Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Davidson, a prisoner at HMP/YOI Chelmsford, on 12 March 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 Steven Davidson was found hanged in his cell on 12 March 2024, at HMP Chelmsford. He was 43 years old. I offer my condolences to Mr Davidson's family and friends.

Mr Davidson was the eighth prisoner to take his own life at Chelmsford in three years. There have been two further self-inflicted deaths at the prison since Mr Davidson died.

Mr Davidson had some risk factors for suicide and self-harm and while he was worried about his upcoming court appearance and potential sentence, he did not share his concerns with staff. In the weeks before his death, staff reported that Mr Davidson had a positive and calm attitude and he was acting as a mentor to other prisoners.

The investigation found that there was little to indicate that Mr Davidson was in crisis, or at heightened risk of suicide and that staff could not have foreseen his actions.

The clinical reviewer concluded that the mental healthcare Mr Davidson received at Chelmsford was not equivalent to what he could have expected to receive in the community.

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 **December 2025**

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Summary

Events

1. On 16 January 2024, Mr Steven Davidson was remanded to HMP Chelmsford charged with stalking. On 22 January, he pleaded guilty at a video conference court hearing. Mr Davidson was due to attend a court hearing for sentencing during the week of 11 March.

2. Mr Davidson had a history of substance misuse, alcohol dependency and poor mental health. He told staff he had last self-harmed (by cutting) during a previous prison sentence over ten years earlier and he had no current thoughts of suicide and self-harm.

3. During a mental health assessment on 16 February, Mr Davidson said he did not want support from the mental health team and denied any thoughts of suicide and self-harm. The mental health team did not see Mr Davidson in the three weeks before his death.

4. At around 8.30am on 12 March, Mr Davidson reported sick from education. He remained in his cell alone. At 11.52am, his cellmate returned from work and was unable to open the cell door. An officer opened the cell door and saw Mr Davidson hanged from the window bars with a ligature around his neck. The officer called a medical emergency code.

5. Prison and healthcare staff attended immediately and started cardiopulmonary resuscitation (CPR). Paramedics arrived at 12.07pm and at 12.30pm pronounced Mr Davidson's life extinct.

Findings

6. Mr Davidson had been at Chelmsford for almost eight weeks when he was found hanged in his cell. He had some risk factors for suicide and self-harm but had apparently settled well and was attending education and acting as a mentor to other prisoners.

7. Mr Davidson told his family he was worried about his court appearance and potential sentence. This might have been a trigger for his actions but he did not share any concerns with staff.

8. The prison did not have a procedure for prison staff to assess whether a prisoner's status or demeanour had changed or if they needed to see healthcare staff after a video conference court appearance.

9. We consider that there were no particular indications that Mr Davidson's risk of suicide had increased in the days before his death and staff had no reason to consider beginning ACCT procedures.

10. The clinical reviewer concluded that Mr Davidson's mental health care at Chelmsford was not equivalent to what he could have expected to receive in the community. He found that healthcare staff did not use appropriate mental health

assessment tools or ensure that Mr Davidson was assessed in the weeks before his death.

Recommendations

- The Head of Healthcare should ensure that mental health staff use clinical assessment tools to deliver robust mental health assessments in accordance with NICE guidelines.
- The Head of Healthcare should review the mental health referral and assessment process to ensure that prisoners are assessed in accordance with NICE guidelines.

The Investigation Process

11. HMPPS notified us of Mr Davidson's death on 12 March 2024.

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 her. No one responded.

13. The investigator visited Chelmsford on 19 March and spoke to the prisoner who shared a cell with Mr Davidson. She obtained copies of relevant extracts from Mr Davidson's prison and medical records, CCTV and body worn video camera (BWVC) footage and the recording of radio transmissions. She also listened to the last telephone calls that Mr Davidson made. The investigator also obtained the HMPPS Early Learning Review and relevant policy documents.

14. NHS England commissioned an independent clinical reviewer to review Mr Davidson's clinical care at the prison.

15. The investigator interviewed eight members of staff at Chelmsford in May and June 2024. The investigator and the clinical reviewer jointly interviewed healthcare staff.

16. 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.

17. The Ombudsman's office contacted Mr Davidson's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Davidson's family asked if Mr Davidson had illicit substances in his system when he died. We have answered the family's question in this report.

