Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Young a prisoner at HMP Littlehey on 13 June 2018

A report by the Prisons and Probation Ombudsman

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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*

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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.

Our 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 John Young died on 13 June 2018 of a heart attack at HMP Littlehey. Mr Young was 61 years old. I offer my condolences to Mr Young's family and friends.

Mr Young had a number of underlying health concerns and held strong but informed views about his own treatment. He refused to take his medication for heart disease and diabetes in the three months before his death. We find that the prison respected his views, and appropriately reviewed both his decisions and the mental capacity to make them.

After Mr Young died, other prisoners suggested that in the days leading up to his death Mr Young had indicated that he was going to die soon and may have deliberately brought about his own death. However, these concerns were not raised with staff prior to Mr Young's death and we consider that the prison acted appropriately with the information it had. We found no compelling evidence that Mr Young intended to cause his own death and note that he said that he wanted to start taking his medication again two days before he died.

We are concerned that Mr Young's family were not informed about his death until nearly seven hours after he died.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **April 2019**

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Summary

Events

1. On 31 May 2007, Mr John Young was sentenced to a minimum of five years' imprisonment under an IPP sentence. On 3 February 2017, he was transferred to HMP Littlehey.

2. On his arrival at Littlehey, it was noted at Mr Young's reception health screen that he had a history of Type 2 diabetes and coronary heart disease. He had medication for both conditions, and was kept under review by the healthcare team.

3. In March 2017, Mr Young declined to take his medication for a few weeks. He also signed a form, indicating that he did not want to be resuscitated if his heart stopped or if he had respiratory failure. In April, he resumed his medication and had no further significant health concerns for the rest of the year.

4. In March 2018, Mr Young returned all his medications and stated that he did not want them or want to have any further medical appointments. In April, a prison GP confirmed this was his intention, and assessed him to have the mental capacity to make such decisions. In May, the same GP confirmed that this was still Mr Young's intention.

5. Mr Young continued to test for diabetes. On 11 June, Mr Young asked if he could resume his medication after he consistently recorded his blood sugar as being very high. A pharmacy technician said he could not resume his medication without a GP review and sent an electronic note to the GP to action this.

6. On 13 June, at approximately 7.50pm, an officer saw Mr Young on the floor of his cell and requested help. Another officer arrived, and they entered his cell where they discovered that he was not breathing. They called an emergency over the radio. There were no healthcare staff on duty. A manager who responded to the call performed cardiopulmonary resuscitation until the ambulance arrived.

7. At approximately 8.15pm, the ambulance crew arrived. At 8.25pm, they pronounced Mr Young dead.

8. After Mr Young's death, several prisoners informed prison staff that Mr Young had indicated that he would die soon. They said that he had been eating excessively in the days leading up to his death.

Findings

Clinical care

9. We agree with the clinical reviewer that the care Mr Young received at Littlehey was equivalent to that which he could have expected to receive in the community. Healthcare staff managed his diabetes and coronary disease well, despite Mr Young's reluctance to take his medication. They also determined that he had the mental capacity to make decisions about his treatment, and respected his decisions while keeping them under review.

10. We also consider the decision by healthcare staff not to restart Mr Young's medication until he had had a full GP review was appropriate.

11. However, we also share the clinical reviewer's view that, ideally, Mr Young should have been treated as a complex case and subject to multidisciplinary reviews given his complex behavioural issues.

Concerns raised by other prisoners

12. We find that the prison acted appropriately in relation to concerns raised by prisoners about Mr Young's behaviour in the period leading up to his death. None of these concerns were raised with prison staff before that time, and there were no other indications that he might be deliberately harming himself.

13. We also consider that there was no conclusive evidence that Mr Young did in fact cause his own death.

Emergency response

14. We consider that the emergency response was appropriate when prison staff discovered Mr Young. We recognise that an emergency response code was not called immediately, but this was done as soon as it was established that Mr Young was not breathing.

15. We also find that the manager's decision to initiate resuscitation was appropriate in the circumstances, and in accordance with the prison's own policy.

Contact with Mr Young's family

16. We are concerned that the prison delayed appointing a family liaison officer, which meant that Mr Young's family were not informed promptly about his death. We are satisfied that its contact with his family was appropriate after this.

