Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stuart Berry, a prisoner at HMP Chelmsford, on 1 February 2024

A report by the Prisons and Probation Ombudsman

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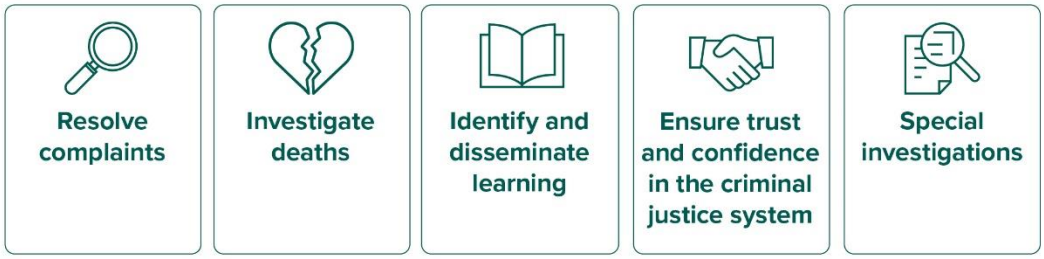
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Stuart Berry died in hospital on 1 February 2024, five days after he was found hanging in his cell at HMP Chelmsford. He was 40 years old. I offer my condolences to Mr Berry's family and friends.

Mr Berry was the seventh self-inflicted death at Chelmsford since February 2021. There has been one further self-inflicted death up to the end of June 2024.

Mr Berry had been at Chelmsford for less than seven hours when he was found hanging. Although staff started suicide and self-harm prevention procedures (known as ACCT) as soon as he arrived, they set observations at only two an hour despite mental health staff at the court having warned the prison that Mr Berry was at extreme risk of suicide. Staff's assessment of Mr Berry's risk of suicide was poor and the frequency of observations they set was too low for his risk level.

We have found poor assessment of risk by reception staff in previous investigations into self-inflicted deaths at Chelmsford. HM Inspectorate of Prisons highlighted similar concerns after their inspection of Chelmsford earlier this year. They concluded that reception interviews lacked depth and they were not confident that the safety processes in place were sufficient to care for prisoners on their first night and early days in custody.

A thorough assessment of prisoners' risk of suicide and self-harm when they first arrive in prison is key to keeping prisoners safe during their early days in custody, particularly for those who are in prison for the first time. I have asked the Prison Group Director responsible for Chelmsford to review the training provided to reception staff on assessing suicide and self-harm risk.

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 **October 2024**

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Summary

Events

1. On Saturday 27 January 2024, Mr Stuart Berry was remanded in prison. This was his first time in prison.

2. Mr Berry had been arrested by police on 26 January, at the Mental Health Urgent Care Department at Basildon Hospital where he had gone to seek help due to struggling with cocaine addiction and feeling suicidal. Police placed him under constant supervision after he threatened to end his life and disclosed recent suicide attempts. A mental health nurse assessed that Mr Berry was at extreme risk of suicide. They completed a prisoner warning form to this effect and telephoned the reception nurse at HMP Chelmsford to warn them that Mr Berry was at high risk of suicide.

3. When Mr Berry arrived at Chelmsford shortly after 2.00pm on 27 January, reception staff started suicide and self-harm prevention procedures (known as ACCT). They set observations at two an hour. They placed Mr Berry in a single cell away from the general prison population as he disclosed that he was a former police officer (he was also a former prison officer, although that was not known until later).

4. Shortly after 9.00pm, during an ACCT check, an officer saw Mr Berry hanging. He radioed a medical emergency code. Prison and healthcare staff responded and immediately started CPR.

5. Prison staff and the ambulance paramedics managed to regain a pulse and ambulance staff took Mr Berry to hospital. He was admitted to the intensive care unit but never regained consciousness and died in hospital on 1 February.

Findings

6. While staff at Chelmsford started ACCT procedures for Mr Berry as soon as he arrived, they did not correctly assess his level of risk and set too low a frequency of observations. Given that a mental health nurse at the court had assessed that Mr Berry was at extreme risk of suicide and had called the prison to warn them, we consider that prison staff should have placed Mr Berry under a higher frequency of observations, possibly even constant supervision, until they had properly assessed his risk and put appropriate protective measures in place.