18. We shared the initial report with Mr Davidson's family. They did not make any comments.

19. We also shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report. Castle Rock Group pointed out some factual inaccuracies in this report and the clinical review. We have amended this report accordingly. The clinical review is also amended and attached as an annex.

Background Information

HMP Chelmsford

20. HMP Chelmsford is a category B local reception and resettlement prison which holds adult men and a small number of young adults. Castle Rock Group provides healthcare services.

HM Inspectorate of Prisons

21. HM Inspectorate of Prisons (HMIP) has inspected Chelmsford five times in the past six years due to ongoing concerns about conditions at the prison.

22. In their 2018 inspection, inspectors reported concerns about how the prison managed prisoners at risk of suicide and self-harm. They noted that many PPO recommendations were never implemented and found there was an almost complete lack of a broad strategic response to the high levels of self-harm and deaths.

23. The following year, HMIP carried out an independent review of progress. Inspectors found that the levels of self-harm remained high and the number of self-inflicted deaths remained worrying, but there had been reasonable progress in improving the quality of care for prisoners in crisis or at risk of self-harm. They found that the quality of ACCT paperwork had improved. However, the prison needed to keep recommendations from the PPO under constant review to ensure that progress was sustained.

24. At the next full inspection in August 2021, inspectors found there was an inadequate response to high levels of suicide and self-harm at the prison. Self-harm incidents had increased significantly, the safer custody team was not properly resourced, and staff lacked confidence in using ACCT monitoring procedures. Despite flaws identified during their previous inspection and subsequent failings identified by the PPO, outcomes had deteriorated, recommendations had not been achieved and prison leaders had repeatedly failed to address deficiencies with ACCT procedures. The Chief Inspector of Prisons invoked the Urgent Notification protocol as he was so concerned about the conditions at Chelmsford.

25. Inspectors carried out an independent review of progress in August 2022. They found that there had been reasonable progress in the work to prevent suicide and self-harm and PPO recommendations were regularly reviewed to ensure that processes were embedded. Inspectors reported that staff were much more confident in using ACCT procedures and the quality of reviews and care planning had improved.

26. The most recent full inspection of Chelmsford was in January and February 2024. Inspectors found that Chelmsford was going through challenges trying to manage many vulnerable prisoners with mental health difficulties and increasing levels of self-harm.

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 August 2024, the IMB reported that the number of self-harm incidents remained high, as did the number of ACCTs opened. The IMB noted that the number of self-harm incidents was 10% lower compared to the previous reporting year and towards the end of the reporting year, the number of self-harm incidents was trending significantly lower.

Previous deaths at HMP Chelmsford

28. Mr Davidson was the 11th prisoner to die at Chelmsford since March 2021. Of the previous deaths, seven were self-inflicted and three were from natural causes. Up to the end of May 2025, there have been two further self-inflicted deaths at Chelmsford since Mr Davidson's death.

29. We have made recommendations to Chelmsford previously about ensuring mental health referrals are actioned promptly and assessments are timely. The Head of Healthcare told us in January 2024 that improvements had been made to the reception process to ensure mental health referrals were made and actioned, as necessary. She said that the list of all new receptions was reviewed the next day to check for any that should have had mental health referrals and ensure they were added to the mental health referrals meeting, and referrals were now part of the quarterly mental health audit.

Assessment, Care in Custody and Teamwork

30. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a care plan to identify the prisoner's most urgent issues and how they will be met.

31. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the actions of the support actions 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. When Mr Davidson was at Moorland, guidance on ACCT procedures was set out in the Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody). From January 2025, this was superseded by the Prison Safety Policy Framework, in which the principles of how an ACCT is managed remain largely unchanged.

Incentives Scheme

32. Each prison has an incentives scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels: basic, standard and enhanced.

Key Events

33. On 16 January 2024, Mr Steven Davidson was remanded to HMP Chelmsford charged with stalking against a former partner. This was not his first time in prison.

34. During a previous sentence, Mr Davidson was managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) on three occasions between June and September 2012 after he harmed himself by cutting.

HMP Chelmsford

35. When he arrived at Chelmsford, Mr Davidson's PER (Person Escort Record, which accompanies the individual from police custody to court and to prison and records details about risk) contained a suicide and self-harm warning. Police custody staff noted that Mr Davidson had self-harmed by cutting during a previous prison sentence in 2012. Under the heading 'medical care', custody staff had noted that Mr Davidson had a history of anxiety and depression and was not prescribed any medication.