Recommendations

- The Governor and Head of Healthcare should ensure that prisoners who refuse medication and/or treatment and so increase their risk of serious health conditions, are discussed in the prison complex case meetings.
- The Governor should ensure that a member of Prison Service staff informs a prisoner's family or next of kin of their death in person, in line with national guidance.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact him. Several prisoners contacted the investigator as a result.

18. The investigator visited Littlehey on 28 June 2018. He obtained copies of relevant extracts from Mr Young's prison and medical records. He interviewed six prisoners and a member of wing staff at Littlehey on that date.

19. NHS England commissioned a clinical reviewer to review Mr Young's clinical care at the prison. The investigator and clinical reviewer interviewed four more members of staff on 10 September 2018.

20. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

21. The investigator wrote to Mr Young's sister to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. Mr Young's sister asked us to consider whether his wishes in respect of resuscitation were respected but otherwise had no specific points to raise.

22. Mr Young's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

23. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Littlehey

24. HMP Littlehey in Cambridgeshire is a medium security prison housing approximately 1,200 men. A considerable proportion of the prison's population are men who have been convicted of sexual offences.

25. Northamptonshire Healthcare NHS Foundation Trust commissions healthcare services at Littlehey. The prison healthcare centre is open from 7.30am to 7.00pm, Monday to Friday, and from 8.00am to 5.30pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Littlehey was conducted in March 2015. Inspectors reported that a small group of GPs who regularly attended the prison had significantly improved patient care. Lifelong conditions were identified effectively and there was an appropriate range of clinics, led by specialist nurses. Inspectors found that hospital appointments for prisoners were rarely cancelled but that risk assessments for keeping medication in-possession were not always reviewed and recorded correctly.

Independent Monitoring Board

27. 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 2018, the IMB reported that overall prisoners were treated fairly and humanely at Littlehey, but recognised that investment was required in the fabric of the prison. The Board noted that prisoners were generally satisfied with the quality of healthcare they received.

Previous deaths at HMP Littlehey

28. Mr Young was the 20th prisoner to die at Littlehey since the start of 2016. We recognise that Littlehey has a high number of elderly prisoners and a high mortality rate due to this. There were no similarities between Mr Young's death and the other deaths at the prison.

Assessment, Care in Custody and Teamwork

29. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the prisoner. Levels of observations and interactions are set according to the perceived risk of harm.

Key Events

30. On 31 May 2007, Mr John Young was sentenced to a minimum of five years' imprisonment under an IPP sentence for sexual offences. This meant he was required to remain in prison until the authorities were satisfied that he no longer posed a danger to the public. Mr Young spent time at several prisons but on 10 December 2008, he was transferred to HMP Bure.

31. On 3 January 2016, Mr Young handed all his medications back to prison wing staff. The next day, he signed a disclaimer to confirm his refusal of treatment. He also told a nurse that he wanted to be left to die. Staff opened an ACCT in order to monitor Mr Young.

32. On 11 January, Mr Smith told a prison GP that he had converted to become a Jehovah's Witness. He said that he did not feel he should take medication, and requested a DNACPR. A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.

33. Two days later, he agreed to resume his medication. On 9 May, a prison GP discussed a DNACPR with Mr Young. He informed him that it was an unusual situation and difficult to grant at this stage because Mr Young was not suffering from a terminal illness, and had a good standard of life. The GP advised Mr Young to submit this request in writing, but he declined to pursue it further at this stage. On 9 May, Mr Young's ACCT was closed.

34. On 3 February 2017, Mr Young was transferred to HMP Littlehey.

35. A nurse reviewed Mr Young at a health screen on his reception at Littlehey. She recorded that in 2010, he had had a stroke which left him weak on his left side and caused some mobility limitations. The nurse also noted that in 2015 he had had a heart attack, and that Mr Young had a history of hypertension (high blood pressure) for which he was prescribed 2.5mg of ramipril daily. The nurse recorded that Mr Young had Type 2 diabetes and was prescribed 80mg of gliclazide daily. She referred him for a blood test for diabetes.