7. Mr Berry was keen to stay in close contact with his family and staff recorded that family contact was a strong protective factor for him. Although Mr Berry had an in-cell phone, he was unable to use it until his list of contact numbers had been approved and added to his personal prison phone account, which would not have happened until after the weekend. He was therefore unable to call his family for his first few days in prison. We consider that this made it even more important that he was observed frequently during this period.

8. Following a self-inflicted death at Chelmsford in 2021, which involved poor assessment of risk by reception staff, we were told that the reception process had been restructured and a reception training package had been delivered, which

included guidance on risk assessment. However, in their recent inspection of Chelmsford, HM Inspectorate of Prisons remained concerned about the risk assessment process for newly arrived prisoners. They found that the initial safety interview carried out by reception staff did not explore prisoners' risk of self-harm in sufficient depth and they were not confident that early days safety processes were sufficient to care for prisoners on their first night and early days in custody. Inspectors also found that prisoners were waiting too long to be able to make phone calls and despite the prison having introduced a process to prioritise new arrivals, this was still not effective.

9. The clinical reviewer found that the clinical care Mr Berry received at Chelmsford was equivalent to that which he could have expected to receive in the community. However, she expressed concern about the frequency of observations set for Mr Berry and said that, in her opinion given Mr Berry's risk factors, had he arrived at a Mental Health Unit he would have been placed on continuous observations.

Recommendations

- The Prison Group Director for Hertfordshire, Essex and Suffolk should:
    - Review the training provided to reception staff at Chelmsford on assessing risk of suicide and self-harm and how to put appropriate monitoring and support in place if an ACCT is opened.
    - Ensure a rigorous quality assurance process is in place that accurately monitors the effectiveness of that training.
    - Review whether Chelmsford is effectively prioritising access to phone calls for newly arrived prisoners, and particularly those on ACCT.

The Investigation Process

10. HMPPS notified us of Mr Berry's death on 1 February 2024.

11. 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.

12. The investigator visited Chelmsford on 9 February 2024. She obtained copies of relevant extracts from Mr Berry's prison and medical records, CCTV and body worn video camera (BWVC) footage and the recording of radio transmissions.

13. The investigator interviewed five members of staff at Chelmsford on 14 and 27 March 2024. Three interviews were conducted over video call.

14. NHS England commissioned an independent clinical reviewer to review Mr Berry's clinical care at the prison. She jointly interviewed staff with the investigator.

15. 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.

16. The Ombudsman's office contacted Mr Berry's father to explain the investigation and to ask if the family had any matters they wanted us to consider. Mr Berry's family asked the following questions:

    - What information about Mr Berry's mental health history was available to prison staff at Chelmsford?
    - What information was reviewed by the staff who opened the ACCT?
    - Why was he placed on half-hourly observations rather than 15-minute observations or constant supervision?
    - Why was he not placed in a ligature-free cell with anti-ligature bedding and why was he allowed to keep a belt and trainers with laces in his cell?
    - What was his mental state at the last check?
    - Did he have his medication?
    - Who carried out CPR?

    These issues have been addressed in this report. The family raised several other issues which have been addressed through separate correspondence.

17. Mr Berry's family received a copy of the initial report and requested some amendments. The solicitor representing them also wrote to us requesting some amendments in our report and the clinical review. The reports have been amended accordingly. The family and solicitor also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to them.

18. The initial report was shared HMPPS. HMPPS did not find any factual inaccuracies.

Background Information

HMP Chelmsford

19. 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

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

21. 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.

22. 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.

23. 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.

24. 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.

25. 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.

26. Inspectors noted that reception was very busy and that most interactions were polite but functional and very brief. Initial safety interviews in reception did not

explore prisoners' vulnerabilities, in particular their risk of self-harm, in sufficient depth. The information about risk that was collected and recorded electronically by reception staff was not routinely reviewed by staff on the induction unit before they conducted a secondary interview. The scope of this second interview was also too narrow, with little evidence of wider risk factors being taken into account or additional support being put in place, for example, for those in prison for the first time.

