Investigation into the circumstances surrounding the death of a man at HMP&YOI Chelmsford in May 2007

Report by the Prisons and Probation Ombudsman for England and Wales

May 2008

This is a report into the circumstances surrounding the death of a man aged 38, at HMP&YOI Chelmsford in May 2007. The man was found hanging in his cell. He had been deeply distressed about the break-up of his marriage and tormented by the abuse he had suffered as a child. From his first day in Chelmsford he spoke of the inevitability that he would kill himself. As is the case with many of my investigations, this report tells a very sad story.

The investigation was led by one of my investigators who was assisted by a colleague. My senior family liaison officer contacted the man's next of kin and maintained contact with them throughout the investigation. A clinical reviewer from Mid-Essex Primary Care Trust undertook an independent clinical review into the care received by the man at Chelmsford, and I am grateful to her. I must also thank the Governor and staff of HMP Chelmsford for their assistance.

The management of someone who feels he has nothing to live for poses an enormous challenge for Prison Service staff. That challenge is all the greater in a chronically overcrowded local prison such as Chelmsford. I judge that wing staff tried very hard to engage the man and to keep him safe. Their job cannot have been made easier by the limitations of the regime and the other pressures typical of a prison stretched beyond the limits of its capacity.

Since the man's death, five other apparently self-inflicted deaths have occurred at Chelmsford in a period of little more than three months (between 27 November 2007 and 5 March 2008). I have yet to establish whether there are any common themes between them or whether overcrowding or staff shortages played a part.

I must apologise for the delay in issuing this report, although this has not delayed the giving of feedback to the prison itself. The report includes a number of additional points the Governor will wish to consider. In general, I think my investigation reflects pretty favourably upon the care and support Chelmsford offered to the man who is the subject of this report. I have made three formal recommendations and highlighted three examples of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **May 2008**

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SUMMARY

The man died, apparently by his own hand, in May 2007 in HMP&YOI Chelmsford. He had a history of depression and had made two previous attempts to kill himself in the community. He was very distressed about the break-up of his marriage and had on-going problems as a result of serious abuse suffered in his childhood.

The man was remanded to Chelmsford on 31 January 2007, charged with arson with intent to endanger life. He told staff in Reception that he would kill himself as soon as he could. An ACCT form was opened and he was placed on constant observation for 48 hours. Attempts were made to get him to engage with mental health staff but he mostly refused to talk about his problems.

The man was moved to C wing on 19 February. He was initially very quiet and unwilling to talk but gradually formed positive relationships with several staff. He was given a trusted job as a wing cleaner and painter and this appeared to improve his mood and increase his interaction with staff and prisoners.

On two occasions, on 17 and 22 April 2007, the man was considered to be in crisis. On both occasions he received appropriate support from wing and healthcare staff. The man's ACCT remained open throughout his time in Chelmsford and he continued to tell staff that he would kill himself one day. The wing Senior Officer (SO) often moved the man's reviews to a day when there was more time for the man to talk. Staff deserve credit for their attempts to engage him and keep him safe.

I recognise that the man remained generally unwilling to engage with the mental health team (MHT) but raise some concerns about the absence of a proactive approach to a very vulnerable prisoner. I make a recommendation designed to improve the monitoring of ACCT reviews.

The prison's response to the man's death was timely, efficient and organised. I make two recommendations about cardiopulmonary resuscitation (CPR) and about responsibility for bringing the defibrillator and oxygen to the scene of an emergency. The prison's liaison with the man's family and friends was of a high standard.

Overall, I make three recommendations and highlight three areas of good practice.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 10 May 2007. The case was allocated to two of my investigators on the same day. One of the investigators visited Chelmsford on 15 May. She met the then Governor, the then Head of Residence), the branch secretary of the Prison Officers' Association), and a member from the Independent Monitoring Board. She was provided with copies of the man's prison record, Inmate Medical Record (IMR), and the staff incident reports written following his death. The investigator contacted the police officer in charge of the police investigation and the Coroner's Officer.

2. The two investigators interviewed staff and prisoners at Chelmsford on 24 and 25 July. The Deputy Governor was given full verbal and written feedback by my investigators after they had concluded their interviews.

