Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Beresford, a prisoner at HMP Chelmsford, on 15 October 2023

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 l 020 7633 4100

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 Daniel Beresford was found hanged in his cell on 13 October at HMP Chelmsford and died in hospital two days later. He was 36 years old. I offer my condolences to Mr Beresford's family and friends.

Mr Beresford's was the sixth self-inflicted death at Chelmsford since October 2020. To the end of April 2024, there have been two more self-inflicted deaths since.

Mr Beresford had a significant history of attempted suicide, self-harm and substance misuse. He appeared to be doing well at Chelmsford and, overall, I am satisfied that there was little to indicate that he was at imminent risk of suicide in the period leading to his death. My investigation found an issue with diversion of prescribed medication and some deficiencies in substance misuse support procedures. I did not find that any of these issues affected Mr Beresford's death.

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 **May 2025**

Contents

Summary

Events

1. Mr Daniel Beresford had a number of factors that indicated he was at risk of suicide and self-harm including a significant history of previous suicide attempts, self-harm and substance misuse. He also had epilepsy, anxiety and depression.

2. Mr Beresford had spent a significant time in prison from 2012. On 20 April 2023, he was released on licence from HMP Ranby. On 20 June 2023, Mr Beresford was recalled to HMP Chelmsford having allegedly committed further offences.

3. Mr Beresford's prescriptions for diazepam and sodium valproate (for anxiety and epilepsy) were continued and he was put on a methadone maintenance programme. The Integrated Drug Treatment Service (IDTS) monitored him, and he received psychosocial substance misuse support from The Forward Trust. Mr Beresford attended education and the gym and gained a trusted position as a wing cleaner.

4. In August 2023, healthcare staff reduced Mr Beresford's diazepam in line with prescribing guidelines, which Mr Beresford was unhappy about. On 3 September, Mr Beresford admitted to buying illicit pregabalin on the wing and said he would continue to do so until he received the correct dose of diazepam.

5. The consultant psychiatrist saw Mr Beresford on 28 September and increased his diazepam. Mr Beresford subsequently told the IDTS that as a result he was no longer buying pregabalin.

6. On 9 October, Mr Beresford asked to see the mental health team. A nurse went to see him the same day, but Mr Beresford said he was not ready to talk. Another nurse went to see Mr Beresford on 10 October and Mr Beresford again said he did not want to speak to anyone. The nurse said Mr Beresford appeared happy and bright.

7. Two of Mr Beresford's friends said that he had spoken of ending his life in the days leading to his death, but they did not believe him and did not tell staff.

8. On 8 October, Mr Beresford told his partner on the phone that he would be "in a box tomorrow". Mr Beresford's partner said she spoke to him on the phone on 9, 10 and 11 October and he apologised for what he had said and spoke about starting a carpentry course. She sent him some money for phone credit so they could speak over the weekend.

9. One of Mr Beresford's friends thought he was under the influence of an illicit substance on 12 October. However, two other prisoners saw him that evening and said he was his usual self. Post-mortem toxicology tests did not find any illicit drugs in Mr Beresford's system.

10. On 13 October at 8.25am, staff found Mr Beresford hanged in his cell. They radioed a code blue emergency (when a prisoner is having difficulty or has stopped breathing) and gave Mr Beresford CPR. Paramedics attended and managed to re-start Mr Beresford's heart. He was taken to hospital but died on 15 October.

Findings

11. Mr Beresford did not self-harm during his last period at HMP Chelmsford and appeared to be settled on his wing. He did well on the graphics course and had a trusted job. Overall, we consider that there was little to indicate that Mr Beresford was at imminent or heightened risk of suicide at Chelmsford when he died.

12. Mr Beresford was able to access illicit pregabalin on his wing in September 2023. At the time, staff shortages meant officers were not supervising the medication queues. This situation was resolved in January 2024, and we are satisfied the prison is now actively monitoring medication diversion and taking steps to reduce it.

13. We found some deficiencies in substance misuse support procedures. Mr Beresford's full assessment took place eight weeks later than planned, his support worker did not record their interactions on his clinical record and The Forward Trust was not invited to integrated drug treatment service (IDTS) meetings. We do not consider these deficiencies affected the outcome for Mr Beresford.

14. The clinical reviewer concluded that the healthcare offered to Mr Beresford was not equivalent to that he would have expected in the community. His second health assessment was eight weeks late and he was not monitored as required during the five-day opiate withdrawal stabilisation period. She did not consider either of these factors affected the outcome for Mr Beresford.