27. Prisoners often arrived in the evening, which did not always allow enough time for reception and first night processes to be conducted effectively. Although most got a hot meal on arrival, too many could not have a shower or make a telephone call on their first night (see below), and inspectors saw no evidence of a reliable system of recording when new arrivals had received these entitlements.

28. A review which focused on improving early days safety processes referred to as a "bus to bed review" (charting the processes from the prison van to arriving on the first night wing) had resulted in a revised safety interview process. However, inspectors were not confident that the changes were sufficient to care for prisoners on their first night and early days in custody.

29. Inspectors found that it took too long for prisoners to be able to make a telephone call after arriving. In their survey, only 14% said that they had had numbers put on their personal prison telephone account within 24 hours, and many prisoners they spoke to had been in the prison for over a week and still had not been able to make a call. Leaders were aware of this issue and had recently implemented a new system to help make sure that new arrivals were prioritised for this process, but this was not yet fully effective.

Independent Monitoring Board

30. 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 2023, the IMB reported that the number of self-harm incidents remained high, as did the number of ACCTs opened. The IMB noted that staffing shortages and turnover were high which impacted service delivery.

Previous deaths at HMP Chelmsford

31. Mr Berry was the tenth prisoner to die at Chelmsford since February 2021. Of the previous deaths, six were self-inflicted and three were from natural causes. Up to the end of June 2024, there was one further self-inflicted death.

32. We have previously made recommendations to Chelmsford about improving staff's assessment of prisoners' risk of suicide and self-harm and management of ACCT procedures. In January 2022, the prison told us that they had restructured the reception process to focus on all aspects of safety and had reminded reception staff to review all documentation that arrived with the prisoner to check for any warnings or other information that related to risk of suicide and self-harm. Staff had also been trained on ACCT procedures, including risk evaluation, and the prison had introduced ACCT champions and ACCT quality assurance checks.

33. In August 2023, after an investigation into a death that had occurred earlier that year which again identified ACCT failings, we asked the Prison Group Director for Hertfordshire, Essex and Suffolk to write to the Ombudsman setting out whether the measures introduced to improve ACCT management at Chelmsford had led to sustained improvement and if not, what further measures they planned to take. The Prison Group Director responded with a range of actions taken by the prison including Safety Summits focusing on improving the quality of ACCT.

Assessment, Care in Custody and Teamwork

34. 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.

Key Events

Background

35. On 26 January 2024, Mr Stuart Berry was arrested at the Mental Health Urgent Care Department in Basildon Hospital where he was awaiting assessment. Mr Berry's drug worker had referred him to the Crisis Team on 25 January, after Mr Berry said he was suicidal and had thoughts of harming others. He had not been taking his antipsychotic medication (for bipolar affective disorder) due to his cocaine addiction. The Crisis Team advised him to go to the Urgent Care Department as they were concerned about the risk he posed to himself and others. He had attended the Mental Health Urgent Care Department on several occasions previously seeking admission. He had said he would end his life by any means if he did not get help.

36. While he was in police custody, Mr Berry was placed under constant supervision after he threatened to end his life and disclosed recent suicide attempts. He disclosed that he had doused himself in petrol and then run into the road while under the influence of cocaine two days before. He had also tried to jump from a bridge.

37. On Saturday 27 January, Mr Berry appeared in court and was remanded in prison. Mental health staff based at the court reviewed Mr Berry and noted that he said he had started hearing voices which had been laughing, getting louder and telling him to end his life. Mental health staff completed a Prisoner Warning Notice (PWN) which said that Mr Berry was at extreme risk of suicide and self-harm. It noted that Mr Berry was feeling suicidal with intent, that there had been recent suicide attempts, and that Mr Berry might be highly vulnerable in prison due to his mental health issues, his first time in prison and as he was an ex-police officer. (Mr Berry was also a former prison officer, having worked at HMP Belmarsh. This information did not come to light until Mr Berry was admitted to hospital.) The form also recorded that mental health staff at the court had telephoned staff at HMP Chelmsford to warn them that Mr Berry would be arriving.