3. A clinical review of the man's medical care while in Chelmsford was commissioned from Mid-Essex Primary Care Trust (PCT).

4. My senior family liaison officer, telephoned the man's listed next of kin, to explain the investigation process and offer the opportunity to be involved in the investigation. The nominated next of kin did not think that staff on his wing could have done any more to help the man. She also said that the standard of family liaison from the prison had been very high. A letter of condolence from the Governor had upset her because it had contained several errors, but once the prison became aware of this she received a letter of apology and two bunches of flowers. The nominated next of kin was deeply saddened by his death but told my FLO that she was not surprised. She thought that the man had probably been planning to kill himself for some time.

HMP&YOI CHELMSFORD

5. HMP&YOI Chelmsford is a category B local prison that serves the courts of Essex and surrounding areas. It predominantly holds sentenced and unsentenced adult male prisoners, but almost a third of the population is made up of young offenders aged between 18 and 20 years. The prison accommodation is split between the original Victorian wings and newly built residential units. Like most local prisons there are constant population pressures, and in July 2007 HM Chief Inspector of Prisons recognised Chelmsford as one of the most overcrowded prisons in England and Wales.

6. C wing is one of the older Victorian wings. It has three landings and holds 132 prisoners, 44 on each landing. At the time the man was there, C wing was designated as the YOI wing but because of population pressures it took some adult prisoners too. The 1s landing (first floor landing) was entirely given over to sentenced young offenders and the 2s and 3s landings (second and third floor landings) were divided between young offenders and adults on remand. Wing staff thought that the adults had a calming effect on the young offenders, with the prisoners on the 2s and 3s landings being much quieter and less volatile than those on the 1s.

7. Staff told my investigators that the regime was hard work but was manageable given a full complement of staff. The number of prisoners on ACCT forms (Assessment, Care in Custody and Teamwork – the Prison Service's system for monitoring and supporting prisoners thought to be at risk of self-harm and suicide) varied. Staff thought that, when more than six ACCTs were open on the same wing at the same time, it became difficult for staff to maintain the quality of entries.

8. HM Chief Inspector of Prisons inspected Chelmsford in a full, announced inspection in July 2007. The inspection revealed a prison suffering from all the problems endemic to an overcrowded system. The population was very fluid with prisoners staying a relatively short time and with insufficient activity to occupy them. Staff turnover was high and shortages were a constant feature.

9. The death of this man was the third apparently self-inflicted death at Chelmsford since I took responsibility for investigating all fatal incidents in prisons in April 2004. Since his death there have been a further five apparently self-inflicted deaths (in a period between 27 November 2007 and 5 March 2008). I have identified no common themes between the death of the man and the two previous deaths. At the time of writing, the investigations into the subsequent five are ongoing.

THE EVENTS LEADING UP TO THE MAN'S DEATH

10. On 30 January 2007, the man was arrested and taken to the police station after setting fire to some rubbish outside his ex-wife's flat. A 'detained persons medical form' completed at the police station described him as low in mood and with suicidal thoughts. He was placed on constant observation and referred to the forensic mental health team after banging his head repeatedly against the police cell wall.

11. On 31 January, the man attended the Magistrates' Court on a charge of arson with intent to endanger life. He continued to bang his head against the wall of the court cell. A Community Psychiatric Nurse (CPN), attempted to talk to him but he refused to speak to her. When the man was subsequently remanded into custody, the CPN phoned Chelmsford prison and passed on her concerns to a member of the healthcare administration team. She also faxed a prisoner warning notice highlighting those concerns.

12. The man was received at Chelmsford that day (31 January) as a remand prisoner. A first reception health screen recorded that he said he had received treatment for depression and anxiety in the past, and that he had attempted to kill himself in November 2006 by jumping off a roof. The man said that he felt suicidal and would take the first opportunity to kill himself. Staff described him as "tearful and low in mood". He was moved to E wing (the induction and first night wing) and placed on constant observation (constant observation is when a prisoner is observed by a designated member of staff who remains constantly in his or her presence). An ACCT form (Assessment, Care in Custody and Teamwork – the process used by the Prison Service to monitor and support prisoners thought to be at risk of self-harm or suicide) was opened on the same day.