15. There was a four-minute delay between staff radioing the code blue and the control room contacting the emergency services.

Recommendations

- The Head of Healthcare, the Integrated Drug Treatment Service (IDTS) and The Forward Trust should together ensure that:
    - All Forward Trust workers record their interactions with prisoners on both SystmOne and Nebula;
    - Prisoners are informed if there are delays in service provision or appointments are unable to take place and
    - The Forward Trust is invited to IDTS meetings.

The Investigation Process

16. HMPPS notified us of Mr Daniel Beresford's death on 15 October 2023.

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

18. The investigator visited Chelmsford on 31 October 2023. She obtained copies of relevant extracts from Mr Beresford's prison and medical records and watched CCTV and body worn video camera (BWVC) footage of the emergency response. She also obtained radio transmissions from 13 October, and recordings of Mr Beresford's prison phone calls. Further information was obtained from the Head of Drug Strategy and The Forward Trust.

19. The investigator interviewed four members of staff and five prisoners in October and December 2023.

20. NHS England commissioned a clinical reviewer to review Mr Beresford's clinical care at the prison. The clinical reviewer jointly interviewed clinical staff with the investigator.

21. We informed HM Coroner for Essex 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 office contacted Mr Beresford's partner to explain the investigation and to ask if she had any matters she wanted him to consider. Mr Beresford's partner asked if anyone else had been involved in his death. We have seen no evidence of third-party involvement. Chelmsford CID also investigated Mr Beresford's death on behalf of the Coroner and were satisfied that there was no third-party involvement. We have sent Mr Beresford's partner a copy of this report.

Background Information

HMP Chelmsford

23. HMP Chelmsford is a local prison that takes prisoners directly from the courts. Castle Rock Group (CRG) Medical provide 24-hour healthcare, including a range of primary care and secondary mental health services. The Forward Trust provide substance misuse treatment services.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Chelmsford was in February 2024. Inspectors found that although Chelmsford remained a challenging jail, staff had worked hard to reduce drugs and other contraband getting into the prison through improved security systems and better intelligence gathering This had led to a reduction in the level of violence and an increase in stability. Drug use was lower than in many similar jails.

25. Partnership working between prison and health care leaders had improved considerably, but mental health provision was disjointed and talking therapies were not being delivered. Prisoners told us that they struggled to get appropriate mental health support, and many were frustrated by not having some of their basic requests met Medicine queues were still not being supervised adequately, despite this being criticised in inspection reports over the last 10 years.

Independent Monitoring Board

26. 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 August 2023, the IMB reported that incidents of self-harm had increased, and incidents of violence had decreased. Most prisoners complained to them about missed appointments due to lack of operational staff to escort them to healthcare and there was a general feeling among prisoners that there was a lack of healthcare support. The number of key worker sessions had increased from an average of 90 per month to an average of 630 per month, although prisoners still complained that it was hard for them to resolve issues.

Previous deaths at HMP Chelmsford

27. There were eight deaths at Chelmsford in the three years before Mr Beresford died. Five of these were self-inflicted and three were from natural causes. There were no similarities between those deaths and Mr Beresford's. Up to April 2024, there had been two further self-inflicted deaths since that of Mr Beresford.

Emotionally unstable personality disorder (EUPD)

28. Also known as borderline personality disorder, EUPD is characterised by emotional instability, intense and unstable relationships, impulsive behaviour and negative

emotions. It is common for people with EUPD to feel suicidal, impulsively self-harm and engage in reckless activities such as drug misuse.

Key Events

29. On 28 January 2022, Mr Daniel Beresford was sentenced to four years and two months' imprisonment for offences of burglary and theft. It was not his first time in prison. Mr Beresford had a long history of self-harm and attempted suicide including fourteen deliberate overdoses of prescribed medication in prison and the community between 2012 and 2022. He also had a history of accidental overdose. His prison record (NOMIS) showed that he had been managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT), on 26 separate occasions since 2013 - most recently in March 2023. Mr Beresford had tied a ligature round his neck twice, once in 2015 and once in June 2016 when he was under threat from other prisoners in HMP Lancaster Farms. Mr Beresford also had a long history of alcohol and substance misuse, epilepsy, anxiety and depression.

30. Mr Beresford was released on licence from HMP Ranby on 20 April 2023. His licence was revoked when he allegedly committed further offences of aggravated vehicle taking and driving while disqualified. Mr Beresford was remanded to custody and taken to HMP Chelmsford on 20 June 2023.