HMP Chelmsford

38. The reception officer at Chelmsford that day said in her statement that during the lunch break, she received a telephone call from the court who were trying to contact the reception nurse. She provided the reception nurse's extension number and told them that the nurse was not in her office during the lunch break. The court staff told her that Mr Berry would be arriving soon and that he was an ex-police officer. She said that the court called a further two times to speak with the reception nurse. Prison staff began arrangements for Mr Berry to be located away from the general prison population.

39. The reception nurse that day told us in interview that before Mr Berry arrived, she received a telephone call from a member of court staff who told her that Mr Berry had a PWN alert due to his high risk of suicide. She received the PWN by email.

40. Mr Berry arrived at Chelmsford at approximately 2.10pm. His Person Escort Record (PER – a document that accompanies prisoners when they move between police

stations, courts and prisons which sets out the risks they pose) noted there was a risk of self-harm or suicide, and that Mr Berry's current observation level was constant physical watch. It said that within the last two days, Mr Berry had tried to hang himself, had doused himself in petrol and had tried to jump from a bridge. The PER also noted that Mr Berry had mental health needs as he was bipolar and heard voices, and that he was prescribed medication which was not with him. It said he had been given diazepam (a sedative) around 12 hours before.

41. A supervising officer (SO) was the reception SO and the reception desk officer that day, so he was the first person to speak to Mr Berry when he arrived. In interview, he said that Mr Berry appeared down, though that was not unusual for people who had just arrived in prison. He said that he was aware that Mr Berry was an ex-police officer (from his digital PER) and had cleared part of the reception area so only he and one other officer were there. He said he explained to Mr Berry that he would be placed in a small unit away from the general prison population to keep him safe and that Mr Berry seemed grateful.

42. At approximately 2.15pm, the reception officer completed a reception interview with Mr Berry. In her statement, she said that Mr Berry told her that he spoke to his son every day and was keen to maintain this contact. She told Mr Berry that he would have an in-cell phone and that he should complete a personal prison phone account application that evening. She added that his numbers would need to be checked (to ensure there were no contact restrictions, for example) before they could be added to his account and that, as it was a weekend, this could not be done immediately. Mr Berry was not pleased about this, so she told him that a call could be made on his behalf, and he should discuss this at his first night interview later.

43. Mr Berry told the reception officer that he was an ex-police officer. He accepted vulnerable prisoner status, and she told him that he would be located separately from the main prison population. She noted from paperwork that had arrived with Mr Berry that he had previously attempted suicide by hanging and setting himself on fire. He said he was having suicidal thoughts but did not have a current plan in place. At 2.35pm, she started suicide and self-harm prevention procedures (known as ACCT) and set observations at two an hour. She said in her statement that one observation an hour was the standard observation level for an ACCT, and she had set observations at a higher frequency for Mr Berry. She did not consider constant supervision necessary as Mr Berry had discussed his family ties and how important family was to him and had showed some forward planning as he had asked about the prison regime.

44. The reception nurse completed Mr Berry's initial health screen. She noted that Mr Berry was already on an ACCT but that he seemed calm. She recorded that he had 'plans for deliberate self-harm without intent'. He told her that he had bipolar disorder and depression and was on medication. He also said that he used cocaine. She completed a mental health referral, a Drug Addiction and Recovery Team (DART) referral and booked a welfare check by a nurse for the next day. Another nurse subsequently noted that Mr Berry had arrived with painkillers and said he had blisters on his feet. She prescribed painkillers to Mr Berry and noted that his mental health diagnoses would need to be confirmed before prescribing mental health medication.