36. On 27 February, a prison GP reviewed the results of Mr Young's blood test. She noted that they were abnormal and she added him to the diabetic clinic. On 3 March, a nurse reviewed Mr Young in her capacity as the diabetes nurse. Mr Young said that he was thinking of stopping his medication because he wanted a single cell. The nurse warned him of the increased risks of stopping his medication and advised him to increase his gliclazide dose due to his abnormal blood test results. She advised him to apply to officers about cells. Mr Young agreed to this, and his gliclazide dose was doubled.

37. On 8 March, a nurse reviewed Mr Young in her capacity as the coronary disease nurse at Littlehey. She recorded that his blood pressure was high and advised him to double his ramipril dose, which he agreed to do. The nurse noted that he told her he had not eaten for three days because he wanted to see what the staff would do. She also noted that Mr Young said he had converted and was now a Jehovah's Witness. He said this guided his beliefs about his medication.

38. On 17 March, Mr Young refused to be relocated into a double cell, and prison staff moved him to the Care and Separation Unit (CSU). A nurse recorded that he was "medically fit to be held in the segregation unit" (CSU). The next day, Mr Young told a nurse that he did not want to take his medication. He continued to refuse medication for several weeks, despite healthcare staff warning him about the danger he faced due to his hypertension and diabetes.

39. On 21 March, a prison GP reviewed Mr Young. She noted that he was refusing to take his medication, and recorded that his blood sugar level was high. Mr Young said that he did not want to be alive, and did not want to be resuscitated. The GP observed that he had no signs of depression or psychotic illness and had not self-harmed. She recorded that Mr Young needed a full mental health assessment and an end of life plan. Mr Young signed a disclaimer to confirm that he was knowingly refusing treatment.

40. The next day, a nurse discussed a DNACPR with Mr Young and he informed her that this was what he wanted. A prison GP later reviewed Mr Young with a nurse, and he confirmed that he did not want to have any life sustaining treatment or any treatment for his diabetes. His DNACPR was agreed and signed that day.

41. Mr Young remained in the CSU for a few weeks. On 28 March, staff opened an ACCT for Mr Young due to his non-compliance with medication. An officer noted that "although there is no imminent danger, there could be consequences due to his diabetes". On 30 March, a nurse noted that he had again refused medication and had also declined his breakfast that morning. The next day, a prison GP recorded that Mr Young was still refusing medication, and had not eaten the previous day. On 2 April, a nurse recorded that Mr Young was still not eating or taking medication, but was drinking plenty of fluids. Throughout this period, Mr Young was still deemed to be medically fit to remain in the CSU.

42. On 3 April, Mr Young was relocated from the CSU into an ordinary single cell. He collected his meals immediately but continued to decline his medication. The following day, Mr Young said he would resume his medication. On 12 April, a pharmacy technician recorded that although Mr Young had started taking his medication again, he was concerned that he would run out. She consulted a prison GP, who confirmed it was safe for Mr Young to restart his medication at his previous dose.

43. On 12 April, Mr Young's ACCT was closed. This was the last occasion on which he was on an ACCT. An officer noted that Mr Young was now collecting his medication, and was otherwise fine.

44. On 28 April, a prison GP saw Mr Young for a scheduled review. He told her that he "wants to meet Jesus, sooner the better" and added that he felt ill and that his legs hurt when he walked. The GP noted that his diabetes blood score was abnormal and that she was not surprised he felt unwell. She advised Mr Young that his blood pressure was not under control, and suggested that he took statins. The GP increased his ramipril daily dose to 7.5mg daily and advised alternative diabetes control, which Mr Young said he would consider. On 16 May, Mr Young started on a 5mg daily dose of linagliptin. (Gliptins work by blocking an enzyme which destroys one of the hormones which regulates insulin production.) On 13

June, a prison GP reviewed Mr Young and noted that he appeared to be in better health. She scheduled a further review for eight weeks.

45. In addition to his diabetes medication, Mr Young was also using testing strips to check his blood sugar level. On 7 July, a nurse had a diabetes review with Mr Young. He said that he was eating what he fancied, but would try to be more sensible. The nurse recorded that his clinical observations were normal other than his blood pressure which was slightly high. On 9 August, a diabetes nurse reviewed Mr Young. She advised him to vary the testing times for his diabetes to provide greater accuracy, and increased his gliclazide to 160mg daily.

