Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mohammed Eumda, a prisoner at HMP Chelmsford, on 30 January 2023

A report by the Prisons and Probation Ombudsman

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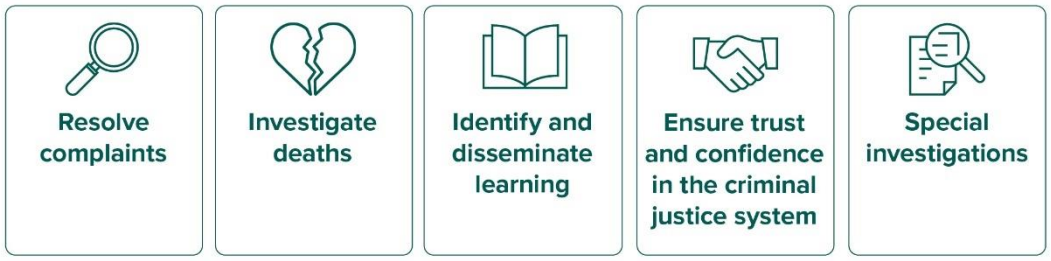
OUR VISION

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

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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.

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 Mohammed Eumda was found hanging in his cell at HMP Chelmsford on 30 January 2023, just over a week after he arrived. Staff and paramedics tried to resuscitate him but were unsuccessful. Mr Eumda was the sixth prisoner to take his life at Chelmsford in three years. He was 28 years old. I offer my condolences to Mr Eumda's family and friends.

Staff started suicide and self-harm monitoring procedures when Mr Eumda arrived at Chelmsford on 21 January 2023. They stopped them four days later, reassured that he was not at risk.

My investigation found that the decision to end suicide monitoring was premature. Staff placed too much emphasis on what Mr Eumda told them, rather than his known risk factors and recent behaviour. They recorded inaccurate information about Mr Eumda's interactions with staff and as a result, made a poor assessment of his risk level. Post-closure monitoring was not carried out as it should have been, which might have flagged concerns in the days leading up to Mr Eumda's death.

HM Inspectorate of Prisons identified multiple weaknesses in suicide and self-harm monitoring processes at Chelmsford during their 2021 inspection, although they reported improvements during their follow up inspection in 2022.

While I am aware that Chelmsford has taken steps to improve the quality of the ACCT process, this case demonstrates that poor decision making and failure to follow basic procedures persists. Senior managers need to review whether the measures introduced are leading to sustained improvements.

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 **November 2023**

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Summary

Events

1. On 21 January 2023, Mr Mohammed Eumda was remanded to HMP Chelmsford charged with arson. It was his first time in prison.

2. Mr Eumda arrived with a suicide and self-harm warning as he had said he would kill himself if sent to prison. Staff started suicide and self-harm monitoring procedures (known as ACCT) and set observations at two an hour.

3. At the first ACCT review the next day, Mr Eumda said that he had had no thoughts of suicide or self-harm overnight or that morning. However, the ACCT case coordinator noted that Mr Eumda was very guarded and quiet. The case review team decided to keep the ACCT open but reduced observations to one an hour.

4. During the night of 24 January, Mr Eumda covered his observation panel with a cloth. The operational support grade (OSG) conducting the ACCT checks repeatedly asked Mr Eumda to remove the cloth, but he refused. On the morning of 25 January, the observation panel was still covered. The OSG banged on the door but got no response so sought help from a colleague. They finally got a response, but Mr Eumda still left his observation panel covered.

5. At the second ACCT review later that morning, Mr Eumda said he felt fine and had no thoughts of suicide or self-harm. The ACCT case coordinator recorded that Mr Eumda had been engaging well with the prison regime and was engaging with staff when spoken to. He noted that Mr Eumda became frustrated when he told him that his next court appearance was not until 20 February as Mr Eumda said his solicitor had told him that he would be in prison for only 24 hours. The case review panel agreed to close the ACCT on the basis that Mr Eumda had not self-harmed in the four days he had been at Chelmsford and said he had no thoughts of suicide or self-harm.