45. The reception SO completed the ACCT Immediate Action Plan at around 3.45pm. He confirmed in interview that he saw Mr Berry's PER. He noted in Mr Berry's prison record that he spoke openly but appeared down. They discussed his previous employment as a police officer and the arrangements for him to have minimal contact with the general prison population. He noted Mr Berry was grateful for the support. Mr Berry told him that four months ago he had attempted to take his life due to a relationship breakdown. He noted that Mr Berry said he had no current thoughts to harm himself and that he told Mr Berry about the peer support available and that also staff were available for him to talk to. They spoke about ways Mr Berry could occupy his time and Mr Berry said he was keen to use the gym and they discussed in cell workout regimes. Mr Berry told him about his bipolar diagnosis, that he would like to restart his medication and had told the reception nurse. He told Mr Berry that a member of the mental health team would attend his ACCT review the next day to discuss his mental health needs. He concluded that although Mr Berry had no current thoughts of self-harm, as this was Mr Berry's first time in prison and he was not on his mental health medication, two observations an hour was appropriate until the review the next day.

46. In interview, the reception SO said that Mr Berry seemed emotional but not unusually so for someone in prison for the first time. He said that Mr Berry told him that he had no immediate thoughts or intent to harm himself. He recognised that this differed from what Mr Berry had told the reception officer but said prisoners' demeanour often changed as they moved through the reception process, once they had had procedures explained to them and been reassured. He said that Mr Berry had a number of concerns, about getting food and drink, getting money and clothes sent in, and going to the gym, but these had all been explained and resolved in his view. He said that Mr Berry talked about his cocaine addiction and spoke positively that prison would force him to stop using cocaine. Mr Berry also told him that he had not taken his bipolar medication for a few days but had spoken to the reception nurse about it. The SO said that the standard level of ACCT observations was one an hour and he decided to keep them higher than that, at two an hour. This was because Mr Berry was emotional, it was his first time in prison, and he had not taken his bipolar medication.

A Wing

47. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to prison radio transmissions from 27 January. She also obtained information from the East of England Ambulance Service. The CCTV was not time stamped. Approximate timings have been calculated by working back from the time of the emergency response.

48. Staff allocated Mr Berry to a single cell on the third floor of A Wing, a small unit above the prison's segregation unit. The reception SO and an officer escorted Mr Berry to A Wing at around 4.40pm. The SO and two officers walked with Mr Berry up to the cell. There was a brief interaction as Mr Berry went into the cell.

49. Staff carried out three checks on Mr Berry at roughly 30-minute intervals, in line with the frequency of checks set in reception.

50. At approximately 6.15pm, Officer A completed a first night in prison (FNIP) interview with Mr Berry. The purpose of this interview is to identify any concerns and any

support needed, to assess whether the prisoner is a risk to themselves or from others, and to share information about general prison procedures and the support available. Next of kin details are also recorded during this interview and a welfare telephone call is offered (where prison staff make a call on the prisoner's behalf).

51. In his statement Officer A said that he had been called over from B Wing (the induction wing) to complete the FNIP interview with Mr Berry. He unlocked Mr Berry, and they went to an office. He said that Mr Berry presented as quite nervous and "closed off". He said that during the interview he reassured Mr Berry about being in prison and after the interview he returned him to his cell. CCTV shows that Mr Berry was out of his cell for around 16 minutes. In his entry on Mr Berry's prison record, he recorded that a welfare call had not been made. When asked about this, he said that he could not remember if a call had been made but he would have offered one.

52. CCTV shows that approximately 20 minutes later, Officer A returned to the cell carrying a carton of milk which he delivered to Mr Berry. CCTV shows that staff subsequently checked on Mr Berry four times at around 30-minute intervals.

53. At approximately 8.25pm, Mr Berry rang his emergency cell bell. Officer B responded and Mr Berry asked him for a spoon. Officer B and Officer C took Mr Berry a spoon at approximately 8.35pm. In his interview, Officer C told us that Mr Berry said he was okay. He thought he seemed like an average prisoner who had just arrived. He said he was not acting bizarrely and did not seem down.

Emergency response

54. At approximately 9.00pm, Officer C returned to Mr Berry's cell to complete an ACCT check. He looked through the observation panel and saw Mr Berry hanging from the window bars. He radioed a code blue (a medical emergency code used when a prisoner is unresponsive or has breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately) and he broke the seal on his key pouch to unlock and enter the cell. Control room staff logged the code blue at 9.04pm and immediately called an ambulance.

