Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jeffrey Watkins a prisoner at HMP Littlehey on 24 October 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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*

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 I oversee can improve their work in the future.

Mr Watkins was found dead on 24 October 2018 in his cell at HMP Littlehey after taking an overdose of his prescription medication. Mr Watkins was 56 years old. I offer my condolences to Mr Watkins' family and friends.

Mr Watkins had a number of factors which affected his mood, particularly his tinnitus which was made worse when other prisoners played music loudly, and which led him to express suicidal thoughts to healthcare staff. He repeatedly complained about volume levels on the wing and, as a result, he was assaulted by another prisoner about six weeks before his death. He was eight years over his life sentence tariff and had recently been refused parole or a move to an open prison. He left a note indicating that he intended to take his own life because he was being bullied by a member of staff over the amount of property he had in his cell, although we do not consider that the member of staff's behaviour was unreasonable.

I am concerned that there is no evidence that prison staff had any meaningful engagement with Mr Watkins in the last two years of his life. If they had done so, they would have been better placed to consider whether Mr Watkins might pose a risk to himself.

When staff found Mr Watkins unresponsive, there was a delay of around 15 minutes before they unlocked his cell. This was unacceptable. There was also a further delay in telephoning an ambulance.

I am also concerned that staff attempted to resuscitate Mr Watkins even though he was clearly dead.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **September 2019**

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Summary

Events

1. Mr Jeffrey Watkins was remanded into custody in 1996, charged with serious sexual and violent offences against his children. In 1997, he was sentenced to life imprisonment with a tariff of 14 years.

2. Until 2009, Mr Watkins was a prolific self-harmer. After this, there was a single minor incident of self-harm in 2016.

3. In 2014, Mr Watkins transferred to HMP Littlehey. He was prescribed medication for his depression and physical health issues. Mr Watkins also suffered from tinnitus, which he said was made worse by other prisoners' loud music. He was prescribed medication to treat this.

4. In June 2017, Mr Watkins told a prison GP that he was becoming increasingly distressed by his tinnitus. The GP said he would refer Mr Watkins for a hospital assessment but failed to do so until November. Mr Watkins made numerous complaints to wing staff about other prisoners playing loud music.

5. Mr Watkins accumulated so much property in his cell that it significantly exceeded prison regulations. In 2017 and early 2018, he was asked to reduce the amount of property in his cell. Mr Watkins complained but complied.

6. In June 2018, Mr Watkins told a hospital consultant that his tinnitus was leading him to have suicidal thoughts. A mental health nurse at the prison subsequently assessed him but did not consider that Mr Watkins posed a risk to himself. A GP prescribed him amitriptyline (a painkiller) for his tinnitus.

7. In August, Mr Watkins was assaulted by another prisoner after he complained about him playing loud music.

8. On 23 October, Mr Watkins was again told that he needed to reduce the amount of property in his cell to comply with Prison Service regulations. Some prisoners who saw Mr Watkins that evening thought he seemed upset about this, while others thought he was his usual self.

9. During the next morning's roll check, an officer found Mr Watkins lying on the floor of his cell. There was a 15-minute delay before staff entered the cell and radioed an emergency medical code, and there was a further six-minute delay before the control room called an ambulance. Staff attempted to resuscitate Mr Watkins. Paramedics attended and pronounced Mr Watkins dead.

10. Mr Watkins had left a note indicating that he had taken his own life because he had been "victimised" by an officer over the property in his cell.

11. The post-mortem report concluded that he had died from an overdose of his prescription medications.

Findings

Assessment of risk

12. There were a number of factors that affected Mr Watkins' mood: his tinnitus and his associated concerns about loud music; conflict with other prisoners over loud music; his failure to obtain parole; and the action taken to remove excessive property from his cell.

13. We are satisfied that staff took appropriate action when Mr Watkins was assaulted by another prisoner.

14. We consider that staff did not fully appreciate the distress his tinnitus caused Mr Watkins and we are not convinced that staff consistently enforced Littlehey's noise reduction policy.

15. We are satisfied that the amount of property in Mr Watkins' cell was significantly above the required levels and posed a health and safety risk. We consider that it was reasonable for a SO to have told Mr Watkins to dispose of some property and that this did not amount to bullying.

16. We are concerned that there is no evidence that wing staff had any meaningful engagement with Mr Watkins in the last two years of his life and that his personal officer made only three entries in his electronic record.

17. We accept that wing staff had no reason to consider that Mr Watkins was at imminent risk of suicide at the time of his death. However, we consider that this was largely because they were unaware of the various factors that affected his mood. If they had engaged with him more, they might have had reason to consider whether Mr Watkins posed a risk to himself.

Clinical care

18. Mr Watkins physical and mental health care was equivalent to that he could have expected to receive in the community. However, there were occasions when healthcare staff did not document their interactions with Mr Watkins or refer him to hospital as intended.

19. We are concerned that the decision to allow him to have his medication in his possession was not reviewed after he told healthcare staff that he was having suicidal thoughts in 2017 and 2018.

Emergency response and prisoner support

20. We are concerned that after an officer saw Mr Watkins lying unresponsive on the floor of his cell, there was a delay of approximately fifteen minutes before staff entered the cell and called an emergency medical code. There was a further six-minute delay in calling an ambulance. While neither of these issues affected the outcome for Mr Watkins since he had been dead for some time when he was found, such may make the difference between life and death in another emergency.

21. Staff attempted to resuscitate Mr Watkins even though this was inappropriate because rigor mortis was present.

22. We are also concerned that some prisoners were not supported effectively after the death of Mr Watkins.

Recommendations

- The Governor should ensure that staff consistently enforce Littlehey's noise reduction policy.
- The Governor should ensure that staff record what action they have taken in response to a 'sharing of risk' form, including the reasons why no action is considered necessary.
- The Governor should ensure that key workers are allocated sufficient time to engage with prisoners.
- The Head of Healthcare should ensure that staff action referrals promptly and record all interactions and risk information in a prisoner's medical record.
- The Governor should ensure that:
    - all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is a potential risk to life, and that local policies and instructions reflect this prominently; and
    - all staff carry a torch during the hours of darkness.
- The Governor should ensure that all prison staff are made aware of, and understand, their responsibilities during medical emergencies, including the need for the control room to telephone an ambulance immediately.
- The Head of Healthcare should ensure that decisions to allow a prisoner to hold medication in possession should be reviewed if a prisoner expresses suicidal thoughts.
- The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.
- The Governor should ensure that prisoners are offered appropriate support following a death in custody or other traumatic event.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with members of staff so that they are aware of the Ombudsman's findings.