6. At around 9.20pm on 30 January, an OSG noticed that Mr Eumda's observation panel was covered. She banged on the door and when she got no response, she fetched an officer. The officer managed to look into the cell. They saw Mr Eumda with a ligature around his neck and called a medical emergency code. Mr Eumda had barricaded the door, but staff managed to enter the cell and started CPR, which was continued by paramedics. However, resuscitation attempts were unsuccessful and at 10.17pm, paramedics pronounced that Mr Eumda had died.

Findings

7. Staff stopped ACCT monitoring prematurely. They placed too much emphasis on what Mr Eumda told them, rather than considering his known risk factors and his recent behaviour. It was inaccurate to record in the case review log that Mr Eumda was engaging well when he had refused to remove the obstruction covering his observation panel throughout the night. Also, Mr Eumda's frustration at being told that he would be in prison for at least four more weeks, should have been seen as a potential trigger for suicide given the reason the ACCT was opened in the first place.

8. There should have been seven days of post-closure monitoring after the ACCT was closed on 25 January. There is no evidence this was done as that section of the ACCT document is blank.

9. We have raised issues with poor quality ACCT management at Chelmsford in previous investigations. HM Inspectorate of Prisons highlighted this issue in its 2021 inspection, though noted some improvements in its follow up inspection a year later. This case shows that poor practice persists. Senior managers need to ensure that measures introduced to improve the quality of ACCT procedures at Chelmsford are having the desired effect.

10. The only interactions Mr Eumda had with mental health staff was at his ACCT reviews and his mental health review after his ACCT was closed. He should have had a mental health assessment and risk assessment following the mental health referral made by the reception nurse, but this did not happen. The clinical reviewer considered this was a missed opportunity to assess Mr Eumda's mental health. She concluded that Mr Eumda's clinical care at Chelmsford was not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Prison Group Director for Hertfordshire, Essex and Suffolk should write to the PPO with the result of their review into whether the measures introduced to improve ACCT management at HMP Chelmsford are leading to sustained improvement and if not, what further measures they are going to take towards improvement.

- The Head of Healthcare should ensure that the mental health team act on referrals appropriately, ensuring that patients are seen independently by the mental health team to complete mental health assessments and risk assessments.

The Investigation Process

11. HMPPS notified us of Mr Eumda's death on 31 January 2023.

12. The investigator issued notices to staff and prisoners at HMP Chelmsford informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Eumda's prison and medical records.

14. The investigator interviewed ten members of staff between 27 March and 6 April.

15. NHS England commissioned an independent clinical reviewer to review Mr Eumda's clinical care at the prison. The clinical reviewer jointly interviewed healthcare staff.

16. We informed HM Coroner for Essex of the investigation. He provided us with the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Eumda's uncle to explain the investigation and to ask if he had any matters he wanted us to consider. He raised no issues but asked for a copy of our report.

18. We shared our initial report with HMPPS. They pointed out some minor factual inaccuracies which have been amended in this report.

19. We sent a copy of our initial report to Mr Eumda's uncle. He did not notify us of any factual inaccuracies.

Background Information

HMP Chelmsford

20. HMP Chelmsford is a category B local prison serving the local courts. It holds around 725 adult and young adult men. Castle Rock Group provides healthcare services.

HM Inspectorate of Prisons

21. The last full inspection of HMP Chelmsford was in August 2021. Inspectors found that the prison was failing in its basic duty to keep prisoners safe. The Chief Inspector of Prisons invoked the Urgent Notification process following the inspection because he was so concerned about the conditions there.

22. Chelmsford had the second highest rate of self-harm out of all local prisons. The strategic approach to reducing self-harm was limited and there had been no detailed analysis of data to understand the risks and priorities for the prison. Despite some serious failings identified by investigations undertaken by the Prisons and Probation Ombudsman (PPO) and others following deaths in custody, HMIP's previous key concern and recommendation about self-harm had not been achieved. The prison's action plan to address PPO recommendations was out of date and many PPO recommendations were repeated over successive action plans. Leaders had repeatedly failed to address problems, such as the deficiencies identified in assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm.

23. There had been over 1,000 ACCTs opened in the previous 12 months which was an increase on previous years. Some prisoners said they had received very limited support while on the ACCT. Staff lacked confidence in using the new ACCT document and HMIP found many weaknesses in its completion. Care plans were missing or incomplete, and risks, triggers and sources of support were rarely identified. Records of interaction with prisoners were often missing, case management was inconsistent, and supervisors did not always complete daily checks on the documentation.