36. A prison officer completed Mr Davidson's first night induction interview. He noted that Mr Davidson presented well and gave no cause for concern. Mr Davidson spoke openly about his previous self-harm, said this was some time ago and he felt very differently now. He said he had no thoughts of suicide and self-harm and was aware of the support available. Prison staff gave Mr Davidson information about Listeners (prisoners trained and supported by the Samaritans to offer a confidential listening service to peers) and the Samaritans. A cell sharing risk assessment (CSRA, assesses a prisoner's suitability to share a cell) recorded that Mr Davidson was suitable to share a cell. Mr Davidson telephoned his father and did not raise any concerns. He continued to telephone his family regularly but did not receive any visits.

37. A reception nurse noted Mr Davidson's previous history of substance misuse, alcohol dependency and poor mental health. He presented with minor symptoms of alcohol withdrawal and said he had been drinking excessively before coming into prison. The nurse used the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) tool to assess Mr Davidson's need for intervention to manage his alcohol related issues. The assessment results indicated a need for low level support. The results of a urine test indicated the presence of diazepam. Due to Mr Davidson's history of substance misuse, the nurse used the Clinical Opiate Withdrawal Scale (COWS) to assess for signs of opiate withdrawal. The results showed that Mr Davidson did not need support for withdrawal from opiates.

38. Mr Davidson's prescribed medications included diazepam (used to treat the symptoms of alcohol withdrawal and anxiety), thiamine (to prevent vitamin deficiency associated with excessive alcohol consumption) and pain relief medication which he was not allowed to keep in his cell. Mr Davidson denied any mental health concerns and he told the nurse that he had no thoughts of suicide and self-harm. The nurse referred Mr Davidson to the substance misuse service (SMS) and mental health team.

39. Mr Davidson spent a night on the induction unit and staff observed him once an hour during the night. The next day, Mr Davidson moved to a shared cell on F wing, a standard wing. Prison staff allocated Mr Davidson a keyworker. His cellmate told the investigator that Mr Davidson told him that his mental health was declining and he was worried about his trial. He did not express any thoughts of suicide or self-harm at any time.

40. On 22 January, Mr Davidson attended court by video conference. He pleaded guilty and was remanded into custody until 11 March. After attending the hearing, he was taken to the prison's reception to see a nurse. Mr Davidson refused to see a nurse, said he did not have any concerns and he signed a disclaimer. Prison staff did not complete a welfare check, or make an entry in Mr Davidson's prison record or the wing observation book to record a change in Mr Davidson's circumstances as they should have done.

41. On 26 January, a mental health nurse completed a mental health triage assessment and referred Mr Davidson for a full mental health assessment.

42. On 31 January, a mental health nurse saw Mr Davidson. He noted that Mr Davidson was struggling with insomnia (difficulty sleeping). Mr Davidson reported no thoughts of suicide and self-harm and was aware of the support available to him. He asked the mental health team to see him once every two weeks.

43. On 2 February, a further mental health assessment took place. The mental health nurse noted that Mr Davidson did not have any symptoms of low mood and he continued to deny any thoughts of suicide and self-harm.

44. On 12 February, Mr Davidson attended court by video conference to determine when he would attend a sentencing hearing. This was estimated to take place week commencing 11 March. After the hearing, staff did not take Mr Davidson to reception to see a nurse, complete a welfare check or make an entry in his prison record. That day, an officer saw Mr Davidson for a keywork session. Mr Davidson said he felt down after an unexpected court decision. Mr Davidson denied any thoughts of suicide and self-harm and said he did not want to see anyone from the healthcare team.

45. On 16 February, the mental health nurse saw Mr Davidson in his cell. The mental health nurse noted that Mr Davidson appeared unkempt, but he did not present with any symptoms related to a psychotic condition. Mr Davidson told the mental health nurse that he did not need any support from the mental health team and denied any thoughts of suicide and self-harm. The mental health nurse referred Mr Davidson to the mental health multidisciplinary team (MDT) to discuss if he needed on-going mental health support. That day, an officer gave Mr Davidson an incentives warning for refusing to attend education. Mr Davidson said that he did not need education and could not see the point in going.