HMP Chelmsford, 20 June 2023 – 12 October 2023

31. Mr Beresford told an officer that he was happy to be at Chelmsford as he had been there before and was familiar with the staff. He said he was detoxifying and asked to see the integrated drug treatment service (IDTS). Mr Beresford said he had a history of self-harm but was currently in a good place mentally and was aware of how to access support if he needed it.

32. A nurse completed an initial health assessment. Mr Beresford said he had epilepsy and misused heroin and crack cocaine. The nurse referred him to the IDTS. Mr Beresford completed a patient questionnaire which indicated that he might be dependent on alcohol, but he was not showing signs of withdrawal and his physical observations were normal. The nurse noted he had a history of self-harm and Mr Beresford said he had no current thoughts about harming himself.

33. Mr Beresford also saw a nurse from the IDTS team. He said he had been in Chelmsford before and had been given methadone for his opiate addiction. He told her that since his release from Ranby, he had been using heroin and crack cocaine daily and drinking heavily. He said he did not use alcohol or drugs when in prison. Mr Beresford gave a urine sample which tested positive for cannabis, benzodiazepines, methadone and cocaine. The nurse completed a Clinical Opiate Withdrawal Scale (COWS) assessment to measure Mr Beresford's symptoms of withdrawal. Mr Beresford scored three, indicating he had no symptoms. Accordingly, Mr Beresford was not prescribed any medication on his first night.

34. Another nurse from the IDTS reviewed him the next day. Mr Beresford showed some signs of withdrawal, and she referred him to the GP who prescribed a seven-day reducing dose of chlordiazepoxide (for alcohol withdrawal) and methadone (for opiate withdrawal). Mr Beresford was started on a dose of 10ml methadone a day to be increased by 5ml a day to a maintenance dose of 40ml. The GP also prescribed him sodium valproate for epilepsy.

35. Also on 21 June, Mr Beresford completed his induction and moved to F Wing in a shared cell. On 26 June, he was allocated to part-time education on the graphics course.

36. Mr Beresford was monitored in line with the IDTS alcohol withdrawal policy for his first five days at Chelmsford. Clinical monitoring of his opiate withdrawal took place on only two out of the five days required.

37. On 23 June, a nurse completed an epilepsy care plan. The same day, Mr Beresford's cellmate told staff he witnessed him having a seizure. Healthcare staff attended and completed a Clinical Institute Withdrawal Assessment (CIWA), which did not indicate that Mr Beresford was suffering alcohol withdrawal. His physical observations were normal indicating no further clinical action was necessary.

38. On 28 June, Mr Beresford met his Forward Trust substance misuse service keyworker for a triage assessment. Mr Beresford scored 9/15 on the Severity of Dependence Scale (SDS) indicating a high level of dependence and a need for structured treatment. He scored 22/40 on an alcohol audit which indicated an elevated risk. The keyworker spoke to Mr Beresford about the risks associated with drinking, how to reduce his consumption and the support networks available. He also gave Mr Beresford harm minimisation advice on using illicit drugs in prison and agreed to see Mr Beresford again a week later to complete a full risk assessment. Mr Bangura recorded the meeting on The Forward Trust case management system (Nebula) but did not make an entry on Mr Beresford's clinical record.

39. On 6 July, Mr Beresford a GP that he had taken a number of different medications for anxiety but only diazepam had worked for him. Mr Beresford's community records confirmed that he had a regular prescription of diazepam for anxiety. The GP restarted Mr Beresford's prescription and referred him to a psychiatrist for a medication review.

40. On 17 July, another GP reviewed Mr Beresford's diazepam prescription and revised it to a reducing dose. This was in line with prescribing guidelines which state that diazepam should be prescribed at the lowest possible dose for the shortest period of time and reviewed regularly with the patient.

41. On 22 July, intelligence was received by the security department that Mr Beresford had sold some of his prescribed diazepam to another prisoner for vape capsules.

42. On 27 July. Mr Beresford had a key worker session with an officer. He said he was fine and had no issues.

43. On 1 August, Mr Beresford received a positive behaviour recognition notification for helping to clean the wing. On 11 August, his graphics tutor recorded that he had produced excellent work, had been supportive to vulnerable members of the class and had helped to create a positive attitude in class.

44. On 3 August, Mr Beresford complained to a GP about the reduction of his diazepam and said he had expected to be on the same dose indefinitely. The GP explained that no one is on diazepam indefinitely and the dose would continue to be reduced.