24. HMIP carried out an independent review of progress in August 2022. Inspectors found that there had been reasonable progress in the work to prevent suicide and self-harm. Staff were much more confident in using the ACCT document and the number of open documents had reduced since the last inspection. The quality of reviews and care planning had improved overall. Most prisoners that inspectors spoke to said they felt supported by staff while on an ACCT. Quality assurance took place regularly and learning was shared with managers. Thirteen officers identified as ACCT champions offered peer support and guidance on the ACCT process.

Independent Monitoring Board

25. 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 31 August 2022, the IMB

reported that the number of self-harm incidents remained high, as did the number of ACCTs opened. They were, however, pleased to note that there had been no deaths during the reporting period and that efforts had been made to improve the ACCT process, including the creation of a team of 13 officers to act as ACCT champions focused on ACCT training and improving the quality of ACCT documentation.

Previous deaths at HMP Chelmsford

26. Mr Eumda was the eighth prisoner to die at Chelmsford since January 2020. Of the previous deaths, five were self-inflicted, one was from natural causes, and one was drug related.

27. In a previous investigation into a death at Chelmsford in March 2021, we found that staff stopped ACCT procedures prematurely. We were told that training had been delivered and ACCT champions were introduced in September 2021 to try to improve the quality of ACCT.

28. In another recent investigation, we found that ACCT post-closure monitoring was not completed properly.

Assessment, Care in Custody and Teamwork

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

30. As part of the process, a care plan (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

Key Events

31. On 21 January 2023, Mr Mohammed Eumda was remanded in prison, charged with arson, and sent to HMP Chelmsford. It was his first time in prison.

32. A nurse carried out Mr Eumda's reception health screen. She reviewed his Person Escort Record (PER – a document that accompanies prisoners between police custody, courts and prisons which sets out the risks they pose) which said that Mr Eumda had hallucinations and heard voices, though he denied this when asked. Mr Eumda also arrived with a Prison Warning Notice (PWN) completed by the court which noted that Mr Eumda had said he would kill himself if he was sent to prison. Mr Eumda refused to answer questions about this when the nurse asked him. She started suicide and self-harm prevention procedures (known as ACCT) and referred Mr Eumda to the mental health team.

33. A Supervising Officer (SO) completed the Immediate Action Plan. She recorded that Mr Eumda was very guarded and refused to discuss anything about self-harm. She set observations at two an hour.

34. The next day, an officer conducted the ACCT assessment interview with Mr Eumda. She noted that English was his second language, and he was slow to speak, but he was fluent. She noted that Mr Eumda denied any thoughts of suicide or self-harm, and only asked questions about the prison regime which she answered.

35. A SO conducted the first ACCT case review with Mr Eumda. A nurse from the mental health team attended. Mr Eumda said that he had had no thoughts of suicide or self-harm overnight or that morning. When the nurse asked him about friends and family in the UK, he said he had none. He said he was from Sudan and had been in the UK for two years and had been working illegally. When the SO asked Mr Eumda if he wanted some purposeful activity, he said he was not going to be there [in prison] long and just wanted to sleep and rest. He asked about the process for buying food and other items, which the SO explained.

36. The SO noted that he would refer Mr Eumda to Nacro (a charity) for support with his housing situation. He also noted that the mental health team were 'doing multiple assessments with him weekly' (this was not the case). He recorded that Mr Eumda was very guarded and quiet, and seemed confused about what was going on. The SO and nurse agreed that the ACCT should remain open, but they reduced observations to one an hour.

37. On 24 January, an Operational Support Grade (OSG) recorded in Mr Eumda's ACCT document that she had been to check on Mr Eumda at around 10.17pm but he had covered the observation panel in his cell door. She asked him to remove the obstruction, but he refused. She noted that she would ask him again on the next check and then report it. She checked him again at 11.15pm according to the ACCT ongoing record but there is no record of any action taken.

38. At 12.39am on 25 January, the OSG recorded in Mr Eumda's prison record that she had been to check on Mr Eumda again and found that he had covered his observation panel with a cloth. She asked him to remove the cloth, but he refused. She told him that she would have to wake him every hour through the night if he did

not remove the cloth and he then removed part of it so he could see out. She recorded that it sounded like he had dragged a piece of furniture away from the door, but he denied this. She noted that she told a custodial manager who was in the wing office when she returned from the check, but there is no record that he took any action.