55. An operational support grade (OSG) and an officer arrived almost immediately, and all three staff entered the cell. The officer and OSG lifted Mr Berry as Officer C untied and cut the ligature from Mr Berry's neck. They then placed Mr Berry on the bed on his back.

56. Another officer arrived at the cell just as the staff had placed Mr Berry on the bed. Another officer followed behind. The first officer said in his statement that he shouted at the other officers to move Mr Berry to the floor, as he saw that Mr Berry's eyes were open and he was not breathing. He and Officer C felt for a pulse. As they could not find one, Officer C started CPR, assisted by the officer.

57. A nurse arrived at the cell approximately two minutes after the code blue was called and helped with the resuscitation attempt. Another nurse arrived soon afterwards and also assisted. Due to the cramped cell conditions, staff moved Mr Berry onto the landing.

58. The East of England Ambulance Service log shows that the emergency call was received at 9.05pm. Paramedics arrived at 9.09pm. Another emergency vehicle arrived at 9.11pm. Prison staff made a second call at 9.12pm, asking how many emergency vehicles would attend. They were told two more emergency response vehicles were on the way. Another emergency vehicle arrived at 9.17pm and the air ambulance car arrived at 9.33pm with two doctors and a paramedic to assist with the resuscitation attempt. To create more space, the air ambulance doctors, paramedics and prison staff moved Mr Berry to a table on the landing.

59. The doctors and paramedics took charge of Mr Berry's care and once stabilised, at 11.00pm, the paramedics took Mr Berry to hospital where he was placed in intensive care. Two officers escorted him. Due to a lack of space in the ambulance, one officer went in the ambulance and the other officer went in the air ambulance car.

Events at the hospital

60. Hospital staff placed Mr Berry in an induced coma. Initially the escorting officers were at the end of Mr Berry's bed. Later that night, hospital staff moved Mr Berry to the intensive care unit (ICU). The bedwatch staff moved to a separate room and completed periodic checks on Mr Berry.

61. On 28 January, there was a change in shift of the hospital bedwatch staff. One of the bedwatch staff was a SO from HMP Belmarsh, who recognised Mr Berry as a former prison officer who had left Belmarsh around 18 months before. He rang the communications room at Chelmsford to report this. Staff at Chelmsford asked if he was happy to continue with the bedwatch, and he said he was. He completed a report about this to senior managers at Belmarsh.

62. Mr Berry never regained consciousness and he died on 1 February. Members of his family were with him when he died.

Contact with Mr Berry's family

63. While arrangements were being made to take Mr Berry to hospital, the duty manager tried to find contact details for Mr Berry's family. However, the prison did not have a telephone number for Mr Berry's family (Mr Berry had not yet applied for any numbers to be added to his phone account and had not provided a phone number for his nominated next of kin when he arrived), so he asked the police for help.

64. In the early hours of 28 January, the police visited the family's address and asked them to contact the prison. The duty governor then broke the news to Mr Berry's family that Mr Berry had been found hanging in his cell and had been taken to Broomfield Hospital. Mr Berry's family went to the hospital at approximately 2.45am on 29 January.

65. Later that day, a prison chaplain and the prison's family liaison officer (FLO) visited the hospital to offer support to Mr Berry's family. However, a senior nurse told the chaplain that the family did not wish to speak to her.

66. The prison chaplain telephoned Mr Berry's father on 30 January and arranged to meet him at the hospital with the deputy FLO to outline the FLO role and offer support.

67. Mr Berry's family accepted an invitation to visit the prison on 12 February to meet senior managers to discuss the events.

Support for prisoners and staff

68. 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.

69. After Mr Berry'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.

70. The prison posted notices informing other prisoners of Mr Berry'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 Berry's death.

Post-mortem report

71. The post-mortem report concluded that Mr Berry died from hanging.

Findings

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

72. 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.