45. On 10 August, wing staff called a code blue emergency when Mr Beresford had a seizure. A prison paramedic responded. When Mr Beresford recovered

consciousness, he said his diazepam had been stopped (this was not the case, it had been reduced) and he was worried it would cause him to have more seizures. Staff put Mr Beresford's mattress on the floor in case he had another seizure in the night. His cellmate said he would press the cell bell if he had any concerns and the night nurse completed regular welfare checks. The paramedic referred Mr Beresford to a GP for review.

46. The next day, a nurse prescriber reviewed Mr Beresford's record and continued his diazepam reduction. At about 10.00pm the same night, Mr Beresford had another seizure and the night nurse attended, assessed him and completed a set of physical observations.

47. On 15 August, Mr Beresford had a key worker session with an officer. He said he was feeling better and had no other concerns. He expressed an interest in becoming a wing cleaner and the officer advised him to complete a wing worker application.

48. On 18 August, the nurse prescriber reviewed and continued Mr Beresford's diazepam reduction regime. On 23 August, Mr Beresford told him that the diazepam was being reduced too quickly and he would like to remain on his current dose. The nurse extended Mr Beresford's reduction regime by two weeks. Mr Beresford was due to see the prison psychiatrist on 25 August, but the appointment was postponed as the psychiatrist was taking part in two-day strike action.

49. On 25 August, Mr Beresford told an officer that he was having increasing thoughts of harming others. He said he had been rated high risk of sharing a cell in the past (this was not the case) and wanted to be made high risk again. He said he was waiting to see the psychiatrist and also asked to see someone from the mental health team. On 28 August, Mr Beresford moved to F Wing but remained in a shared cell.

50. On 30 August, Mr Beresford met the substance misuse service keyworker for his full substance misuse assessment. The keyworker said Mr Beresford seemed in a good mood and did not raise any issues. He agreed to meet him again in four weeks. Mr Beresford asked for in-cell packs on heroin and crack cocaine use to complete in the meantime. The keyworker recorded the meeting on Nebula but did not make an entry on Mr Beresford's clinical record.

51. On 3 September, Mr Beresford tested positive for pregabalin (used to treat epilepsy and anxiety but not prescribed to Mr Beresford) in a random urine test. He admitted to a member of The Forward Trust that he had been obtaining pregabalin illicitly on the wing because his diazepam prescription was not managing his anxiety. He complained that his appointment with the psychiatrist had been cancelled and not re-booked. She warned Mr Beresford of the dangers of taking illicit medication and that his methadone might be reduced for his own safety if he continued to take non-prescribed medication. She completed a security information report. (She was on long term sick leave during the investigation and was not interviewed.)

52. On 4 September, a nurse recorded that if Mr Beresford took illicit pregabalin again, staff should tell her as she was a non-medical prescriber (a nurse qualified to prescribe medication).

53. On 6 September, the mental health team discussed the waiting list for the psychiatrist and booked Mr Beresford for another appointment as a medium/high priority. The Mental Health Team Leader told the clinical reviewer that the national strike had resulted in a higher than usual number of patients waiting for appointments. She said that Mr Beresford would not usually have been considered as a medium or high-risk mental health patient but, as he had missed an appointment, he was triaged as such to prioritise him for rescheduling.

54. On 11 September, a nurse recorded that Mr Beresford was pacing up and down the wing stairs talking to himself. She asked him if he was all right and he ignored her. She tried to talk to him again a minute or so later and he apologised and said he was not feeling mentally very well. She said Mr Beresford either failed to make eye contact while talking to her or stared at her intently. She said his speech rambled and he ruminated on the same things. Mr Beresford said that he was not getting the correct medication for his mental health and the mental health team were not doing enough to sort it out. He said he was worried that he would hurt someone if the issue was not resolved as he had attacked a previous cellmate. He said two appointments with the psychiatrist had been cancelled (this was not true, it was only one) and this had increased his anxiety and paranoia.

55. The nurse informed the mental health team and advised wing officers that Mr Beresford should be in a single cell. She spoke to the orderly officer the next day to make sure Mr Beresford had been given a single cell and was reassured that the matter was in hand. She updated Mr Beresford, who thanked her and said that he was relieved. (She left HMP Chelmsford after Mr Beresford died and the prison was unable to provide us with her contact details.)