46. On 19 July, a prison GP reviewed routine diabetes blood tests which revealed abnormalities. He feared that these could be indicative of something more serious, so referred Mr Young to the Haematology Department the same day. On 15 August, a prison GP reviewed Mr Young at Addenbrookes Hospital. He noted that Mr Young's blood was now normal, but scheduled a follow up review. On 17 October, a prison GP reviewed Mr Young and informed the prison that he had no fresh medical issues and that his blood results had remained stable.

47. On 29 November, Mr Young declined a flu jab which he was entitled to receive because of his diabetes. Otherwise, Mr Young continued to take his medication and to test his blood sugar levels. He had no significant concerns for the rest of the year.

48. On 9 January 2018, a prison GP examined Mr Young after he complained of pain from his left hip radiating down his left leg. Mr Young declined pain killing medication but agreed to do some exercises. On 15 February, a prison GP reviewed Mr Young, who said that the pain had improved to a manageable level. He noted that Mr Young had a TENS machine and advised him to use this but seek a review if the pain worsened. (TENS machines provide relief from pain by using a mild electrical current directly to the area concerned.)

49. On 22 March, a nurse saw Mr Young in a blood clinic for a scheduled blood test. He declined the test, and returned all his medication, stating he had not taken any for the past week. He told the nurse that he did not want any further medical appointments unless he requested them. The following day, Mr Young signed a disclaimer to confirm his medication refusal. Three days later, he told a nurse that he felt better without his medication. She reminded Mr Young of the likely long-term benefits of taking his medication and recorded this conversation in his medical records.

50. On 30 April, a prison GP saw Mr Young due to staff concerns about his refusal to take his medication. She recorded that Mr Young had the mental capacity to make decisions about his treatment and completed a Mental Capacity Act assessment. The GP explained to Mr Young how diabetes impacted on the body. She said in interview that he appeared to understand, and was aware that his blood sugar level was high, but that he said he felt terrible when taking tablets. The GP noted in Mr Young's records that he was possibly depressed and might feel better if he had therapy or took antidepressants. She also recorded that he had a good understanding of his diabetic condition.

51. On 23 May, a prison GP reviewed Mr Young. He confirmed that it was still his intention to decline medication but asked the GP to look into an alternative diabetes treatment which involved surgery to remove 1g of fat from the pancreas. In interview, the GP said that she later looked into this but that this was still a theoretical method outlined in a research paper which was some way from the treatment stage. The GP said that this exchange also pointed to Mr Young's knowledge and understanding of his condition and the treatment that was available. Mr Young reported that he felt low at this time of year, but did not explain why.

52. Mr Young continued to decline his medication but carried on testing his blood sugar levels with the help of a fellow prisoner. In interview, the prisoner said that Mr Young's blood sugar levels were at the maximum level the machine could measure, and that he persuaded him to go to healthcare to restart his medication.

53. On 11 June, Mr Young told a pharmacy technician that he wanted to restart his medication. She told him that he could not do this without a GP review due to the potential dangers of resuming after such a long period. She consulted her manager and then sent an electronic message to a prison GP to arrange a review. The GP was not at work that day but said at interview that she would have arranged a review with Mr Young before starting his medication again. She said she would not have regarded this as an urgent appointment.

Events of 13 June

54. On 13 June, at approximately 5.15pm, Mr Young was locked in his cell for the evening. At approximately 7.50pm, an officer was performing a roll check of the cells when he discovered Mr Young lying on the floor of his cell. He could not get a response. The officer saw another officer near the office and ran over to get his assistance. They entered Mr Young's cell and when they found that Mr Young was not breathing, one of them called a code blue emergency on the radio. (A code blue is an emergency radio code which indicates someone is unconscious or having problems breathing and immediately alerts healthcare staff and the control room to call for an ambulance.)

55. Littlehey do not have healthcare staff on duty in the evenings and an emergency ambulance was called. Other staff arrived quickly in response to the emergency, including a Custodial Manager (CM). He observed that Mr Young had fluid coming out of his nose and mouth, with food hanging out of his mouth. The CM could find no pulse, so he instructed officers to move Mr Young onto the landing. He then started cardiopulmonary resuscitation (CPR). In interview, the CM stated that he was aware that Mr Young had signed a DNACPR, but because there was food in his mouth he thought he might have been choking.

56. At approximately 8.15pm, the ambulance crew arrived and took over Mr Young's care. At 8.25pm, they pronounced Mr Young dead.