39. The OSG made another entry at 5.30am, which said that she had asked Mr Eumda several times during the night to remove the cloth covering his observation panel, but he had refused. She recorded that the cloth was still there at the routine 5.30am check and so she had banged on the door, but Mr Eumda failed to respond. She fetched an officer, and they finally got a response, though the cloth was still on the panel. The OSG recorded a negative behaviour warning in Mr Eumda's prison record.

40. At around 9.15am, the SO held the second ACCT case review. A nurse from the mental health team attended. The SO recorded that Mr Eumda had been engaging well with the prison regime; he had been showering, collecting food regularly and engaging with staff when spoken to. He noted that Mr Eumda was still very guarded, and he said this was due to the language barrier (staff told us that Mr Eumda could converse in English). He offered an interpreter, but Mr Eumda declined.

41. Mr Eumda said he had no issues and had been sleeping a lot. He said he was confused when he first arrived because he was not sure how long he was going to be in prison. The SO told him that his next court appearance was not until 20 February. Mr Eumda said his solicitor said had told him that he would be in prison for only 24 hours, and he became frustrated when the SO told him it would be at least four weeks. Mr Eumda said that he had been in a mental health hospital and had been discharged because they thought he was well enough, but he had set a fire within 24 hours, which is what brought him into custody.

42. Mr Eumda told the SO and nurse that he had no thoughts of suicide or self-harm and felt fine. The SO recorded that Mr Eumda had not self-harmed in the four days he had been at Chelmsford, that he would be monitored for seven days during the ACCT post-closure period and that the nurse would see if the mental health team could offer more support. The SO and nurse both agreed that the ACCT should be closed.

43. There is no evidence that the post-closure monitoring was carried out as that section of the ACCT document is blank.

44. On 29 January, a nurse saw Mr Eumda for a mental health review. He recorded that Mr Eumda said things were going well and he had no issues with his mental health.

Events of 30 January

45. At around 9.20pm on 30 January, an OSG went to check on Mr Eumda and found his observation panel was covered with a cloth. She tried to get a response from him by knocking on the door. When there was no reply, she fetched an officer, who was nearby. The officer radioed for staff assistance.

46. The officer managed to look into the cell through a gap in the cloth and saw Mr Eumda had a ligature around his neck. She called a code blue (a medical emergency code used when a prisoner is unconscious). Another officer arrived at the cell and they tried to enter, but Mr Eumda had barricaded the cell door. The officer kicked the door open and found that a locker had been placed against the door to stop it opening. The two officers, plus a third who had arrived, entered the cell and cut the ligature. They moved Mr Eumda to the landing outside the cell so there was more space and started CPR.

47. Healthcare staff responded and continued CPR until paramedics arrived. Paramedics arrived nine minutes after officers entered the cell. They continued resuscitation attempts, but these were unsuccessful. At 10.17pm, they pronounced that Mr Eumda had died.

Contact with Mr Eumda's family

48. After Mr Eumda's death, the prison appointed a prison chaplain as the family liaison officer. With the help of the police, he identified that Mr Eumda had an uncle in the UK, who lived in Birmingham. A family liaison officer from HMP Birmingham visited Mr Eumda's uncle to break the news of his death.

49. The prison contributed to the cost of Mr Eumda's funeral in line with national policy.

Support for prisoners and staff

50. After Mr Eumda'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 Eumda'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 Eumda's death.

Post-mortem report

52. The post-mortem report concluded that Mr Eumda died from hanging.

Findings

Management of Mr Eumda's risk of suicide and self-harm

53. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff must follow if they identify that a prisoner is at risk of suicide or self-harm.

54. Mr Eumda arrived at Chelmsford with a suicide and self-harm warning as he had said he would kill himself if he was remanded to prison. The reception nurse correctly started ACCT monitoring but staff stopped ACCT monitoring at the second case review four days later.