56. On 15 September, Mr Beresford had another key worker session with an officer. He said he was happy on the wing and enjoyed being a wing cleaner. He said his only concern was that his medication had been changed and this was causing him to have seizures. He said he was trying to get a GP appointment. The officer offered to chase this up for him if he encountered any difficulty getting one. She told us that Mr Beresford was always polite and chatty and willing to talk.

57. On 17 September, Mr Beresford tested positive for pregabalin. He confirmed to a member of The Forward Trust that he was still using it illicitly. He said he took it as and when he could get it because it helped with his anxiety. She warned him again about the dangers of illicit use. Mr Beresford said he had spent 17 years in prison and would continue to self-medicate until he received the correct dose of diazepam. He said he did not care if his methadone was reduced as a precaution. She noted that Mr Beresford did not show any signs of sedation. She informed a nurse and the substance misuse team and booked Mr Beresford for another drug test four weeks later.

58. The same day, Mr Beresford received a positive behaviour recognition notification from an officer, who said that he was always polite and happy to help, respectful to staff and prepared to “go the extra mile” in his wing cleaning role.

59. On 18 September, Mr Beresford was due to be discussed in the mental health triage meeting, but staff ran out of time and agreed to discuss him at the next meeting on 25 September.

60. On 19 September, a member of the IDTS saw Mr Beresford for a welfare check. Mr Beresford said he was happy with his methadone dose and his only concern was his diazepam prescription. The member advised him to complete a healthcare application form and request a GP review of his medication. The member said he discussed harm minimisation with Mr Beresford in detail. Mr Beresford denied any thoughts of suicide or self-harm and the member be noted that he was able to articulate his needs well. The next day, Mr Beresford received another positive behaviour recognition notification for his high standard of cleaning and positive attitude.

61. On 21 September, healthcare staff added Mr Beresford to the GP waiting list after he said he was experiencing seizures in the night and had put in an application to see someone but had not had a reply.

62. On 23 September, a nurse checked Mr Beresford due to his reported night-time seizures. Mr Beresford's physical observations were normal, and he said he was not experiencing headaches or dizziness.

63. On 25 September, staff discussed Mr Beresford in the mental health triage meeting. The meeting noted he was due for review by the psychiatrist on 28 September.

64. That evening at 6.15pm, an officer radioed a code blue emergency after he discovered Mr Beresford lying on his floor and shaking. A nurse responded and assessed him. Mr Beresford was conscious and able to speak but she noted signs of seizure. Mr Beresford recovered and was given something to eat and drink. The nurse checked Mr Beresford the next morning. He said he had not had any further seizures and his physical observations were normal.

65. That afternoon, a nurse attempted to review Mr Beresford's methadone prescription in the light of his second positive test for pregabalin. She said initially Mr Beresford agreed to speak to her in a quiet corner of the wing but when she explained why she wanted to see him he became dismissive. He told her that everyone from healthcare was the same and just came to the wing to lie to him and walked off.

66. The nurse said Mr Beresford looked bleary eyed and his speech was slurred. She said she wondered whether he was under the influence of drugs, although he was playing chess when she arrived which suggested to her that he was reasonably alert. She said she tried to persuade Mr Beresford to speak to her, but he would not engage. She said she was aware of Mr Beresford's history of overdose and that he was on more than one medication that might make him drowsy. She therefore decided to reduce his methadone by 5ml to 35ml as a safety measure. She said she did not inform the wing staff of her concerns that Mr Beresford was under the influence.

67. Mr Beresford tested positive for pregabalin at a drug test that day. Staff did not submit an information report (IR). That evening Mr Beresford refused to take his epilepsy medication.

68. On 26 September, an Operational Support Grade (OSG) answered Mr Beresford's cell bell at about 8.30pm. Mr Beresford said he was feeling unwell and was worried he might have another seizure. The OSG contacted the night nurse and she said she would come to the wing when she had finished checking new arrivals in

reception. She arrived at about 10.00pm, but Mr Beresford refused to see her. He then changed his mind, and the OSG asked her to come back.

69. A nurse said Mr Beresford said he had fallen out of bed. She cleaned a small cut on his head, but it did not require a dressing. The nurse asked him why he had refused his epilepsy medication that evening, and he said that he was not happy that his dose had changed. (We presume he was referring to his methadone and diazepam as his epilepsy medication had not changed.) He said he had tried to talk to healthcare staff, but no one was listening. The nurse gave him his epilepsy medication, a painkiller for his headache and requested a GP appointment for him.

70. The next day, Mr Beresford again refused to take his epilepsy medication. A nurse tried to persuade him to change his mind and Mr Beresford said he would discuss it with the psychiatrist at their appointment the next day.

