullivan died from asphyxiation and hanging. Toxicology tests, including tests for new psychoactive substances, showed that no drugs or alcohol were present.

# Findings

## Assessing the risk of suicide and self-harm

82. When Mr Sullivan first went to prison in 2010, he was appropriately assessed as being at serious risk of suicide and self-harm, was appropriately managed under ACCT procedures and supported by the in-reach mental health team. Although staff monitored Mr Sullivan under ACCT procedures in December 2013 after he had problems with another prisoner on the wing, there was little to indicate that Mr Sullivan was at increased risk from July 2012 to March 2016.
83. Prison Service Instruction 64/2011 (Safer Custody) lists a number of risk factors and triggers that might increase prisoners' risk of suicide or self-harm, including relationship instability, history of suicide attempts and personality disorder diagnosis (all of which Mr Sullivan had). It says that after speaking to a prisoner, staff should use their judgement in combination with all available evidence to inform their decision about whether a prisoner poses a risk to himself.
84. Although upset, Mr Sullivan seemed able to cope with the news that his partner had been raped and remained supportive of her. Staff who knew about the alleged rape were not concerned about his risk of suicide or self-harm.
85. The chef spoke to Mr Sullivan the day after his partner told him she was pregnant. She said that while the conversation was difficult, he was his "normal self". He was angry that his partner was minded to continue with the pregnancy, and said he would end their relationship if she did. She said there was nothing in his body language or the way he presented himself or spoke to suggest that he might harm himself. She felt she knew him well but there was nothing to make her think she needed to start ACCT procedures.
86. Neither the offender supervisor nor an officer were concerned that Mr Sullivan might harm himself but thought it was more likely that he might hurt someone else. Mr Sullivan had assured the offender supervisor that she did not need to be worried about him hurting himself. She felt his history suggested that when a situation had gone wrong, he became a risk to others. (We have seen some intelligence to support this view, but there is intelligence indicating Mr Sullivan had been assaulted in the past and we know of previous suicide attempts.) She said that since Mr Sullivan's death, she had gone over in her mind many times whether she should have started ACCT procedures, but said she had not been worried about his risk of suicide based on how he presented. A prisoner said Mr Sullivan did not always say what he felt and had never spoken to him about taking his life. He said he would have told staff to keep an eye on Mr Sullivan if he had been concerned about him.
87. Relationship breakdown is not uncommon in prison and many prisoners face similar issues. When the offender supervisor spoke to Mr Sullivan the day before he died, she said he sounded more positive and appeared able to cope. She is an experienced offender supervisor. Based on her conversations with Mr Sullivan and knowing him for several years, her assessment was that he was not a risk to himself. While with the benefit of hindsight, we know this to be incorrect, it was not an unreasonable judgement. She spoke to Mr Sullivan several times in the last week of his life and knew what was happening with his relationship. If

anyone was in a position to assess his real feelings and risk, it was her. Even if staff had started ACCT procedures, it is unlikely that Mr Sullivan's risk would have been assessed as high and that monitoring would have been set at an adequately high level to have prevented his actions.

### **Morning roll count and unlock procedure**

88. At 6.00am, an officer did a roll count and check of all prisoners. We watched the CCTV of this check and are concerned that he did not look inside the cells for long enough to check the well being of Mr Sullivan, or indeed, other prisoners on the wing. He shone his torch in each cell, but did not look inside for more than a second. We are doubtful that this is long enough for an officer to check the apparent wellbeing of prisoners.
89. The officer told us that he directs the torch on to the bed and looks for a person lying there. If he sees someone, he is content and continues his check. If there is no figure on the bed, he looks around the cell and knocks on the door or puts the light on in order to check where the prisoner is. He did not remember his check of Mr Sullivan's cell on the morning of 24 March, but said he would have seen Mr Sullivan on his bed and that if he had not, he would have made certain of his whereabouts. Mr Sullivan was found with significant rigor mortis at 8.13am, and we are not persuaded by the officer's account of his roll check at 6.00am. We believe it is likely that Mr Sullivan was already dead at the time of the check.
90. Another officer unlocked the cells on the two's landing at 7.30am on 24 March. He told us that it was not usual practice to make a visual check of prisoners or get a response from them. Lowdham Grange told us there is no staff instruction about this issue. He locked Mr Sullivan's cell around 7.55am and unlocked it again about 8.10am so he could go to work. At no time did he look inside the cell properly, because if he had, he would have found Mr Sullivan hanged.
91. For their own safety, officers are supposed to look through the observation hatch before unlocking a cell door. When unlocking cells, they should also take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states:

“Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead.”
92. Nearly 45 minutes passed after the first unlock of his cell before Mr Sullivan was found, and in between, the cell had been relocked and unlocked again by the same member of staff. It was the prisoner next door, and not an officer, who eventually found Mr Sullivan and raised the alarm. Although this did not affect the outcome for Mr Sullivan, in other circumstances, poor unlock procedures could lead to a delay in giving effective emergency treatment.