13. The ACCT document shows that, on 1 February, the man told staff he had nothing to live for. He said he had been separated from his wife for seven months and wanted to kill himself in prison because it would be on the news. He said that, if he killed himself "on the out", no one would know.

14. Later the same day, the wing nurse saw the man in her capacity as a trained ACCT Assessor. (Every prisoner on an ACCT must have an assessment by a trained assessor within 24 hours of the form being opened.) The man told her that he had tried to kill himself in the past and had "had enough". He did not want to live with "the pain inside" and would try to kill himself if it did not stop. The nurse referred him to the mental health team (MHT). An ACCT review was held shortly afterwards. The review concluded that he was clearly distressed and should remain on constant observation until he felt more settled and supported.

15. Also on 1 February, a consultant forensic psychiatrist reviewed his case. The psychiatrist spoke to his GP who went through his notes with him. The psychiatrist concluded that the man was not suffering from a mental illness and was therefore not suitable to be seen by the MHT. He wrote in the man's Inmate Medical Record (IMR) that any threats or acts of deliberate self-harm

were to be dealt with “by the usual prison mechanisms”. The psychiatrist did not interview the man. By this time the man appears to have been taken off constant observation and put on hourly observations for 24 hours.

16. On 4 February, the man attended an ACCT review with a Registered Mental Nurse (RMN), the wing officer and the wing SO. The record of this review was contained in the man’s IMR and not his ACCT document. The man asked to go to education to do maths or computer studies. He said he had good days and bad days but did not feel there was anything in his cell with which he could hurt himself. The review decided that staff should record three conversations a day with him on his ACCT form and observe him once an hour at irregular intervals during the night and during patrol state (when the prisoners are locked in their cells and a minimal number of staff are present on the wing).

17. On 8 February, the man had a further ACCT review. I have not seen a record of this review but the on-going record shows that the form was to remain open and be reviewed again after one week. On 15 February, the man refused to contribute to his ACCT review. On 16 February, he was due to see a psychiatrist but did not keep the appointment. Later the same day, the psychiatrist wrote in the man’s IMR that he felt there was “little point” in psychiatric staff continuing to try to see him.

18. On 17 February, an officer (signature illegible) had a long conversation with the man during which he said that he did not have anything “on the out” and had more stability in prison. The man said he did not want to be involved in group work and wanted “to keep his head down”. On 19 February, the man was moved to C wing.

19. On 20 February, the man went to a maths class in the education department and was noted to be more cheerful on his return. On 22 February, he attended another ACCT review. The man told the review that he was making efforts to occupy his mind and was seeking work. He said he had a number of issues from his childhood and would one day kill himself. He was escorted back to his cell and given a Sudoku puzzle book.

20. On 26 February, an officer (signature illegible) wrote in the man’s ACCT form that he had not eaten for two days. The officer said he was very concerned about his mental state and that he appeared very low. The same officer spoke to him later the same evening; The man promised he would talk to a member of staff if he felt like harming himself. The officer wrote that he would pass on his concerns to a CPN (Community Psychiatric Nurse).

21. On 27 February, the man was seen to be happier after a legal visit. He told staff that he did not think he would get “life”. He talked about his ex-wife a lot. The next day the man refused lunch. He told staff that he did not want to hurt himself but just wanted to be in bed. That afternoon he attended a workshop and was reported to be in good spirits.

22. In the very early morning of 2 March, the man had a long conversation with the night patrol officer. The officer reported in the man’s ACCT document that the

man had been suffering from unpleasant flashbacks from his past. The officer said that the man, "was not sure how much more he could take". Afterwards, the man told him that he would be okay for the night and thanked him for listening.

23. At 9.30am on 2 March, the man attended an ACCT review with the duty SO and the duty officer. The man said that he was still very low and had thoughts of self-harm and suicide. He described himself as "mentally drained and tired of life". The SO wrote that she would look into moving him to G wing as he wanted to work full time and settle down. The man also expressed an interest in in-cell activities.

24. On 7 March, the man refused his lunch and appeared to be in low spirits. On 9 March, he was seen sitting on his cell floor with his head in his hands. He told staff he did not want to talk. On 11 March, the man asked for an employment form as he felt ready to work. He also wrote a list of the bad things that had happened in his life in preparation for his next ACCT review. On 15 March, he handed in his job application and asked to do a gym induction the following week.