71. The psychiatrist reviewed Mr Beresford on 28 September as planned. He noted that Mr Beresford had been referred to him by the GP for long-standing anxiety and a poor response to a number of standard anxiety treatments including citalopram, sertraline and mirtazapine. He said Mr Beresford appeared flat and down in mood. He reported feeling anxious but denied any thoughts of suicide or self-harm. He agreed to increase Mr Beresford's diazepam from 2mg once a day to 5mg twice a day until he could review him again in four weeks. He concluded that Mr Beresford showed some features of emotionally unstable personality disorder (EUPD). Mr Beresford said he was happy with the increase in his diazepam and with the psychiatrist's plan to review him again in four weeks.

72. The investigator listened to Mr Beresford's telephone calls from 29 September until his death. On 4 October, Mr Beresford told his partner that he was not well and felt in a low mood. He asked her for help with money and she said she was unable to help him. As the call progressed Mr Beresford contributed less to the conversation and there were long periods of silence.

73. On 6 October, Mr Beresford told his substance misuse service keyworker that he was unhappy that his methadone had not been put back to his previous maintenance dose of 40ml. The keyworker said it had been reduced because Mr Beresford had tested positive for pregabalin. He explained the dangers of mixing illicit medication with prescribed medication. Mr Beresford said he was no longer taking illicit drugs and was starting to feel the positive effects of being abstinent. The keyworker recorded the meeting on Nebula but did not make an entry on Mr Beresford's clinical record.

74. Mr Beresford rang his partner and said that he felt like he was ruining her life, and her life would be better without him in it. He said he had been in a low mood for a few weeks.

75. On 8 October, a member from the IDTS team saw Mr Beresford for an IDTS review. He said he was happy with his dose of methadone and was abstinent from illicit drugs. Mr Beresford raised no other issues.

76. On 8 October, Mr Beresford spoke to his partner three times. These are the last calls he made on the prison telephone system. They discussed their relationship. Mr Beresford said that he did not want to keep letting his partner and son down and

his partner said he needed to think about whether he was going to change his behaviour in the future. Mr Beresford said several times over the three calls that his mental health had deteriorated. At the end of the third call said he could not deal with his partner anymore as his mental health "was that bad". He said she would never have to hear from him again and he would be "in a box tomorrow". His partner then ended the call abruptly.

77. A prisoner and friend of Mr Beresford's said that Mr Beresford had told him a few days before he died that he "did not want to be here anymore" when they were in the lunch queue together. He said he told Mr Beresford he was there for him. He did not tell staff.

78. On 9 October, Mr Beresford did not attend a planned GP appointment for a medication review. The clinic administrator offered him another one that afternoon, but Mr Beresford said he did not want to see the GP. The same afternoon a nurse went to see Mr Beresford after he asked to speak to someone from the mental health team. Mr Beresford told him that he was not ready to talk, and the nurse put him on the list to be seen the next day.

79. Another nurse from the mental health team went to see Mr Beresford on 10 October. Mr Beresford apologised and said he did not want to speak to the mental health team after all. The nurse said Mr Beresford was playing cards with his friends and appeared to be in a good mood. He said Mr Beresford was "happy and bright" and told him not to take it personally, but he just did not need to speak to anyone from the mental health team.

80. On 11 October, a member of the IDTS team said she was on F Wing seeing another prisoner when Mr Beresford called her over. She said he blamed her for his methadone being reduced after he had tested positive for pregabalin. Mr Beresford said he was no longer using illicit pregabalin because his diazepam had been increased and asked for his methadone to be increased back to 40ml.

81. In a statement to the police made after Mr Beresford died, his partner said Mr Beresford had called her from a friend's illicit mobile phone on 9, 10 and 11 October. She said that they had both said sorry for the call on 8 October and she had sent him some money to top up his phone credit for the weekend. On 11 October, she said Mr Beresford seemed fine. He said he wanted to start a carpentry course at the prison and was getting on well with the other prisoners. Mr Beresford's partner said there was nothing in the call to suggest Mr Beresford was at risk of suicide.

82. On 12 October, a friend of Mr Beresford's, who also lived on F Wing, said they had been due to play chess together, but Mr Beresford was too "high". The friend said pregabalin was "everywhere" but the main problem in the prison was psychoactive substances (known as Spice). Another friend said he had seen Mr Beresford that evening and there were no signs that Mr Beresford was thinking about harming himself. He had a coffee with his friend and his cellmate.