46. On 18 February, the mental health MDT discussed Mr Davidson and decided that he should remain under the care of a GP at the prison. At interview, a mental health nurse said he expected a GP to review Mr Davidson's mental health needs to determine if he required further support. This did not happen. The mental health team did not see Mr Davidson again before his death. That day, an officer saw Mr Davidson for a keywork session. Mr Davidson said that he was annoyed he had

received an incentives warning. The officer explained that he was expected to attend education unless he was unwell. Mr Davidson received another incentives warning on 28 February, again for refusing to attend education.

47. On 6 March, an officer saw Mr Davidson for a keywork session. The officer noted that Mr Davidson was attending education regularly and was a mentor to other prisoners. She also noted his positive, calm and patient attitude. Mr Davidson did not have any concerns and said that he was enjoying his role as a mentor. He said that he did not have any thoughts of suicide and self-harm.

48. On 8 March, Mr Davidson telephoned his daughter. He said that he was not feeling great but did not express any thoughts of suicide and self-harm.

49. During a telephone call with his father the following day, Mr Davidson said that he was worried about the sentence he could receive. He told his father that he was considering changing his plea but did not know how to do this. Mr Davidson did not express any thoughts of suicide and self-harm.

50. On 10 March, Mr Davidson telephoned his daughter and said he hoped that the court would take his mental health into consideration. He told his daughter he would call her in the next few days. Mr Davidson did not telephone his family again.

Events of 12 March

51. The following account has been taken from documentary evidence provided by Chelmsford, CCTV and Body Worn Video Camera (BWVC) footage, medical records and transcripts of interviews with staff.

52. At around 8.30am, Mr Davidson told an officer that he felt sick and was not well enough to attend education. Mr Davidson collected his medication and returned to his cell. Mr Davidson was alone in the cell because the prisoner who shared the cell was at work. Mr Davidson did not speak to staff again or use his cell bell, and staff had no reason to check on him.

53. Mr Davidson's cell mate returned to the wing at 11.52am. Around two minutes later, he told the officer that he was unable to get into the cell and Mr Davidson was not responding. The officer opened the cell door and saw Mr Davidson standing against the window with a ligature attached to the bars and around his neck. The officer immediately radioed an emergency code blue (to indicate a prisoner is unconscious or having difficulty breathing). On hearing the code call, staff in the control room called for an ambulance.

54. A supervising officer (SO) responded and entered the cell. He used his anti-ligature knife to remove the ligature from Mr Davidson's neck and started CPR. Healthcare staff arrived and took over Mr Davidson's care. Paramedics arrived at 12.07pm and continued with life saving procedures. At 12.30pm, paramedics pronounced life extinct.

55. Mr Davidson left a note to his father. He said sorry and said he should not have pleaded guilty.

Contact with Mr Davidson's family

56. At 1.30pm, the prison appointed an SO as the family liaison officer. At 2.50pm, the SO and a prison offender manager visited Mr Davidson's father and broke the news of his death. The SO stayed in contact with Mr Davidson's father to offer advice and support.

57. In line with national policy, the prison contributed towards Mr Davidson's funeral costs.

Support for prisoners and staff

58. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

59. After Mr Davidson's death, the then Deputy Governor 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. On 15 March, the Samaritans attended the prison and spoke to prisoners and staff.

60. The prison posted notices informing other prisoners of Mr Davidson'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 Davidson's death.

61. Safer custody staff gave prison Listeners and the induction unit manager postvention leaflets to share with prisoners and staff.

Post-mortem report

62. The post-mortem report gave Mr Davidson's cause of death as hanging. The toxicology report detected the presence of Mr Davidson's prescribed medications in his blood at levels in line with his prescribed doses.

63. The report said that there was evidence of the use of cannabis. There was no evidence of the use of synthetic cannabinoids in the hours prior to Mr Davidson's death. The pathologist commented that there was no significant toxicological event that may have contributed to Mr Davidson's death.

Findings

Assessment of risk

64. Mr Davidson had been at Chelmsford for almost eight weeks when he was found hanged in his cell. He had a limited history of self-harm, having last self-harmed over ten years earlier during a previous prison sentence. Prison Service Instruction (PSI) 64/2011 on safer custody (in place at the time of Mr Davidson's death and now replaced by the Prison Safety Policy Framework), required all staff who had contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. Mr Davidson had some of these risks including that he was on remand and his offence was against his former partner. Mr Davidson was also worried that he would receive a longer sentence than expected.