55. We consider that staff stopped ACCT monitoring prematurely. Staff placed too much emphasis on what Mr Eumda told them, rather than considering his known risk factors and his recent behaviour. On the same morning that his ACCT was closed, Mr Eumda had covered his observation panel and refused to comply with instructions to remove the obstruction. It was inaccurate to record in the case review log that Mr Eumda was engaging well. Also, Mr Eumda became frustrated at the case review when told that he would be in prison for at least four more weeks, which should have been a cause for concern. Mr Eumda had told court staff that he would kill himself if sent to prison so learning that he was going to be in prison for much longer than he expected should have been recognised as a potential trigger for suicide.

56. When interviewed, the ACCT case coordinator said that he was satisfied that Mr Eumda had been engaging in the regime because he had been showering, eating and going out for exercise. He also said that the post-closure monitoring should have picked up any issues once the ACCT was closed. He said that in hindsight, he should have noted that Mr Eumda had been covering his observation panel and asked him about it, but he said that prisoners covered their observation panel 'every other day' and it was not uncommon for them to cover their observation panel when washing or using the toilet.

57. There is no evidence that the post-closure monitoring, which should last for seven days after the ACCT is closed, took place. This section of the ACCT paperwork is blank. The ACCT case coordinator said at interview that the post-closure monitoring was the responsibility of officers and would be overseen by the SO. He said he was not on shift for the four days after he closed the ACCT so could not say why the post-closure monitoring was not done.

58. We have identified premature closure of ACCT and failings in post-closure monitoring in previous investigations at Chelmsford. We are aware that Chelmsford has introduced various measures to try to improve the quality of ACCT management, including ACCT champions and increased quality assurance, but this case demonstrates that poor decision making and failure to complete basic procedures persists. We recommend:

The Prison Group Director for Hertfordshire, Essex and Suffolk should write to the PPO with the result of their review into whether the measures

introduced to improve ACCT management at HMP Chelmsford are leading to sustained improvement and if not, what further measures they are going to take towards improvement.

Clinical findings

59. The clinical reviewer concluded that the care Mr Eumda received at Chelmsford was not equivalent to that which he could have expected to receive in the community.

60. The Head of Healthcare told the clinical reviewer that if a mental health referral is made, the prisoner should receive a mental health assessment and risk assessment before discharge. This did not happen in Mr Eumda's case. The reception nurse referred him to the mental health team when he arrived but his only interactions with the mental health team were at his two ACCT reviews and the mental health review on 29 January. The clinical reviewer considered that this was a missed opportunity to assess Mr Eumda's mental health and complete a risk assessment, which should have happened outside the ACCT process. We recommend:

The Head of Healthcare should ensure that the mental health team act on referrals appropriately, ensuring that patients are seen independently by the mental health team to complete mental health assessments and risk assessments.

Governor to Note

Obscured observation panels

61. We understand that Chelmsford does not have a specific policy on how staff should respond to obscured observation panels. The local policy on roll checks says, '…the Physical Security of the cell must not be obstructed i.e., observation glass, windows bars, cell lights. If they are obscured, then the prisoner must remove the obstruction immediately'. It does not say, however, what should happen if the prisoner refuses to remove the obstruction.

62. Throughout the night of 24/25 January, Mr Eumda refused to remove the cloth covering his observation panel. The OSG said that she knocked on the door each time to ensure that Mr Eumda responded and was still alive. She mentioned it to a custodial manager and recorded a negative behaviour entry. However, at no stage did staff consider entering the cell to remove the obstruction. There is no evidence that anyone spoke to Mr Eumda about why he should not cover his observation panel, or that anyone took any robust action to address the concern. A SO told us that it was commonplace for prisoners to cover their panels.

63. As Mr Eumda was on an ACCT, we consider that it was particularly important for staff to be able to visually check on him. A verbal response alone tells staff very little about the prisoner's wellbeing or safety. The Governor should consider issuing clear guidance to staff on what they should do if an observation panel is obscured, particularly for those being monitored under ACCT.

Inquest

64. At the inquest, held from 1 to 11 October 2024, the jury concluded that Mr Eumda died by suicide. They considered that the following factors may have contributed more than minimally to Mr Eumda's death:

- The failure of the mental health team to assess Mr Eumda within five days of arrival and to assess his level of risk outside of the ACCT process.
- The premature closure of the ACCT on 25 January 2023.
- The failure of the mental health nurse to prepare adequately for the ACCT review on 25 January 2023 and failure to reopen the ACCT on 29 January 2023.

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