83. A prisoner said that Mr Beresford had stopped going to the gym about two weeks before he died and had been upset in the days leading to his death. In contrast, another prisoner thought Mr Beresford had been "better than ever".

Events of 13 October

84. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to prison radio transmissions from 13 October. She also obtained information from the East of England Ambulance Service. The following account has been taken from all sources.

85. At about 7.32am, an officer looked through Mr Beresford's observation panel as part of a standard check of every prisoner on F Wing. In his prison statement, the officer said Mr Beresford was in bed under the covers and clearly breathing.

86. At 8.25am, another officer unlocked Mr Beresford's cell door and discovered him suspended from the window by a ligature made from a sheet. She said she tried to radio a code blue emergency but was unable to get through. She shouted for staff and another officer radioed a code blue within seconds. Staff supported Mr Beresford, removed the ligature, laid him on his bed and began cardio-pulmonary resuscitation.

87. Radio traffic showed that the communications officer phoned for an ambulance at 8.28am, almost four minutes after the code blue was called. He immediately informed the call handler that Mr Beresford was not breathing which allowed the emergency to be correctly triaged and an ambulance dispatched with the highest priority.

88. At 8.28am, a member of staff arrived with the emergency equipment followed within a minute by a number of nurses. A nurse told an officer to stop CPR so she could check Mr Beresford's pulse. He had no pulse, so healthcare staff continued CPR. They attached a defibrillator and gave Mr Beresford oxygen. The defibrillator did not detect a shockable heart rhythm and advised them to continue CPR.

89. Staff moved Mr Beresford to the landing and continued treatment. Paramedics arrived at 8.40am and took over CPR. They gave Mr Beresford adrenaline and attached a Lucas machine (an automatic chest compression machine). At 8.52am, Mr Beresford's heart started beating again and he was taken to hospital.

90. After Mr Beresford was taken to hospital, a prisoner told a member of wing staff that Mr Beresford had previously told him that he had had enough of being in prison but did not have the courage to hang himself.

91. Mr Beresford was put on life support in hospital. Subsequent scans showed no brain activity, life support was withdrawn, and he died on 15 October.

Contact with Mr Beresford's family

92. At 10.00am on 13 October, the prison chaplain telephoned Mr Beresford's partner to tell her he had been taken to hospital and was very unwell. She offered to pay for a taxi to the hospital, but Mr Beresford's partner said her family would bring her. Mr Beresford's partner arrived at the hospital at 2.20pm. She was present when he died two days later. The prison offered a financial contribution to Mr Beresford's funeral in line with national policy.

93. Mr Beresford's partner and her mother accepted an invitation to visit the prison. The prison held two memorial services for Mr Beresford and prisoners raised a significant sum of money to be donated to a charity of the family's choice. The prison chaplain also attended a separate service held by the family.

Support for prisoners and staff

94. After Mr Beresford was taken to hospital on 13 October, a custodial 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.

95. On 15 October, the prison posted notices informing other prisoners of Mr Beresford'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 Beresford's death. Listeners (prisoners trained by The Samaritans to provide confidential peer support) attended F Wing the day after Mr Beresford died.

96. All but one prisoner interviewed said they had received appropriate support after Mr Beresford's death. We informed the Head of Safer Custody, and she arranged for further support to be offered to this prisoner.

Post-mortem report

97. The pathologist gave Mr Beresford's cause of death as hanging. Toxicology tests showed the presence of methadone and diazepam at therapeutic levels and the pathologist concluded that these had not affected Mr Beresford's death. No pregabalin or illicit drugs were detected.

Inquest

98. The jury at the Coroner's inquest held between 25 and 28 April 2025 gave a verdict of suicide and did not list any contributing factors.

Findings

Assessment of risk

99. Mr Beresford had a number of factors that indicated he was at risk of suicide and self-harm including previous suicide attempts, self-harm and substance misuse. In contrast to his previous periods in prison, Mr Beresford did not attempt suicide or self-harm at Chelmsford. He appeared to be settled on his wing, had done well on the graphics course and had a trusted job. Mr Beresford had been concerned about the reduction of his diazepam, but the psychiatrist increased his dose two weeks before he died and he appeared happy with that decision. Two prisoners told the investigator that Mr Beresford had talked about ending his life but did not tell staff. Although some of Mr Beresford's friends thought he had been low in mood, others did not, and his partner had no concerns about him when she last spoke to him on 11 October. We consider that there was little to indicate that Mr Beresford was at imminent or heightened risk of suicide at Chelmsford before 13 October.