73. Mr Berry arrived at Chelmsford with a suicide and self-harm warning in his PER, which said he had been on constant physical watch in police custody due to his recent suicide attempts and very high risk of suicide. The reception nurse also received a Prisoner Warning Notice (PWN) by email from the court, which said that Mr Berry was at extreme risk of suicide (due to multiple factors including recent suicide attempts, his mental health history, it was his first time in prison, and he was an ex-police officer). Court staff had called the reception nurse to warn her.

74. The reception nurse did not share the contents of the PWN with the reception officers and there was no multi-disciplinary conversation about Mr Berry before he arrived. We are satisfied, however, that the PER set out clearly Mr Berry's high risk of suicide, his recent suicide attempts and the fact he had been under constant supervision in police custody. The Head of Healthcare told us that healthcare staff used to send copies of PWNs to the reception inbox, but it was not monitored routinely. Since Mr Berry's death, a new process had been introduced where a reception officer was designated as the point of contact for healthcare staff to liaise and share information with, including warning notices from the courts.

75. Although reception staff started ACCT procedures as soon as Mr Berry arrived at Chelmsford, they set observations at only two an hour. We consider that this was objectively too low given the information staff had about Mr Berry's extreme risk of suicide. Both the reception officer and the reception SO said that it was standard for ACCT observations to be set at one an hour and they therefore considered that two an hour was appropriate given that Mr Berry was at higher risk. We disagree. Observations at roughly half-hourly intervals was not enough to keep Mr Berry safe given his risk profile.

76. We also note that part of the reception officer's reasoning for not placing Mr Berry under constant supervision was his close family ties and how important family contact was for him. Yet during the same reception interview, the officer had told Mr Berry that he would be unable to use his in-cell phone until after the weekend, which meant that he would have been unable to call his family for at least two days. This was clearly a key protective factor for Mr Berry which he did not have access to during his first few days in prison. In our view, this made it even more important to have very frequent observations of Mr Berry over that period.

77. Following a self-inflicted death at Chelmsford in 2021, which also highlighted poor assessment of risk by reception staff, the prison told us that the reception process had been restructured and reception staff had been reminded to review all available documentation so that they could fully assess the risk of suicide and self-harm. A reception training package had also been delivered which included guidance on risk assessing, the importance of reviewing all available information and recording and

sharing risk information. However, the circumstances of Mr Berry's death demonstrate that reception processes for assessing risk are still inadequate, even when staff have reviewed information indicating very high levels of risk.

78. HM Inspectorate of Prisons has also highlighted that procedures for keeping prisoners safe during their early days at Chelmsford are inadequate. In their recent inspection earlier this year, inspectors found that despite some improvements having been made to early days safety processes, such as a new safety interview process in reception and changes to staff shift patterns to accommodate the frequent late arrivals, these were not all embedded effectively, and they were not confident that the processes were sufficient to care for prisoners on their first night and early days in custody.

79. Inspectors found that initial safety interviews in reception did not explore prisoners' vulnerabilities, particularly their risk of self-harm, in sufficient depth and information about risk that was collected and stored electronically by reception staff was not routinely reviewed by staff on the induction unit before they carried out a secondary interview (the FNIP interview). The scope of the secondary interview was also too narrow, and inspectors saw little evidence of wider risk factors being taken into account or additional support being put in place, for example for those in prison for the first time.

80. Inspectors reported that it took too long for prisoners to be able to make a telephone call after arriving. In HMIP's survey only 14% said that they had numbers added to their phone account within 24 hours, and many prisoners said they had been in prison for over one week and had still been unable to make a call. The prison had introduced a process to ensure that new arrivals were prioritised, but this was still not fully effective.