65. In the week before his death, prison staff reported that Mr Davidson was engaging well in education and was enjoying his role as a mentor to other prisoners. It is possible that his upcoming court appearance and potential sentence was a trigger for Mr Davidson's actions, but he did not express any particular concerns to staff or family that he spoke to in the days before his death.

66. We are satisfied that there was little evidence that Mr Davidson's risk of suicide had significantly risen in the days before his death and that staff could not have foreseen his actions. We make no recommendation.

Court appearance

67. PSI 07/2015, Early days in custody instructs that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance by video conference. Prison Service Order (PSO) 3050, Continuity of Healthcare for Prisoners, says that prisons must have procedures in place so that prisoners who have attended court by video conference who request help, or who are identified as needing help, from healthcare staff, are told how to access it and are able to receive it in an appropriate timeframe.

68. There are key times when a prisoner is likely to be at an increased risk of suicide and self-harm. It is important that staff identify any change of circumstances and put appropriate support in place to manage any identified risk. At the time of Mr Davidson's death, there was no procedure in place at Chelmsford for prison staff to assess whether a prisoner's status or demeanour had changed or if they needed to see healthcare staff after a video conference court appearance. Mr Davidson appeared in court by video conference on 12 February. While he had already pleaded guilty in January, this court appearance was apparently significant for him. On this occasion he did not see anyone from the healthcare team and staff did not make an entry in Mr Davidson's prison record about the hearings or the outcomes. We note that Mr Davidson's keyworker saw him after his video conference court appearance on 12 February, and while he said he felt down after an unexpected court decision, he denied any thoughts of suicide and self-harm and said he did not want to see healthcare staff.

69. Since Mr Davidson's death, the prison has introduced a process that prison staff and healthcare staff must follow after a prisoner attends court by video conference. The Head of Safety told us that all prisoners are taken to the healthcare unit and given the opportunity to see a nurse. A disclaimer must be completed if the prisoner refuses.

70. Prison staff are required to complete a video conference welfare check form which identifies a change of circumstances, if the hearing outcome was expected, if the prisoner agreed to see healthcare staff, the impact on their wellbeing and risk of suicide and self-harm. The completed form is entered onto the prisoner's record and an entry made in the wing observation book with an emphasis on identifying prisoners who are at increased risk. In light of the steps taken by Chelmsford we do not make a recommendation.

Clinical and mental health care

71. The clinical reviewer concluded that Mr Davidson's clinical care at Chelmsford was of a good standard and equivalent to what he could have expected to receive in the community. However, he concluded that Mr Davidson's mental healthcare was not equivalent.

72. The clinical reviewer said that healthcare staff did not achieve the requirements of the National Institute for Health and Care Excellence (NICE) Guideline NG66 which recommends the use of standardised assessment tools such as the Correctional Mental Health Screen tool, the Patient Health Questionnaire and the Generalised Anxiety Disorder Questionnaire. The clinical reviewer said that healthcare staff did not complete an appropriate mental health assessment. We recommend:

    The Head of Healthcare should ensure that mental health staff use clinical assessment tools to deliver robust mental health assessments in accordance with NICE guidelines.

73. The mental health team reviewed Mr Davidson on 16 February 2024 and noted that he appeared unkempt and declined further support. The nurse noted that Mr Davidson should remain under the care of a GP at the prison. The clinical reviewer said that Mr Davidson's history of depression indicated the need for a further mental health assessment. We recommend:

    The Head of Health should review the mental health referral and assessment process to ensure that prisoners are assessed in accordance with NICE guidelines.

Good practice

74. Mr Davidson received consistent keywork sessions at Chelmsford from an officer. She made detailed and informative entries in Mr Davidson's prison record. The quality of the officer's keyworker sessions enabled a positive and supportive relationship to develop with Mr Davidson and an improvement in his behaviour. This was demonstrated in his willingness to act as a mentor to other prisoners.

Inquest

75. At the Inquest held between 13 and 21 October 2025, the Coroner concluded that Mr Davidson died from hanging.

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