Concerns raised by other prisoners

57. The following day, four prisoners expressed concerns about Mr Young's recent behaviour. A Supervising Officer (SO) recorded these concerns. None of these issues had been raised with officers prior to Mr Young's death.

58. A prisoner said that Mr Young had been angry on Monday of that week (11 June) when told that he would have to see a GP before receiving his medication again.

59. A prisoner said that Mr Young's blood sugar levels had been unreadable for the two weeks prior to his death. He also said that, although Mr Young had never explicitly said that he wanted to kill himself, when he said, "See you tomorrow" to Mr Young on the Wednesday (13 June), Mr Young had replied, "No, this is goodbye".

60. A prisoner told the SO that in the days before Mr Young died, he had been eating excessively and consuming vast quantities of liquids. In interview, the prisoner said that Mr Young had been acting strangely on the evening he died. When the prisoner had said, "See you tomorrow", Mr Young had replied, "No, it is goodbye". The prisoner also said that a few days earlier, Mr Young had checked that he was still on a DNACPR. He said he had complained when prison staff began performing CPR on Mr Young because of this. He said that Mr Young had "always said he wanted to be with God – in God's garden" but that he could not say whether he took his own life or just knew he was going to die.

61. A prisoner told the SO that Mr Young told him on the day that he would be dead "tomorrow". He added that he did not take it seriously at the time. In interview, the prisoner said that Mr Young had started saying that he wanted to die approximately five to six weeks earlier. He said that the day before Mr Young died, he said, "I am going to die tomorrow", and on Wednesday morning he said, "It is soon going to be over".

62. A prisoner, who is a Jehovah's Witness, said in interview that Mr Young spoke to him a couple of times in the days before he died. He did not appear depressed and gave no indication of giving up. The prisoner confirmed that not only is suicide contrary to the beliefs of Jehovah's Witnesses, but that there was also a duty to stay alive. However, he said that Mr Young was not a fully-fledged Jehovah's Witness because he had not been baptised.

Contact with Mr Young's family

63. Following Mr Young's death, the prison appointed a prison manager as the family liaison officer (FLO). Just before midnight, the FLO arrived at the prison along with another manager.

64. One of Mr Young's friends was listed as his next of kin but there was no record of any contact between them on his prison record. The FLO noted that there had been regular contact between Mr Young and his sister, so she decided to inform her of her brother's death. At 3.00am the following morning, the FLO and manager informed Mr Young's sister at her home of his death. They answered her questions and offered their support.

65. On 29 June, the FLO called the mobile number recorded for Mr Young's friend. The person who answered confirmed that she had the right person but said that he did not know Mr Young.

66. Mr Young's funeral was held on 5 July. The prison contributed to the cost in line with national guidelines.

Support for prisoners and staff

67. After Mr Young's death, a CM 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.

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

Post-mortem report

69. The post-mortem concluded that Mr Young died from a coronary artery thrombosis (a heart attack caused by a blood clot inside a blood vessel in the heart) and coronary atherosclerosis (a build-up of plaque inside the arteries causing them to narrow). Mr Young's earlier heart attack and his diabetes were cited as secondary causes of death.

Findings

Clinical care

70. The clinical reviewer concluded that the care Mr Young received while he was at Littlehey was equivalent to that which he could have expected to receive in the community. Mr Young was a very complex case and he had a number of health concerns. We agree with the clinical reviewer that healthcare staff appropriately monitored and managed his diabetes and coronary heart disease, and made referrals to external specialists when necessary.

71. Mr Young's health concerns were further complicated by his refusal to take his medication on occasions, most notably in the three months prior to his death. Mr Young held strong religious beliefs as well as an aversion to his medication, which he said made him feel ill. We consider that healthcare staff appropriately sought confirmation of his intention to refuse on a regular basis, and Mr Young was formally assessed to have the mental capacity to make these decisions.

72. When Mr Young sought to restart his medication a few days before he died, we consider that the staff acted appropriately in refusing to restart it without a full GP review. We note the clinical reviewer's view that, given the length of time he had been declining his medication, this review was important but not urgent, and that it was appropriate to schedule this at the next convenient GP surgery. We also note the clinical reviewer's findings that even if Mr Young had received his medication when he requested it on the Monday, it is unlikely to have had time to deliver a therapeutic dose and to have prevented his death.