81. Our investigation has shown that the reception risk assessment process failed to properly assess Mr Berry's very high risk of suicide and as a result, staff put inadequate monitoring in place. They also failed to recognise his increased vulnerability due to being unable to contact his family. We recommend:

The Prison Group Director for Hertfordshire, Essex and Suffolk should:

- **Review the training provided to reception staff at Chelmsford on assessing risk of suicide and self-harm and how to put appropriate monitoring and support in place if an ACCT is opened.**
- **Ensure a rigorous quality assurance process is in place that accurately monitors the effectiveness of that training.**
- **Review whether Chelmsford is effectively prioritising access to phone calls for newly arrived prisoners, and particularly those on ACCT.**

Location

82. Newly arrived prisoners are normally placed on the induction wing (B Wing) for their first few days. However, Mr Berry was placed in a standard single cell on A Wing as soon as he arrived. This was to keep him away from the general prison population

due to his vulnerable prisoner status as a former police officer. We consider that this was an appropriate location for him.

83. Mr Berry's father asked why Mr Berry was not placed in a 'safer cell'. Safer cells are designed to make the act of suicide or self-harm by ligature as difficult as possible. This is achieved by reducing known ligature points as far as possible and by installing specialist anti-ligature furniture and fittings as an integral part of the cell fabric. Chelmsford has no safer cells at present, only constant supervision cells. The prison has advised that there are four cells currently being made into safer cells, one on A Wing, one on C Wing and two on G Wing.

Access to items that could be used as ligatures

84. Mr Berry's father asked why Mr Berry was allowed to have certain items in his cell such as his belt, trainers and the bedsheet that he used as a ligature. The prison must have strong justification to remove personal items from prisoners due to the negative impact that removal of items can have on wellbeing. Justification would include where a prisoner has tried to self-harm using an item such as a belt or laces, or where they have said that they intend to use such items. This was not the case for Mr Berry. As for bedsheets, these would be removed from prisoners only in exceptional circumstances.

Clinical care

85. The clinical reviewer concluded that the clinical care Mr Berry received at Chelmsford was equivalent to that which he could have expected to receive in the community.

86. However, the clinical reviewer said that in her opinion, had Mr Berry arrived in a Mental Health Unit with his risk factors, he would have been placed on constant observations.

Inquest

87. At the inquest, held from 6 November to 5 December 2025, the jury concluded that Mr Berry died by suicide contributed to by neglect. The jury's narrative conclusion covered the care he had received in the community as well as in prison. Their findings relating to the care he received in prison were as follows:

Healthcare

a) The healthcare nurse located at prison reception seriously failed to adequately assess, document and act upon Stuart's risk of suicide and self-harm.

b) The level of observations set for Stuart was a serious failure.

c) The healthcare reception nurse in the prison seriously failed to appropriately communicate vital, relevant and available information to prison officers on 27th January 2024.

d) The reception nurse should have definitely referred Stuart to be seen by the on site specialist Mental Health Nurse on the same day.

The above shortcomings collectively probably more than minimally contributed to Stuart's death.

Prison staff

a) The Suicide and self-harm (SASH) and Assessment Care in Custody and Teamwork (ACCT) training provided to prison reception staff to identify risk and set adequate observation levels was "not fit for purpose." Therefore unsatisfactory.

b) The decision not to set Stuart's observations to constant was a serious failure.

c) The steps taken by prison staff to mitigate Stuart's identified risks of suicide and self-harm were both inappropriate and inadequate.

d) The decision to place Stuart in a cell with accessible metal bars in the window, without constant observation was an extreme failure.

e) The officer conducting the First Night in Prison (FNIP) interview should have been aware that Stuart was on an ACCT.

f) The quality of Stuart's FNIP interview was inadequate. A competent FNIP interviewer should have acted on information more appropriately.

g) No evidence of official training. "On the Job" training for an FNIP is unsatisfactory.

h) The assessment and management of Stuart's risk at HMP Chelmsford demonstrated serious failings. The whole process was severely impeded by poor completion of the ACCT and questionable input in respect of observations and conversations.

The above collectively probably more than minimally contributed to Stuart's death.

Findings of Neglect

i. The adequacy of sharing of available information by the healthcare reception nurse with prison staff constituted neglect.

ii. The observation level set at HMP Chelmsford by prison staff, on the basis of the information available to them and in the context of the cell on A wing into which Stuart was to be placed for his first night in custody, including the availability of ligature points, amongst others, in the form of bars at the window constituted neglect.

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