The Investigation Process

23. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact her. Several prisoners responded and were interviewed as part of the investigation.

24. She visited Littlehey on 31 October 2018. She obtained copies of relevant extracts from Mr Watkins' prison and medical records.

25. She interviewed 11 members of staff and 15 prisoners at Littlehey between October 2018 and February 2019.

26. NHS England commissioned a clinical reviewer to review Mr Watkins' clinical care at the prison.

27. 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.

28. We contacted Mr Watkins' next of kin to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She wanted to know how Mr Watkins had obtained the batteries which were found in his stomach during the post-mortem examination. Prison staff said that these items could be obtained from healthcare staff, hospital staff or other prisoners.

29. We also contacted Mr Watkins' friend, who he had listed as his next of kin. She wanted to know how and why Mr Watkins had died. These questions are answered in the main body of the report.

30. Mr Watkins' next of kin and friend received a copy of the initial report. They did not make any comments.

31. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Littlehey

32. HMP Littlehey in Cambridgeshire is a medium security prison holding approximately 1,200 men convicted of sexual offences.

33. Northamptonshire Healthcare NHS Foundation Trust commissions healthcare services at Littlehey. The prison healthcare centre is open from 7.30am to 7.30pm, 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

34. The last inspection of HMP Littlehey took place in March 2015. Inspectors found that safety processes were effective and there were very few violent incidents. They found that formal processes for dealing with perpetrators and victims needed improvement but victims appreciated the support of peer supporters in the 'buddy' scheme. Prisoners at risk of suicide and self-harm were generally well supported. The availability of illegal drugs was lower than at other prisons and support for prisoners with substance misuse issues was good.

35. Inspectors also found that relationships between staff and prisoners were good. Health services were also good and were responding effectively to the needs of the growing ageing population. They concluded that offender management and resettlement were most in need of improvement, in terms of addressing the risk and needs presented by this group of prisoners.

Independent Monitoring Board

36. 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 resettlement opportunities for prisoners needed improvement. They noted that there had been a slight increase in violence but that there were robust processes in place to manage both perpetrators and victims. They found that prisoners were generally satisfied with the healthcare they received.

Previous deaths at HMP Littlehey

37. Mr Watkins' death is the only self-inflicted death at Littlehey since 2016. There have been 26 deaths at Littlehey due to natural causes during the same period. None of these deaths raised issues relevant to this investigation. Since Mr Watkins' death, there have been three further deaths, all from natural causes.

Assessment, Care in Custody and Teamwork (ACCT)

38. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will

occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

39. Mr Jeffrey Watkins was arrested in October 1996 charged with sexual and violent offences against his children. He was remanded into custody. In March 1997, he was convicted and the following month received a life sentence with a tariff (the minimum amount of time he had to spend in prison) of 14 years. His wife, who was his co-defendant, received a sentence of 15 years imprisonment. They divorced in 2003. Mr Watkins had no contact with his family after his arrest.

40. Mr Watkins completed various programmes related to his offending, including one for enhanced thinking skills in 1998; a sex offenders' treatment programme in 1999; and an extended sex offender treatment programme in 2013.

41. Mr Watkins had a long history of cutting himself which started when he was nine years old. He said he used self-harm as a coping mechanism. This continued in custody and Mr Watkins was often subject to Prison Service self-harm and suicide prevention procedures, known as ACCT. In 2009, Mr Watkins saw a psychotherapist for Eye Movement Desensitisation and Reprocessing (EMDR) which aims to alleviate the distress associated with traumatic memories. Apart from one later isolated incident in 2016, he stopped self-harming at this point and found alternative ways of coping.

42. Mr Watkins spent time in several prisons. While at HMP Parkhurst, in July 2012, he was stabbed by another prisoner. Paramedics attended and treated Mr Watkins who did not need to go to hospital. Mr Watkins told staff that he had suffered from post-traumatic stress disorder in the past and was now having flashbacks because of the assault. A nurse referred him to the mental health team who assessed him. They noted that he did not have a severe and enduring mental illness and hoped that the stress he felt after the attack would lessen over time. Mr Watkins was reviewed regularly by the mental health team both at Parkhurst and at subsequent prisons. In January 2013, he was prescribed citalopram (an antidepressant).

January 2014 – October 2018, HMP Littlehey

43. In January 2014, Mr Watkins transferred to HMP Littlehey. He had a history of Irritable Bowel Syndrome (IBS), which was managed with a high fibre diet and intermittent use of loperamide. He also had osteoarthritis for which he was prescribed naproxen (a painkiller). A GP also continued his prescription of citalopram. All of Mr Watkins' medication was held in his possession as he had no history of non-compliance with medication in prison.

44. Mr Watkins also suffered from tinnitus (hearing noises within the ears or head). He said this was worse in prison and affected his mood and sleep. He said he found it especially difficult to cope with other prisoners' music. A GP prescribed Mr Watkins betahistine to help lessen the symptoms of tinnitus.

45. In January 2016, Mr Watkins complained to staff about another prisoner's loud music. He later cut his arm as he said he had had enough of the music. Staff opened an ACCT. Mr Watkins moved landings and staff opened a victim support plan to assist him. The next day staff closed Mr Watkins' ACCT. On 21 January, staff closed Mr Watkins' victim support plan as Mr Watkins said he no longer felt

under threat and that his issues had been resolved. He did not self-harm again after this.

46. Also in January 2016, a mental health nurse assessed Mr Watkins. He said he was worried about his forthcoming parole hearing and about his own safety in prison, given his earlier assault. Mr Watkins told the nurse he had last attempted suicide in 2007 (there are no further details of this) and had no current thoughts of suicide or self-harm. The nurse noted that she would refer Mr Watkins to the trauma management group.

47. In April, Mr Watkins attended a Parole Board hearing. A psychologist had recommended that he be assessed for a therapeutic community (a participative, group-based approach used to treat mental illness, personality disorders and substance misuse) but Mr Watkins continued to refuse this. Over the following months, Mr Watkins attended a trauma management group run by the prison mental health team and engaged positively. In June, Mr Watkins received the Parole Board's decision that he was to remain in a closed prison.

48. In September, staff conducted volumetric control checks in Mr Watkins' cell. (These controls specify how much property prisoners can hold in their cells.) His property exceeded the amount he was permitted and he agreed to put some of his paperwork in property boxes in reception. Mr Watkins said he helped other prisoners with their legal issues and that some of his property related to this.

49. In November, Mr Watkins told his offender supervisor, that he was prepared to die in prison as he thought that people had not been honest with him. He told the investigator that he thought Mr Watkins was explaining that he would spend the rest of his life in prison rather than suggesting that he would take his own life.

2017

50. In June 2017, Mr Watkins told a GP that he was becoming distressed by his tinnitus. The GP said he would refer him to the hospital audiology department, but failed to do so. He later apologised to Mr Watkins.

51. In July, Mr Watkins' personal officer recorded in his electronic prison record that Mr Watkins had complained about loud music on the landing "on numerous occasions". The officer noted that, although staff listened out for this, it had not caused concerns and could be Mr Watkins' "way of engaging in conversation".

52. In August, an officer warned Mr Watkins that he had too much property in his cell. He recorded that the amount of paperwork in Mr Watkins' cell, was a serious fire risk. He noted that Mr Watkins had paperwork stacked on his toilet and all around the walls and that he had to put paperwork in front of his cell door in order to use the toilet and this was a fire risk. Mr Watkins failed to remove enough property.

53. In November, a GP referred Mr Watkins to the hospital audiology department to review his tinnitus. The doctor recorded that Mr Watkins' symptoms sometimes made it difficult for him to sleep and made him question the point of living. His symptoms were made worse by loud noise.

54. Also in November, staff again asked Mr Watkins to reduce the amount of paper and other materials in his cell. They noted that the items were a fire risk and prevented staff from searching his cell effectively.

55. Later that month, Mr Watkins' offender manager assessed him. She noted that Mr Watkins wanted to relocate to Worcester after being released. He had been assessed as unsuitable for the Healthy Sex Programme and refused to engage with assessments for other therapeutic programmes.

2018

56. On 5 February 2018, staff again asked Mr Watkins to reduce the amount of property in his cell. Mr Watkins filled two volumetric control boxes but still had over 16 boxes and 80 books left in his cell. He claimed that this was all legal paperwork (which is allowed) but staff disputed this. They explained that the amount of paper in the cell posed a fire risk to Mr Watkins and to others.

57. On 6 March, Mr Watkins submitted a complaint about other prisoners' music. A member of staff responded, saying that the noise would be monitored and prisoners would be considered for transfer to another wing if they did not comply with acceptable noise levels. On 27 March, Mr Watkins submitted another complaint about the same issue.

58. Also in March, his offender supervisor chaired a sentence planning meeting with Mr Watkins and a psychologist to try to plan a way for Mr Watkins to progress towards release. Mr Watkins was unwilling to consider undertaking the one to one work with a psychologist that was suggested.

59. On 16 April, an officer recorded in Mr Watkins' electronic prison record that he had eventually complied with the volumetric control requirements and had reduced the amount of property in his cell, despite raising several complaints.

60. On 23 April, staff submitted an intelligence report recording that Mr Watkins may be being bullied by another prisoner. A prisoner told the investigator that Mr Watkins was being bullied by two other prisoners who kicked his door repeatedly and called him derogatory names. On 26 April, staff spoke to Mr Watkins about the allegation. Mr Watkins said that one of the prisoners played loud music which affected his tinnitus and that he kept ringing his cell bell at night to report it. He said the other prisoner had been told that he had complained and that, although he was not being bullied, the prisoner was "giving him dirty looks". He said he kept out of the other prisoner's way. Staff offered him a move to another wing but he said there was no point as there might be loud music on another wing. Staff were directed to monitor music levels and interactions between the other prisoner and Mr Watkins.

61. On 30 May, Mr Watkins told a GP that his tinnitus was affecting his mood, which was made worse by loud music on the wing. He said he wanted to buy noise cancelling headphones but had been told that this required authorisation. The GP asked administrative staff to chase the audiology department for Mr Watkins' appointment. He increased Mr Watkins' prescription of betahistine and planned to review him in six weeks.

62. On 4 June, healthcare staff told Mr Watkins that they had no objection to the headphones but that he needed to check with security staff. On 20 June, Mr Watkins attended hospital to assess his tinnitus. He told the consultant that the tinnitus made him have suicidal thoughts. The consultant wrote to the prison healthcare department recording this and asked staff to refer Mr Watkins to the mental health team on this basis, which they did on 25 June. On 28 June, the prison received a letter from the hospital with advice about the treatment of his tinnitus. Staff booked Mr Watkins an appointment with a nurse to discuss this.

63. On 2 July, a nurse met Mr Watkins to discuss his tinnitus. The nurse gave Mr Watkins the information leaflet from the hospital and requested a follow-up appointment with them.

64. On 9 July, a mental health nurse assessed Mr Watkins. He noted that Mr Watkins had told hospital staff that he might react to other prisoners' loud music with aggression or by taking his own life. However, the nurse assessed that Mr Watkins had said this out of frustration and concluded that Mr Watkins did not pose a risk to himself and was making plans for his future. The nurse said Mr Watkins was calmer at the end of the interview having been given the opportunity to voice his frustrations. The nurse assessed that no further mental health input was needed at that time and planned to review Mr Watkins again, if necessary, after Mr Watkins' tinnitus had been reviewed at the hospital. The nurse reviewed Mr Watkins' medical record after assessing him as he said he had not had an opportunity to do so before the appointment.

65. On 10 July, the offender supervisor met Mr Watkins with a member of staff from the programmes team to discuss how Mr Watkins could progress with his sentence. They discussed the possibility of Mr Watkins moving to G wing or to another prison with a therapeutic community but he refused to consider these options. Mr Watkins said that he wanted to focus on his health issues and on lessening his symptoms of tinnitus while remaining in his current location. The offender supervisor suggested a move would solve this issue but Mr Watkins refused to consider it. He agreed to provide further information for Mr Watkins about the regime at HMP Warren Hill. Mr Watkins said he was not going to attend his forthcoming Parole Board hearing.

66. On 11 July, a nurse recorded that Mr Watkins sometimes thought that "being dead would be better than enduring the noise [of his tinnitus]". The nurse noted that Mr Watkins' risk to himself was due to environmental issues and his perceived lack of support from the prison rather than to any mental health issues and noted that he would raise Mr Watkins' risk issues with the prison's safer custody department. He discussed Mr Watkins in the mental health meeting.

67. The nurse also emailed a 'sharing of risk' information form to the prison's safer custody department setting out details of Mr Watkins' significant history of suicide and self-harm. It also included details of his tinnitus and the fact that a noisy environment was "likely to be very distressing" to Mr Watkins who had a "history of self-harm when stressed". He said Mr Watkins was booked to see the GP and asked wing staff to "please review current situation and management on the wing". On 12 July, safer custody recorded the 'sharing of risk' information in Mr

Watkins' electronic prison record. The nurse also telephoned wing staff to make them aware of Mr Watkins' situation

68. On 18 July, a GP reviewed Mr Watkins who asked to be prescribed amitriptyline (a painkiller) for his tinnitus. The GP agreed and prescribed Mr Watkins with 42 tablets. He also noted that Mr Watkins was waiting for a hospital audiology appointment.

69. On 20 July, the offender supervisor attended Mr Watkins' Parole Board hearing. Neither Mr Watkins nor his solicitor attended.

70. On 12 August, a prisoner confronted Mr Watkins about his complaints about the volume of his music. Mr Watkins allegedly threw food at the other prisoner who punched Mr Watkins several times in the face and head, resulting in him falling to the floor. Another prisoner intervened to stop the assault. Both Mr Watkins and the other prisoner had their privileges taken away and were monitored in line with the violence reduction policy. The other prisoner was moved from the wing. Staff submitted an intelligence report which noted there was no intelligence linking the two prisoners. A nurse assessed Mr Watkins injuries and Mr Watkins was also placed on a victim support plan due to the assault.

71. A prisoner told the investigator that he was not aware of Mr Watkins having any further issues with any prisoners after this. He (who was located on the same landing) said he could not hear any loud music himself. Some other prisoners also told the investigator that the loud music on the wing stopped after this incident, although some said that it continued until Mr Watkins died.

72. On 27 August, Mr Watkins' behaviour was reviewed and as there had been no further incidents, his privileges were restored. He was also removed from the victim support plan as there had been no further concerns that Mr Watkins was under threat.

73. On 31 August, an officer recorded that the disciplinary charge against Mr Watkin's of assaulting the other prisoner had been dismissed. He recorded that Mr Watkins "appeared to be gloating and showed slight arrogance" when he told him this and he noted that Mr Watkins needed to understand that he had been in a potentially volatile and dangerous scenario and things could have turned out much worse. He also noted that, although the disciplinary charge had been dismissed, Mr Watkins still had a period to serve on the basic regime under the Violence Reduction policy as he had been involved in a violent altercation.

74. On 4 September, Mr Watkins wrote to the police asking them to investigate the alleged assault on him by the other prisoner. He wrote that loud music had driven him to "the verge of suicide on several occasions" due to his tinnitus. He said that he had complained about the alleged perpetrator's music several times and the other prisoner had threatened and then assaulted him as a result.

75. On 5 September, a GP reviewed Mr Watkins' tinnitus. Mr Watkins said it had improved slightly since he had been taking amitriptyline. The doctor agreed to increase Mr Watkins' dose and prescribed him a further 28 tablets which he received the next day.

76. On 7 September, HMPPS wrote to Mr Watkins to tell him that the Parole Board had decided he should not be released or moved to open conditions. His offender supervisor gave Mr Watkins a copy of the letter. It said that he had not made progress in addressing his risk factors since the last parole review in 2016. It also recommended that he consider a move to a therapeutic community. The next parole review was scheduled for 20 months' time. Mr Watkins telephoned a friend and said that he would be appealing the decision.

77. A prisoner said that he thought Mr Watkins had become despondent and depressed due to the amount of time he had spent in prison. He said that Mr Watkins thought there was no point in engaging with the parole process as he was not going to be released. He did not think Mr Watkins presented a risk of harm to himself.

78. Other prisoners said that, in general, Mr Watkins had a small group of friends he associated with and trusted. A prisoner said that Mr Watkins often kept to himself and, during the last two months of his life, increasingly isolated himself. He said that he would come out of his cell to collect his meals but did not make eye contact and spent most of his time in his cell. A prisoner said that Mr Watkins' legal books were his "pride and joy" and that helping other prisoners with their applications (requests), complaints and legal matters was "all that kept Mr Watkins going in prison".

79. On 12 September, Mr Watkins saw a hospital consultant about his tinnitus. He told her that his tinnitus had become more difficult to cope with over the last 18 months and that his sleep was affected, he suffered from depression and PTSD, and had had thoughts of suicide. The consultant recorded that Mr Watkins was keen to try bilateral white noise generators which she could send to Mr Watkins, subject to the prison's approval.

80. A nurse said that he reviewed Mr Watkins after his hospital appointment and he had no concerns that Mr Watkins posed a risk to himself. The nurse said that Mr Watkins said he was still concerned about the noise on the wing. He did not document this in Mr Watkins' medical record.

81. On 21 September, Mr Watkins telephoned his friend and told her that he had been granted legal aid to appeal the Parole Board's decision. His offender supervisor told the investigator that he saw Mr Watkins regularly in passing and spoke to him at least weekly. He said Mr Watkins was mainly concerned with the noise on the wing. He offered Mr Watkins the chance to visit another wing, with a view to moving there, but he declined. He told the investigator that he had no concerns that Mr Watkins was a risk to himself.

82. On 28 September, Mr Watkins collected 21 citalopram tablets. On 12 October, Mr Watkins collected 28 amitriptyline tablets and 28 citalopram tablets. On 14 October, Mr Watkins telephoned a friend and said he was struggling to cope with the loud music on the wing. On 15 October, healthcare staff gave Mr Watkins a white noise generator.

83. Mr Watkins' personal officer told the investigator that he spoke to Mr Watkins once or twice a week. He said the only issue Mr Watkins raised with him was the noise on the wing but the officer thought that this had improved over the last few

months. He said Mr Watkins never told him he had tinnitus. The officer said he saw Mr Watkins about a week before he died and that he had no concerns that he was a risk to himself.

84. On 21 October, a Supervising Officer (SO) was conducting volumetric control checks of the cells on C wing. He noted that Mr Watkins had an excessive amount of property in his cell. His wardrobe was full of books and paperwork and books were stacked underneath his furniture. Staff later counted 84 books in Mr Watkins' cell.

85. On 23 October, around 2.00pm, a SO asked an officer to accompany him to talk to Mr Watkins about his property. The SO told the investigator that he asked Mr Watkins to comply with volumetric control and reduce the property in his cell over the following two days. He also removed around 200 blank complaints forms Mr Watkins had on his noticeboard, which prisoners should obtain for themselves from the prisoner information desk.

86. Mr Watkins did not reply to the SO's instruction. The SO said that he was surprised by Mr Watkins' reaction, since he would normally want to discuss matters. The SO returned a short time later and gave Mr Watkins two boxes to store his personal items and one for his legal items. He told Mr Watkins that the rest would be stored in the property store at the prison or be sent to the external contractor for storage. Again, Mr Watkins did not protest. When the SO questioned this, Mr Watkins replied, "What will be, will be." The SO told the investigator that, while this reaction was out of character, he had no concerns about Mr Watkins. An officer said that, in his experience, Mr Watkins' reactions varied from day to day and this did not seem out of character.

87. A prisoner told the investigator that he was sitting in his cell next door while a SO was taking to Mr Watkins. He told the investigator that he heard the SO telling Mr Watkins that he was not allowed to help other prisoners. He said that the SO told Mr Watkins to pack his legal books away and if he did not comply, his life would be "living hell". He said that Mr Watkins did not respond to this. He said he spoke to Mr Watkins about this afterwards. Mr Watkins said he could not be bothered to submit a complaint about the SO. However, he told him he was not going to give up his legal books. Other prisoners told the investigator that Mr Watkins said he was being bullied by the SO about his property.

88. Prisoners also noticed that Mr Watkins had reacted very differently to the previous occasions when he had been asked to reduce the amount of his property. They said he was very quiet and seemed "down". A prisoner told the investigator that in the past Mr Watkins had told him that they would have to take him out first before they could get his legal books out. He took this to mean that he would die before he would let staff take his books.

89. Prisoners told the investigator that Mr Watkins returned their legal paperwork to them that evening, saying that he had been told he was no longer allowed to help them. A prisoner said that Mr Watkins told him that a SO and am officer had told him he was a "pain in the arse" to the prison and he would not get away with complaining any more. Mr Watkins said that unless he complied with putting his property into storage, the SO had said that he would "make his life a misery". He told him that it was a waste of time speaking to a Custodial Manager (CM) about

it, that he was “done” and “finished”. The prisoner told the investigator that he thought that Mr Watkins meant he did not want to ‘battle’ the prison anymore. He had no concerns that Mr Watkins posed a risk to himself.

90. Other prisoners told the investigator that Mr Watkins seemed his usual self that evening and was laughing and joking.

91. A prisoner was in a cell next to Mr Watkins. He told the investigator that Mr Watkins came into his cell just before he was locked in his own cell, as he did every night. They spoke about what had happened with a SO and Mr Watkins said, “We’ll see tomorrow.” The other prisoner thought that Mr Watkins seemed ‘down’ about it but thought he meant they would talk about it the next day.

92. An officer locked Mr Watkins into his cell around 7.15pm. She said he was sitting on his bed. She asked him whether he was “alright” and he said that he was. The officer said that there was nothing out of the ordinary about Mr Watkins.

93. An Officer Support Grade (OSG) completed the roll check around 8.00pm. He told the investigator that he could not remember specifically checking Mr Watkins but he was certain that he would have assured himself of every prisoner’s welfare during this check.

Events of 24 October

94. On 24 October, an officer started his roll count of prisoners at around 5.05am. When he checked Mr Watkins’ cell, he discovered Mr Watkins was lying on the floor on his left side. The officer said that prisoners sometimes sleep on the floor and he thought he saw Mr Watkins’ leg move so he continued to check the other prisoners on the landing. He could not remember whether the night light was on in the cell but said there was light coming in through Mr Watkins’ window. There is no CCTV on C wing.

95. When the officer had finished his roll count, he returned to check on Mr Watkins to ensure he was sleeping. He estimated this was around five minutes later. He knocked on Mr Watkins’ cell door but he did not respond. He went to the wing office on the floor above and telephoned the communications room and asked them to summon an assistant orderly officer to come to C wing. The communications room then radioed officer who went straight to C wing.

96. The officer said he waited in the wing office and estimated that another officer reached the wing around five minutes later. They both went to Mr Watkins’ cell and could not get a response. One officer said the night light was on in the cell but was very dim. Neither of them had a torch. He said it was difficult to see whether Mr Watkins was breathing. One officer went to the wing office and telephoned the communications room again to get permission to enter Mr Watkins’ cell. The other officer remained at Mr Watkins’ cell door trying to get a response.

97. A CM, who was in charge of the prison, was told by staff in the communications room that a prisoner was lying on the floor. The CM gave an officer permission to go into Mr Watkins’ cell. He also radioed for other staff to go to the cell.

98. The officer returned to the cell and, along with the other officer, went into Mr Watkins' cell. They estimated that this was around five minutes after he had first reached the cell. The officers noted that Mr Watkins was not breathing and that he was very cold and stiff. An officer radioed a code blue emergency. An OSG in the communications room logged the code blue at 5.29am. Both officers estimated that the CM and another officer reached the cell a few minutes later.

99. The officer went into the cell with the CM. The CM said Mr Watkins was cold to the touch and there were signs that rigor mortis had set in. He thought Mr Watkins was dead. The CM and officer turned Mr Watkins onto his back. There was vomit on the floor. They could not detect a pulse. The officer attached a defibrillator and attempted resuscitation. The CM asked an officer to telephone the control room to request an ambulance again. He went to the wing office to do so. The CM and an officer continued chest compressions. An OSG logged calling the ambulance at 5.35am. Paramedics arrived at the prison gate at 5.50am, where they were met by staff and escorted to Mr Watkins. Paramedic records show that Mr Watkins was cold and stiff when they arrived, with rigor mortis in his arms and jaw. Paramedics pronounced Mr Watkins dead at 6.01am.

100. During the attempted resuscitation, an officer found a note, dated 23 October, on top of Mr Watkins' television. It indicated his intention to take his own life due to being "victimised" by a SO.

Contact with Mr Watkins' family

101. An officer was appointed as family liaison officer (FLO). Mr Watkins had listed his mother as his next of kin. The prison established that his mother was dead and staff were unsure whose address Mr Watkins had listed. The FLO and an officer travelled to the address, a significant distance away. The FLO said he did not consider it appropriate for staff from a prison closer to the address to break the news as he was not at that stage sure what relationship the person living there had with Mr Watkins. At 4.00pm, they reached the address – that of a friend of Mr Watkins who he called 'mother'. (They had met in prison years previously when she taught Mr Watkins yoga and they shared the same faith.) Staff informed her of his death. She was already aware of Mr Watkins' death, however as she had been informed by his solicitor.

102. On 29 October, Mr Watkins' next of kin, one of his victims, telephoned Littlehey asking about his death. The FLO returned her call and she confirmed that she was happy to discuss his death. The FLO remained in contact both with Mr Watkins' next of kin and his friend over the following weeks. In line with prison policy, he offered Mr Watkins' next of kin a contribution to the funeral expenses.

Support for prisoners and staff

103. After Mr Watkins' death, the Head of Equalities, Social Care and Healthcare, debriefed 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.

104. The prison posted notices informing other prisoners of Mr Watkins' 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 Watkins' death.

105. The investigator spoke to prisoners who had been friends of Mr Watkins. Most of them said they had felt poorly supported after Mr Watkins' death. They said that they had not been told personally about his death and nobody had checked on their welfare since.

Post-mortem report

106. The post-mortem report said that Mr Watkins' cause of death was a mixed drug overdose. The toxicology report said that Mr Watkins may have taken an excessive amount of amitriptyline and citalopram before he died, although it was difficult to determine this with any certainty due to post-mortem changes in the concentrations of the drugs. Both medications had been prescribed to Mr Watkins. The post-mortem also found four small batteries in Mr Watkins' stomach. These did not contribute to his death.

Findings

Risk factors

107. Mr Watkins had a long history of self-harm, dating back to when he was a child. He underwent therapy in 2009 and stopped self-harming, apart from an isolated incident in 2016. Following this incident, he told staff that he had attempted suicide in the community and had last tried to take his own life in 2007. There is nothing further documented in his prison record about this suicide attempt.

108. Mr Watkins had four issues that affected his mood: his tinnitus and his associated concerns about loud music; conflict with other prisoners over loud music; his failure to obtain parole; and the action taken to remove excessive paperwork from his cell.

Tinnitus and loud music

109. Individuals respond to tinnitus in different ways. Some cope well, but others find it extremely distressing. There is evidence that stress can make tinnitus – or the ability to cope with it – worse.

110. Mr Watkins clearly struggled with the volume of other prisoners' music and its effect on his tinnitus. In January 2016, he self-harmed saying he could not cope with the loud music. In July 2017, his personal officer recorded that Mr Watkins had made "numerous complaints" about loud music on the landing. In November 2017, he told a GP his tinnitus made him question the point of living, and in May 2018, he told a GP it was affecting his mood. In June 2018, he told a hospital consultant it was making him feel suicidal. In July, he repeated this to a prison nurse, and the nurse shared information about Mr Watkins' history of self-harm, and the effect the tinnitus had on his mood with safer custody staff and it was noted in his electronic prison record. In September, he told the police he was feeling suicidal and repeated this to a hospital consultant.

111. We are concerned that there is no evidence that wing staff took any action in response to the 'sharing of risk' form a nurse completed. This was a missed opportunity for staff to understand how seriously Mr Watkins' tinnitus affected him, and how distressing he found loud music, and to consider whether he might pose a risk to himself as a result.

112. Littlehey has a noise reduction policy introduced in July 2014. It says that prisoners are not allowed to play loud music at any time and must buy headphones if they want to listen to loud music. If music can be heard outside a cell, it is deemed too loud. Staff should challenge prisoners and ask them to reduce the volume of music if it exceeds the accepted volume. This should be recorded in the wing observation book and a prisoner's record. If a prisoner does not follow the instructions, he should be given a verbal warning that his equipment may be confiscated the following day. If a prisoner continues to play loud music, he should be issued with a written warning, his stereo should be removed until the next day, and the prisoner could face disciplinary procedures. He may also lose his stereo for a longer period.

113. Staff told the investigator that they did not think that there was an issue with loud music on the wing at the time Mr Watkins died. A CM said that Mr Watkins had complained less about the noise on the wing over the last few months of his life. Some prisoners also said that this was the case, although others said that they thought Mr Watkins had continued to be distressed by loud music until he died.

114. Staff were aware of the noise reduction policy and said they enforced it. A CM was satisfied that staff dealt with it appropriately on the wing. He said he had spoken to other prisoners who Mr Watkins complained about, and who, he said, had responded well to his requests to turn their music down.

115. We appreciate that it is difficult for staff to always be aware of loud music occurring on the wing, especially at night. However, such issues can have a negative impact on prisoners' mental health, as they did for Mr Watkins. We make the following recommendations:

The Governor should ensure that staff record what action they have taken in response to a 'sharing of risk' form, including the reasons why no action is considered necessary.

The Governor should ensure that staff consistently enforce Littlehey's noise reduction policy.

Conflict with other prisoners

116. Mr Watkins' complaints to staff about loud music brought him into conflict with other prisoners. We are satisfied that staff took action in response to these concerns. In April 2018, staff investigated allegations that he was being bullied by prisoners he had complained about. In August, when Mr Watkins was assaulted by another prisoner he had complained about, staff moved the other prisoner to another wing and monitored Mr Watkins under their victims' policy. However, some prisoners said they thought Mr Watkins self-isolated after he was assaulted.

117. We are concerned that there is no evidence that staff considered what impact the assault might have had on Mr Watkins' mood.

Parole

118. At the time of his death, Mr Watkins had been in prison for 22 years and was eight years over his tariff. In September 2018, about six weeks before his death, he was told that the Parole Board had decided he should not be released or moved to open conditions, and he appears to have become increasingly despondent about his prospects of ever being released.

119. We are concerned that there is no evidence that wing staff considered whether the Parole Board's decision might have an impact on Mr Watkins' mood.

Volumetric Control

120. Prison Service Instruction (PSI) 12/2011, *Prisoners' Property*, says that the property a prisoner has in his possession (that is, in his cell) must fit into two standard size volumetric control boxes, apart from items that are exempt from

volumetric restrictions. (The list of exemptions includes legal papers.) When a prisoner's property exceeds this amount, he must be encouraged to send excess items away, or they may be placed in storage. The PSI says that Governors must ensure that the volume of property held is regularly checked and does not become excessive. In practice some leeway is often allowed.

121. Mr Watkins was told he needed to reduce the volume of items in his cell in September 2016; August 2017; and February and October 2018. The last occasion was the day before Mr Watkins was found dead.

122. An unusually large number of prisoners asked to speak to the investigator after Mr Watkins' death. Most were concerned about the SO's treatment of Mr Watkins and some told the investigator that they had witnessed this first-hand the day before he died. They alleged that the SO had "bullied" Mr Watkins, raised his voice and said he would make his life a "misery" or "living hell" if he did not comply with his requests. The SO denied this and said he spoke calmly to Mr Watkins.

123. Prisoners also said that the SO had previously told Mr Watkins to stop helping other prisoners with their legal issues, something which was very important to Mr Watkins. The SO told the investigator that he did not know that Mr Watkins was helping other prisoners until after he died.

124. An officer who was with a SO when he spoke to Mr Watkins, said that the SO did not raise his voice or tell Mr Watkins that he would make his life "a misery". He said that the SO was calm throughout but "straight to the point". A CM also said he had no concerns about the SO's conduct generally. He said he was a "professional" officer, who could be assertive when necessary.

125. Other prisoners told the investigator that the SO enforced the rules and had a "direct" or "blunt" manner. However, they said he did not bully prisoners, and they believed he was being unreasonably blamed for contributing to Mr Watkins' death.

126. It is clear that the amount of property in Mr Watkins' cell had been a concern for at least two years and that the SO was not the first member of staff to ask Mr Watkins to reduce it. The descriptions in his prison record suggest that the amount of property was very significantly in excess of the limit. The investigator saw Mr Watkins' cell after his death and confirmed that the amount of property in it exceeded the allowance to an unusual degree. It would have impeded any meaningful search of a cell, besides being a health and safety risk, both in terms of a fire and tripping hazard.

127. This was not, therefore, a case of a prisoner being slightly over his allowance or of staff enforcing the rules over-rigidly. Although we recognise that being asked to dispose of some property may have upset Mr Watkins, we are satisfied that it was reasonable for the SO to ask Mr Watkins to reduce the amount of property in his cell.

Assessment of risk

128. At the time of Mr Watkins' death there were a number of issues that may have affected his mood: he was finding it increasingly difficult to cope with his tinnitus; he had been assaulted by another prisoner after complaining about his loud music; he may have been self-isolating as a result; he had been refused parole and despaired of ever being released; and he had been asked to dispose of his excess property. We are concerned that wing staff appear not to have been aware of this combination of issues and that, as a result, they did not consider whether Mr Watkins might pose a risk to himself and his death came as a shock to them.

129. There is very little evidence that wing staff engaged with Mr Watkins or had got to know him, even though he had been at Littlehey for nearly five years. Staff described him as a prisoner who kept himself to himself and associated with a small group of friends. Most of the entries in his electronic prison record were about Mr Watkins' parole reviews (by his offender supervisor), about his altercation with another prisoner in August 2018, and about the amount of property in his cell. There are virtually no entries about Mr Watkins' wellbeing or mood.

130. Although his personal officer told the investigator that he spoke to Mr Watkins once or twice a week, he recorded only three entries in Mr Watkins' electronic record – in July 2017, April 2018 and August 2018 – and he said he did not know Mr Watkins had tinnitus. Given what an important issue his tinnitus was for Mr Watkins, we find it very surprising and worrying that his personal officer was not aware of it and the distress it was causing him. In contrast, an officer, Mr Watkins' previous personal officer, recorded regular informative entries in his record in and clearly made an effort to get to know him.

131. There is no evidence that staff took any note at all of a nurse's sharing of risk' report in July 2018 which set out Mr Watkins' distress about his tinnitus and asked staff to review the situation. There is also no evidence that staff considered whether Mr Watkins' parole knock back in September 2018 might have affected him.

132. Although we accept that wing staff had no reason to consider that Mr Watkins was at imminent risk of suicide at the time of his death, this was largely because they were unaware of the various factors that affected his mood. He repeatedly told other people that his tinnitus made him feel suicidal and that he despaired of ever being released, and if wing staff had engaged with him more, they might have had reason to consider whether Mr Watkins posed a risk to himself

133. We hope that the new key worker scheme will mean that staff spend time engaging with prisoners, and we recommend:

The Governor should ensure that key workers are allocated sufficient time to engage with prisoners.

Clinical care

134. The clinical reviewer concluded that Mr Watkins' mental health treatment was equivalent to that he could have expected to receive in the community. He was referred to the mental health team at times of high stress and responded well to the team's interventions. The clinical reviewer also concluded that Mr Watkins' tinnitus, osteoarthritis and IBS were appropriately managed and treated.