Access to pregabalin

100. Although we have seen no evidence that it affected his death, we are concerned that Mr Beresford was able to access pregabalin with apparent ease at Chelmsford. This is most likely to have been diverted medication prescribed to another prisoner. In their report of a diagnostic support visit to Chelmsford in 2019, HMPPS Substance Misuse Team identified ample opportunity for prisoners to divert medication due to a lack of supervision from prison staff. Officer and prisoner focus groups suggested an issue with trading prescribed medication which was backed up by the experiences of healthcare staff. Similarly, a supply reduction targeted support visit in August 2021, identified a need for better supervision of medication queues to reduce diversion.

101. The Head of Drug Strategy said that during the period Mr Beresford was at Chelmsford staffing levels had not been sufficiently high to allow officers to supervise medication administration. On 22 January 2024, the prison implemented mandatory monitoring of all high trade medications, including pregabalin. Officers are now required to attend medication hatches to help supervise prisoners. Prisoners on pregabalin are monitored as part of the monthly prison drug strategy and medicines management meetings. The pharmacy team monitor incidents of diversion and submit information reports to the security department. He said monitoring of medication was still not perfect and he had asked the pharmacist to develop officer training on monitoring medication and the risks associated with prisoners using unprescribed medication. The training will be delivered on shutdown training days.

102. At the time of writing the prison were due to trial a medication pod with a lockable door and transparent sides. Individual prisoners will be locked in the pod to collect their medication and only be allowed out once the pharmacist is content they have taken it appropriately. The pod will be trialled on the induction unit and rolled out to other wings if successful.

103. We are satisfied that the prison is now actively monitoring diversion and is taking appropriate steps to reduce it. We therefore make no recommendation.

Substance misuse support procedures

104. Nine weeks elapsed between Mr Beresford's Forward Trust triage assessment and his full assessment – eight weeks later than planned. This was due to staff shortages, but Mr Beresford was not warned this would be the case. The meetings with his Forward Trust support worker were not recorded on his clinical record although they had access to this. Healthcare staff do not have access to Nebula. This meant that the IDTS team, who were responsible for Mr Beresford's methadone maintenance programme, were unsighted on his psychosocial substance misuse support. The Forward Trust's Patient Safety Investigation Report identified these issues and also that management oversight of delays in assessments was insufficient and Forward Trust support workers were not invited to IDTS meetings.

105. Effective communication and information sharing is important to all care. Mr Beresford was prescribed a number of drugs that had a sedative effect and had admitted to buying illicit medication. It was therefore especially important that everyone involved in his substance misuse treatment had access to all available information. Although we cannot say that these issues affected Mr Beresford's death, they might prove significant in other cases and so we make the following recommendation:

The Head of Healthcare, the Integrated Drug Treatment Service (IDTS) and The Forward Trust should together ensure that:

- **All Forward Trust workers record their interactions with prisoners on both SystmOne and Nebula;**
- **Prisoners are informed if there are delays in service provision or appointments are unable to take place and**
- **The Forward Trust is invited to IDTS meetings.**

Clinical Care

106. The clinical reviewer concluded that the healthcare offered to Mr Beresford was not equivalent to that he would have received in the community because his secondary health assessment took place some eight weeks after it should have done, and he was only monitored for opiate withdrawal on two days of the required five-day stabilisation period. She also concluded that neither of these factors affected Mr Beresford's death.

Governor to Note

107. In line with Prison Service Instruction 03/2013, *Medical Emergency Response Codes*, Chelmsford use an emergency code system to indicate the seriousness of an incident to staff. Calling an emergency code should automatically trigger the control room to call an ambulance. Although staff radioed a code blue as soon as

Mr Beresford was found hanged, radio traffic and the ambulance call recording indicated that it was four minutes before the control room contacted the emergency services, largely because the control room officer appeared busy with other radio messages. While we cannot say that it affected the outcome for Mr Beresford, paramedics are experts in resuscitation, have more sophisticated equipment such as Lucas machines and are able to administer adrenaline. It is therefore crucial that they are summoned immediately in life threatening situations. The Governor will want to ensure that this happens in the future.

Good practice

108. The family liaison offered by the prison chaplain in this case was of a high standard. She went above and beyond what could reasonably be expected, demonstrating a high degree of empathy and willingness to spend time with Mr Beresford's family.

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 l 020 7633 4100