73. Mr Young had a DNACPR in place from 22 March 2017 until he died some 14 months later. We recognise that the DNACPR was never formally reviewed during that period, but agree with the clinical reviewer that Mr Young had regular reviews with healthcare staff during that period. When he stopped taking his medication in March 2018, a prison GP assessed Mr Young's mental capacity and noted that he had full capacity to understand the decisions he was making about his healthcare. It is also telling that Mr Young appears to have checked that his DNACPR was still in place a few days before he died, as this suggests that he had not changed his mind about not wanting to be resuscitated. Prison staff and fellow prisoners were aware that a DNACPR was in place.

74. The comments from the other prisoners suggested that Mr Young might have deliberately intended to shorten his own life, both by neglecting his medication and health, and through potentially damaging dietary behaviour. He certainly appears to have adopted a very poor diet and was aware that he was registering very high readings in his personal diabetes tests. We accept that for reasons of medical confidentiality, prison staff would not have been aware that Mr Young was not taking his medication. We also accept that prison staff were not aware that fellow prisoners had any concerns until after Mr Young died, and so could not reasonably have taken extra measures to monitor him. It is also notable that healthcare staff would not necessarily have been aware that Mr Young was neglecting his diet, apart from what he told them himself.

75. We agree with the clinical reviewer that, ideally, Mr Young would have been subject to multidisciplinary reviews given his complex behavioural issues. Mr

Young was never regarded as a complex case, and was consequently never subject to multidisciplinary reviews. The Head of Healthcare said that Mr Young would have been discussed as part of the daily handover process due to being DNACPR, but we have not seen evidence of this. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners who refuse medication and/or treatment and so increase their risk of serious health conditions, are discussed in the prison complex case meetings.

76. We have not identified any compelling evidence to suggest that Mr Young was deliberately trying to bring about his own death. Although fellow prisoners have reported that he said things which might, in hindsight, appear to indicate a desire, or even intention, to die, none of them took this seriously at the time, and nobody reported anything to prison staff. Nor did Mr Young leave any note, and he did not indicate any such thoughts to his sister, to whom he spoke on a regular basis.

Emergency response

77. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two code medical emergency response system in place. A code blue should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance.

78. When an officer first discovered Mr Young lying on the floor of his cell, he did not use an emergency code immediately. He requested assistance from another officer and a code blue was called a couple of minutes later once they had entered Mr Young's cell and established that he was not breathing. An ambulance was then called immediately and arrived at the prison promptly. Although we recognise that a code blue was not called immediately, we consider that the emergency response was triggered as soon as it was established that Mr Young was not breathing.

79. Littlehey have a local policy relating to DNACPR which sets out the criteria for the recording and monitoring of prisoners on a DNACPR notice and when CPR should and should not be attempted. It specifically states that staff should be aware of which prisoners are on a DNACPR. It also states that:

> "The DNACPR only applies with cardiac or respiratory arrest.
>
> It does not apply with self harm or suicide or incidents such as choking, falls etc."

80. Mr Young was on a DNACPR notice, which was recorded in control room records. We note that the CM performed CPR but we accept that this was due to his belief that Mr Young had choked on his food, and was in keeping with the prison's DNACPR policy.

Contact with Mr Young's family

81. Prison Rule 22(1) states: "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the

governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

82. Under Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* "prisons must ensure that an appropriate member of staff engage with the next of kin of prisoners who are seriously ill", and that "time will be of the essence in order to try to ensure that the family do not find out about the death from another source."

83. Despite Mr Young's death being confirmed at 8.25pm, it was three hours before the prison appointed a family liaison officer. We find that after the FLO had established that there had been no contact between Mr Young and his nominated next of kin, she appropriately decided to inform Mr Young's sister of his death. We consider that the FLO then acted appropriately and promptly in informing her in person. However, we consider that the initial delay in appointing them meant that Mr Young's family were not informed of his death until 3.00am the following morning. We therefore make the following recommendation:

The Governor of Littlehey should ensure that a family liaison officer is appointed promptly when a prisoner dies so that they can inform the prisoner's family or next of kin of their death in person as soon as possible, in line with national guidance.

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Independent Investigations

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