**The Director should ensure that when conducting roll counts or unlocking or locking a cell door, staff check that prisoners are safe and that there are no immediate issues that need attention.**

### Personal officer scheme

93. Lowdham Grange's personal officer scheme says that personal officers will "provide prisoners with a focal point and involve wing officers in decisions relating to the care, control and well being needs of prisoners allocated to them". Prisoners are allocated a personal officer and a secondary officer, who will act in the personal officer's absence. The wing manager is responsible for advertising which staff are the primary and secondary personal officers. Personal officers are asked to ensure that up to date behaviour and conduct records are maintained on a weekly basis, with both positive and negative comments. Managers audit the system to ensure documents are up to date with relevant and quality comments.
94. Mr Sullivan had a primary personal officer and a secondary officer. (The secondary officer said he was not sure who Mr Sullivan's secondary officer was, and that, in reality, prisoners spoke to whoever was on duty if their personal officer was not there.) The primary personal officer said he took the personal officer scheme seriously and talked regularly to the prisoners he was responsible for. This was reflected in the regular entries he made about Mr Sullivan in the electronic case notes. It is clear from these and speaking to Officer Sullivan, that he knew him well. However, Mr Sullivan should have been assigned a new personal officer when his own left the wing in October 2015. Instead, we found that a number of cells on Mr Sullivan's wing still had this officer listed as their personal officer when we investigated in April 2016.
95. Although Mr Sullivan did not benefit from regular contact with his personal officer from October 2015, we are satisfied he received a good level of support from his offender supervisor. She knew him well and he felt able to talk to her. While it is reassuring that Mr Sullivan had staff he felt comfortable talking to, it is clear that the prison's personal officer protocol was not implemented effectively on Mr Sullivan's wing. Two prisoners did not know who their personal officers were when we asked them.

**The Director should ensure that prisoners are assigned a new personal officer if their current one leaves their role, and in line with the personal officer protocol, that personal officers understand their responsibilities.**

### Resuscitation

96. Prison and medical staff tried to resuscitate Mr Sullivan despite the presence of rigor mortis. The clinical reviewer said resuscitation attempts were futile.
97. Although the nurse felt confident as the emergency response nurse, she did not fully assess Mr Sullivan's condition and was not aware that resuscitation is not appropriate if there is rigor mortis or blood pooling. The other nurses who went to the cell continued the resuscitation efforts she had started.
98. We understand the commendable wish to attempt and continue resuscitation until death has been formally recognised, but staff should understand that they

are not required to carry out cardiopulmonary resuscitation in some circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. Lowdham Grange's contingency plans say that healthcare staff should not start or continue resuscitation if rigor mortis is present, but offer no such guidance to discipline staff. Officer C said staff were trained always to try to resuscitate until a qualified medical person told them to stop.

99. European Resuscitation Council Guidelines 2010 say, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ..." The guidelines define examples of futility as including the presence of rigor mortis. In October 2014, the British Medical Association, the Royal College of Nursing and the Resuscitation Council UK issued guidance about making appropriate decisions about resuscitation. The guidance says that every decision should be based on a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

**The Director should ensure that all staff receive guidance about the circumstances in which resuscitation is inappropriate.**

#### **Staff support**

100. While we recognise that Lowdham Grange debriefed staff involved in the emergency response and we are not making a formal recommendation, it would have been better if all staff who felt affected by his death, particularly those who knew him well, were offered appropriate support.

#### **Clinical review**

101. The clinical reviewer concluded that the healthcare Mr Sullivan received at Lowdham Grange was equivalent to the care he would have received in the community.
102. While, sadly, it would have made no difference to the outcome in Mr Sullivan's case, the clinical reviewer felt that five minutes was too long for staff to bring a defibrillator to Mr Sullivan's cell. He recommended that the prison should review where defibrillators are kept and the process for taking them to an emergency, which the Head of Healthcare will need to address.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations