Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mani Kurian Kattampakkal, a prisoner at HMP Littlehey, on 9 February 2024

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Mani Kurian Kattampakkal was found unresponsive in his cell with a ligature around his neck on 9 February 2024 at HMP Littlehey. Staff and paramedics tried to resuscitate him but were unsuccessful. He was 58 years old. I offer my condolences to Mr Kurian Kattampakkal's family and friends.

Mr Kurian Kattampakkal was the fourth self-inflicted death at Littlehey in three years. He had given no indication to staff that he was at risk of suicide in the lead up to his death and I am satisfied that staff could not have foreseen his actions.

There was a delay in staff starting CPR when they found Mr Kurian Kattampakkal unresponsive. Neither of the two staff who found him were trained in first aid. Despite Littlehey's health and safety risk assessment saying that 80% of staff on duty at night should be first aid trained, only 14% were on the night Mr Kurian Kattampakkal died. The prison has since introduced mandatory first aid training for all staff.

I make no recommendations.

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

Adrian Usher
Prisons and Probation Ombudsman **August 2024**

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Summary

Events

1. On 6 September 2022, Mr Mani Kurian Kattampakkal was recalled to prison for breaching his licence conditions. On 25 November, he was moved to HMP Littlehey.

2. A nurse completed Mr Kurian Kattampakkal's initial health screen and noted that he had mental health issues and a history of suicide attempts. A psychiatrist saw Mr Kurian Kattampakkal and prescribed him antipsychotic medication.

3. Mr Kurian Kattampakkal continued to take his medication and was seen regularly by the mental health team.

4. On 23 January, Mr Kurian Kattampakkal told prison staff that other prisoners thought he had been giving information to staff about prisoners taking drugs on D Wing and he therefore felt under threat. Staff moved Mr Kurian Kattampakkal to the segregation unit for his own protection.

5. On the evening of 8 February, Mr Kurian Kattampakkal spoke to his son. The conversation was strained and difficult. Staff were unaware of the nature of the call.

6. At around 5.15am on 9 February, while conducting the early morning routine roll count, an operational support grade (OSG) looked into Mr Kurian Kattampakkal's cell and noticed that the shape in the bed did not match his size. Another officer happened to be walking past, so the OSG called him over and asked him to have a look in the cell.

7. The officer turned on the night light and could see Mr Kurian Kattampakkal's feet under the shower curtain. He knocked on the cell door, but Mr Kurian Kattampakkal did not respond.

8. The OSG called a code blue at 5.16am and they both entered the cell. They saw that Mr Kurian Kattampakkal was lying on the floor unresponsive with a ligature tied around his neck. The officer used his anti-ligature knife to cut the ligature from Mr Kurian Kattampakkal's neck. The OSG fetched a defibrillator and both he and the officer tried to attach the defibrillator pads to Mr Kurian Kattampakkal's chest, but the pads would not stick. The night custodial manager responded to the code blue and at 5.23am, he arrived and started CPR.

9. Ambulance paramedics arrived at 5.35am, and continued CPR. They were not able to regain a pulse and at 6.11am, they declared that Mr Kurian Kattampakkal had died.

Findings

10. Mr Kurian Kattampakkal had given no indication to staff at Littlehey that he was at risk of suicide. He was taking his antipsychotic medication and had told staff that he had no thoughts of suicide or self-harm. We are satisfied that staff could not have foreseen his actions.

11. Due to the OSG's sharp observation skills, staff identified that Mr Kurian Kattampakkal was unresponsive and called a code blue. However, they did not start CPR. Neither the OSG nor the officer who found Mr Kurian Kattampakkal were first aid trained.

12. We found that insufficient staff on duty that night were first aid trained, despite a local policy that 80% of staff on duty at night should be first aid trained. There were no contingencies in place to address the shortage of first aid trained staff on duty. The prison has since introduced mandatory first aid training for all staff, starting in November 2024.

13. The clinical reviewer concluded that overall, the care that Mr Kurian Kattampakkal received was equivalent to that which he could have expected to receive in the community.

14. We commend the OSG for the diligence he showed when conducting his roll count. We also note the good practice showed by the night custodial manager when he arranged for all the prison gates to be opened to enable quick access for the ambulance.

15. We make no recommendations.

The Investigation Process

16. HMPPS notified us of Mr Kurian Kattampakkal's death on 9 February 2024.

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 her. No one responded.

18. The investigator visited Littlehey on 21 February. She obtained copies of relevant extracts from Mr Kurian Kattampakkal's prison and medical records.

19. The investigator interviewed two members of staff by video call.

20. NHS England commissioned a clinical reviewer to review Mr Kurian Kattampakkal's clinical care at the prison. The investigator and clinical reviewer interviewed one member of staff by video call.

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

22. The Ombudsman's office contacted Mr Kurian Kattampakkal's wife to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Kurian Kattampakkal's wife did not respond.

23. The initial report was shared with HMPPS. HMPPS pointed out some factual inaccuracies, and this report has been amended accordingly.

Background Information

HMP Littlehey

24. HMP Littlehey is a category C training prison for men convicted of sexual offences. Northamptonshire NHS Foundation Trust provides healthcare services at the prison. The prison healthcare centre is open from Monday to Thursday from 7.30am to 7.30pm, on Fridays from 7.30am to 5.20pm and at weekends from 8.00am to 5.50pm. 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

25. The most recent inspection of HMP Littlehey was in September 2023. Inspectors reported that Littlehey continued to be an overwhelmingly safe prison, with little violence. They found that referrals for the mental health team were mainly received from staff in reception, but also from other prison staff, and prisoners could self-refer. All new and ongoing patients were discussed at the weekly multidisciplinary team meeting. The service also provided a twice-weekly drop-in clinic, where prisoners could receive basic advice and signposting.

26. They also noted that levels of self-harm, which were low at the time of the previous inspection, had decreased by about 30% and were well below the average among similar prisons. Only a minority of self-harm incidents were serious, and reviews were conducted on these to try to identify any lessons to be learnt.

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 annual report for the year to 31 January 2023, the IMB reported that the prison continued to be generally safe and secure and that prisoners were treated with respect and decency. They reported that previous PPO recommendations had been accepted and implemented.

28. The Board also noted the introduction of mental health drop-in clinics on a Friday afternoon which had helped prisoners manage their mental health and seek ad hoc support as they needed it.

Previous deaths at HMP Littlehey

29. Mr Kurian Kattampakkal was the fourth prisoner to take his life at Littlehey since February 2021. There were 38 deaths from natural causes at Littlehey between February 2021 and 2024. There were no similarities between the findings from our investigation into Mr Kurian Kattampakkal's death and the findings from our investigations into the previous deaths at the prison.

Key Events

30. On 6 September 2022, Mr Mani Kurian Kattampakkal was recalled to prison for breaching his licence conditions in relation to a conviction for sexual offences. He was sent to HMP Wandsworth. (He had no release date as this had to be agreed by the Parole Board at an oral hearing. This had not happened by the time he died.)

31. On 25 November, Mr Kurian Kattampakkal was moved to HMP Littlehey. A nurse completed Mr Kurian Kattampakkal's initial health screen at Littlehey and noted that he had several long-term health issues, including diabetes and bipolar disorder for which he received regular medication.

32. On 10 January 2023, a nurse saw Mr Kurian Kattampakkal to complete a mental health assessment. Mr Kurian Kattampakkal told the nurse that he had previously tried to take his life by jumping in front of a bus and had tied a noose in his attic with the intention to take his life. Mr Kurian Kattampakkal said he had no current thoughts of suicide or self-harm. She recorded that Mr Kurian Kattampakkal had a high assessment score that indicated he was suffering with severe depression. She referred him to the mental health team.

33. On 13 January, a psychiatrist saw Mr Kurian Kattampakkal and prescribed quetiapine (an antipsychotic medication that can be used as a mood stabiliser). He recorded that that he would be reviewed again in three months' time.

34. Over the next 12 months, a mental health nurse regularly saw Mr Kurian Kattampakkal. She noted that he was taking his medication and reported no thoughts of suicide or self-harm.

35. On 23 January, Mr Kurian Kattampakkal told prison staff that other prisoners thought he had been giving information to staff about prisoners taking drugs on D Wing and he therefore felt under threat. Staff moved Mr Kurian Kattampakkal to the segregation unit for his own protection.

36. A mental health nurse saw Mr Kurian Kattampakkal in the segregation unit and noted that he had no thoughts of self-harm and was fit for segregation.

37. Prison security staff looked at where in the prison Mr Kurian Kattampakkal could be safely located and on 26 January, he was moved from the segregation unit to L Wing.

38. Mr Kurian Kattampakkal had regular key work sessions with his allocated key worker who had no concerns. Staff recorded no concerns about him on L Wing.

39. Mr Kurian Kattampakkal made frequent calls to his son and ex-wife. All calls are recorded. The investigator listened to the calls Mr Kurian Kattampakkal made in the months leading up to his death. The conversations were strained as it was clear that the family struggled to come to terms with his offences, but Mr Kurian Kattampakkal did not say that he was feeling low or suicidal.

40. On the evening of 8 February, Mr Kurian Kattampakkal spoke to his son. It was a difficult conversation and Mr Kurian Kattampakkal's son implied that his father would be better off dead. Staff were not aware of the call or its nature.

Events of 9 February

41. On 9 February at around 5.15am, an operational support grade (OSG) started his early morning routine check. When he got to Mr Kurian Kattampakkal's cell, he looked through the observation panel and noticed that the shape in the bed did not match the size of Mr Kurian Kattampakkal. He said that from his prison picture displayed on the card outside the cell, Mr Kurian Kattampakkal looked like a larger man and the shape in the bed was of a small frame.

42. At the same time, an officer was walking through L Wing. The OSG called the officer to the cell to have a look. The officer knocked on the cell door and called Mr Kurian Kattampakkal's name, but he did not respond. He turned on the night light and they could see Mr Kurian Kattampakkal's feet on the floor at the bottom of the shower curtain in the toilet area.

43. At 5.16am, the OSG called a code blue over the radio (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately). The officer opened the cell door and saw that Mr Kurian Kattampakkal was lying unresponsive on the floor with a ligature tied around his neck.

44. The officer used his anti-ligature knife to cut the ligature from Mr Kurian Kattampakkal's neck. The control log shows that at 5.18am, the OSG in the control room called an ambulance.

45. The officer told the OSG to fetch a defibrillator (an electronic device that gives an electric shock to try to restart the heart) while he checked for signs of life. It was clear that Mr Kurian Kattampakkal was not breathing. Both the officer and the OSG tried to attach the defibrillator pads to Mr Kurian Kattampakkal's chest, but they were unable to do so because the pads would not stick. Body worn camera footage shows that at 5.23am, a custodial manager (CM), the night orderly officer (the senior officer in charge of the prison at night), arrived and immediately started CPR.

46. At 5.35am, paramedics arrived and continued resuscitation. The paramedics were not able to regain a pulse and at 6.11am, they declared that Mr Kurian Kattampakkal had died.

Contact with Mr Kurian Kattampakkal's family

47. At around 12.30pm on 9 February, a family liaison officer (FLO) at HMP Lewes went to Mr Kurian Kattampakkal's wife's home to tell her of her husband's death (having first visited the old address on Mr Kurian Kattampakkal's prison record).

48. After Mr Kurian Kattampakkal's family had been told of his death, a CM and an officer at Littlehey took over the role of FLOs. The CM met with Mr Kurian Kattampakkal's family at the hospital mortuary and maintained contact and offered support in arranging Mr Kurian Kattampakkal's repatriation to India.

49. The prison paid the repatriation expenses in line with national instructions.

Support for prisoners and staff

50. After Mr Kurian Kattampakkal's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

52. The post-mortem report concluded that Mr Kurian Kattampakkal died from ligature strangulation.

Findings

Assessment of Mr Kurian Kattampakkal's risk of suicide

53. Mr Kurian Kattampakkal had bipolar disorder and told staff at Littlehey that he had attempted suicide in the past. However, he took his antipsychotic medication as prescribed and was seen regularly by the mental health team. He told staff that he had no thoughts of suicide or self-harm and there were no indications that he was struggling with his mental health or that he was in crisis in the days before his death.

54. Mr Kurian Kattampakkal's final phone call with his son was difficult but staff were not aware of the nature of the call. We are satisfied that staff could not have foreseen his actions.

Emergency response

55. When staff found Mr Kurian Kattampakkal unresponsive with a ligature tied around his neck, they immediately called a code blue and cut the ligature. However, they did not start CPR as neither the officer nor OSG were first aid trained.

56. Littlehey does not have 24-hour healthcare so there are no healthcare staff in the prison during the evening and night. If a code blue is called during this time, prison staff must respond and start emergency first aid.

57. On the night Mr Kurian Kattampakkal died, only three members (14%) of staff on duty were first aid trained. The night orderly officer was one of them and he started CPR when he arrived. However, the other two first aid trained members of staff were in positions they could not leave (one was undertaking constant supervision and one was opening the prison gates to enable the ambulance to enter), which meant that the night orderly officer had to continue with CPR, rather than oversee the management of the incident which should have been his role.

58. Littlehey's local risk assessment says that 80% of staff on a night shift should be trained in first aid, and the risk assessment form says that contingencies should be put in place if the number of first aid trained staff on any night shift falls below 80%.

59. At interview the investigator asked the night orderly officer if any contingencies had been put in place, given that the percentage of staff trained in first aid on duty on the night Mr Kurian Kattampakkal died fell well below the requirement. He was not familiar with the risk assessment document and seemed unaware of the need for contingencies if the 80% requirement was not met.

60. The training manager told the investigator that only 31% of staff at Littlehey were trained in first aid and that it had been difficult to increase numbers as the training was voluntary and many staff did not want to do it. The prison is bringing in a new policy where first aid training will be mandatory for all staff. However, this training is not starting until November and will take several months for all staff to be fully trained.

61. While we do not make a recommendation, we bring this issue to the Governor's attention.

Clinical care

62. The clinical reviewer found that the care that Mr Kurian Kattampakkal received was of a good standard and equivalent to that which he could have expected to receive in the community.

63. The clinical reviewer noted that the care that Mr Kurian Kattampakkal received for his mental health was of a high standard and above expected practice.

Good practice

64. When the OSG completed his morning routine check, he looked through the observation panel and noticed that the shape in bed did not look like that of Mr Kurian Kattampakkal. His excellent observation skills meant that staff checked on Mr Kurian Kattampakkal and identified that he was unresponsive. He should be commended for showing such professional curiosity and diligence.

65. After responding to the code blue, the night orderly officer directed staff to open all the entrance gates to the prison, to allow ambulances quick access. He should be commended for his quick thinking and pragmatic approach.

Inquest

66. At the inquest, held from 6 to 8 August 2025, the jury concluded that Mr Kurian Kattampakkal died by suicide.

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