135. We are concerned that there was a delay referring Mr Watkins for an audiology appointment. A doctor recorded that he would do this in June 2017 but it was not actioned until November. We are also concerned that record keeping was not always adequate. A nurse did not document his follow up appointment with Mr Watkins on his medical record.

136. We therefore make the following recommendation:

The Head of Healthcare should ensure that staff action referrals promptly and record all interactions and risk information in a prisoner's medical record.

In possession medication

137. Mr Watkins was assessed as suitable to keep his medication in his possession throughout his time at Littlehey. The clinical reviewer concluded this was appropriate.

138. We consider, however, that the appropriateness of allowing Mr Watkins to keep his medication in his possession should have been reviewed when he told various healthcare staff in 2017 and 2018 that his tinnitus led him to have thoughts of suicide. We recommend:

The Head of Healthcare should ensure that decisions to allow a prisoner to hold medication in possession should be reviewed if a prisoner expresses suicidal thoughts.

Emergency response

Entering Mr Watkins' cell

139. National policy on entering cells at night is set out in Prison Service Instruction (PSI) 24/2011, *Management and Security of Nights*. The PSI says that, under normal circumstances, authority to unlock a cell at night must be given by the night orderly officer and a cell should be opened with a minimum number of staff present, in accordance with local risk guidelines. However, the PSI goes on to say, that the preservation of life must take precedence over this and where there is or appears to be a threat to life, cells may be opened without the night orderly officer being present, and entered by staff on their own if they feel safe to do so, having performed a dynamic risk assessment and informed the control room.

140. An officer saw Mr Watkins lying on the floor of his cell at about 5.05am. He told the investigator that he would enter a cell on his own if there was a threat to life and he thought it was safe to do so. He said he did not go into Mr Watkins' cell

on his own because he was not sure whether there was a genuinely life-threatening situation and because he had no prior knowledge of Mr Watkins.

141. We accept that the officer made a reasonable decision not to enter the cell on his own. However, we are concerned that he did not use his radio to call for immediate assistance when he could not get a response from Mr Watkins, but instead went to the office on the landing above to make a telephone call. We are also concerned that he did not enter the cell when he was joined by another officer and we do not understand why he again went to the wing office to make a telephone call to ask for permission to enter the cell. As they he been unable to get a response from Mr Watkins for around 10 minutes at this stage, we consider that he should have radioed a code blue emergency code.

142. We are also concerned that neither officers had a torch and could not, therefore, see clearly into the cell. Sunrise was not until 7.39am on 24 October and it is difficult to understand how an officer could conduct an effective roll check at 5.00am without a torch. (He was only able to see Mr Watkins lying on the floor because the light was on in the cell.)

143. We are concerned that a CM said, incorrectly, that staff should never enter a cell on their own. He said three members of staff should normally be present, although in some life-threatening situations it might be possible to go in with two if a manager's permission had been obtained first. Both officers agreed with this. It is particularly worrying that a CM is not aware of national policy.

144. There is no CCTV on C wing to show how long it took officers to enter Mr Watkins' cell. Different officers offered various estimates, but we consider that it likely to have been upwards of 15 minutes from when an officer first saw Mr Watkins lying on the floor. We consider this to have been an unacceptable delay.

145. While the delay in entering the cell did not make a difference to the outcome for Mr Watkins as it appears he had been dead for some time, it might do in another emergency. We make the following recommendation:

The Governor should ensure that:

- **all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is a potential risk to life and that local policies and instructions reflect this prominently; and**
- **all staff carry a torch during the hours of darkness.**

Emergency Response Codes

146. PSI 03/2013, on medical emergency response codes, requires prisons to have a protocol on communicating the nature of a medical emergency, the type of equipment to take to the incident and to ensure that there are no delays in calling an ambulance. It states that if a medical emergency code is radioed, the control room must call an ambulance immediately.

147. Littlehey's local policy requires that the use of the medical emergency codes complies with PSI 03/2013. This requires that staff should radio a code blue

emergency when a prisoner has difficulty breathing or is unconscious, and ensure that an emergency ambulance is called automatically.

148. An OSG in the control room logged that an officer radioed a code blue at 5.29am and that she called the ambulance at 5.35am. The OSG said she did not call an ambulance straightaway because her priority initially had been to ensure staff were attending the emergency. We have listened to the radio traffic from the emergency response and are not satisfied that there was any need for a delay in requesting an ambulance.

149. The delay in calling an ambulance did not affect the outcome for Mr Watkins as he had been dead some time before he was discovered. However, in another medical emergency, a delay could make the difference between life and death. We therefore make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including telephoning the ambulance immediately.

Resuscitation

150. An officer said he did not start resuscitation as he was not sure whether he should due to decency issues as he thought Mr Watkins was dead. A CM said if a prisoner is not breathing, he would always start CPR. He said he had a slight doubt as to whether Mr Watkins was dead since there was some warmth in the side of his neck. However, the CM also told the investigator that even if he had been certain that Mr Watkins was dead he would probably still have attempted to resuscitate him. A CM, and two officers also said they would always attempt resuscitation. An officer said he had found trying to resuscitate Mr Watkins distressing, because he knew that they would be unable to save him.

151. An officer told the investigator that the paramedics queried why officers had attempted to resuscitate Mr Watkins since he had clearly been dead for several hours.

152. While we accept that staff were trying to act in the best interests of Mr Watkins, it was inappropriate to attempt resuscitation since rigor mortis was present. 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. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made based on a careful assessment of each individual’s situation. These decisions should never be dictated by ‘blanket’ policies. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

Prisoner support

153. Mr Watkins had been at Littlehey for nearly five years, living on C wing for all that time. Several prisoners knew him well and were affected by his death. Most of the prisoners we spoke to said that they had not received any support after Mr Watkins' death. They said they had found out about his death from other prisoners and that staff had not spoken to them to check how they were coping.

154. A CM said that they had put extra Listeners on the wing the morning that Mr Watkins died. However, he acknowledged that more emphasis could have been placed on supporting the individual prisoners who knew Mr Watkins well. The CM said that, after the investigator raised her concerns about this, he had personally spoken to some of these prisoners. We make the following recommendation:

The Governor should ensure that prisoners are offered appropriate support following a death in custody or other traumatic event.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141