25. On 17 March, the man attended an ACCT review with the duty SO and a officer. The SO noted that the man appeared to be much happier and was looking to occupy his time. He asked if he could be a wing cleaner and the SO said she would consider it. The man said his thoughts of self-harm were much less frequent and he had not thought of suicide for some time.

26. On 27 March, the man was once again reported to be in a low mood and did not eat his dinner. An officer spent some time talking to him and offered to get some books and CDs. The officer discussed the man with an SO and they agreed to talk to him in the office the next day to see if they could cheer him up.

27. On 28 March, the man attended the day care support group for prisoners on open ACCT forms. The wing nurse reported that the man presented with low self-esteem and made little eye contact with the rest of the group. The man was unwilling to discuss his problems but was told he could attend the group again if he wanted to. The man appears to have been given a book to take back to the wing. Later the same day, the nurse recorded that the man had agreed to an assessment by the MHT. An officer arranged for the man's CDs to be brought over from Reception. The man again refused his evening meal.

28. On 29 March, the man stayed in his cell in the morning and said he did not want his lunch. In the afternoon he was given a job painting the wing. He told staff later that day that he was very happy being a wing painter and cleaner, and was reported to be in much better spirits. On 30 March, the man told the officer that he was enjoying painting and getting into his book.

29. On 31 March, the man attended an ACCT review with the duty SO and an officer. The man was reported to be more positive and taking a pride in his appearance. He said he was enjoying working as a painter and was much

"happier in himself". The SO and the officer decided to keep the ACCT form open as the man's court appearance was getting nearer.

30. On 5 April, the man told staff that he felt depressed and things were "getting on top of him". Later that day, the officer reassured him that there would be regular C wing staff on duty over the weekend. The man remained quite low over the next two days. He missed meals and association and appeared subdued. On 7 April, staff were sufficiently concerned to increase the observations to hourly.

31. On 9 April, the man appears to have become agitated as he was not sure whether he was going to court the next day. (He does not appear to have attended court on 10 April.) At 9.13pm on 10 April, a nurse was called to see him after he became distressed. The nurse wrote in the man's IMR that he appeared not to be coping, and was upset with the situation on C wing because there were lots of alarm bells being pressed and prisoners fighting. The nurse discussed the man with the RMN, and the man was moved to the healthcare centre overnight for observation.

32. On 11 April, the man attended Crown Court and returned to C wing at 7.00pm. He told staff that he had been scared and upset but was feeling much happier. He added that his court appearance had been "a little confusing and a bit of a waste of time". The man had been due for his MHT assessment but this was postponed until 17 April because of his court appearance.

33. On 12 April, the man attended an ACCT review with the wing SO. The man said that his mood had improved but he still had bad days. The Wing SO said staff should monitor him more frequently if he began missing meals and stopped interacting. The man said again that he would kill himself "at some stage". The SO decided that the man's observations could be reduced from hourly to the previous level of three conversations per day. Over the next few days the man seems to have been in better spirits. Staff, particularly one of the landing officers, involved him in various jobs and the man responded positively.

34. At 2.00pm on 17 April, the man attended his MHT assessment. The staff nurse assessed him. The man told her that he coped with life events by isolating himself and being guarded. He said his moods fluctuated. One day he might be tearful and unable to cope and the next day he would be elated and motivated. The man said he found it difficult to talk about his emotions but would try to attend the day care support group and work through his issues. The nurse described him as a "clean, tidy, intelligent man". She said he appeared mildly elated with an underlying depressed mood, adding that he had suicidal depressive thoughts and expressed hopelessness for the future. The staff nurse completed a care plan for him to attend the day care support group and the creative writing group. She wrote on his care plan progress notes that he appeared to be keen to go to the latter group.

35. At 4.50pm on 17 April, the man told staff he was feeling much better and that he couldn't wait to "go to court and sort his problems out". Later that evening he seems to have become more subdued.

36. On 18 April, the landing officer reported that the man had worked with him that morning and had been in good spirits, laughing and joking. The man had a visit the same day and returned in good spirits. Later, the officer noticed him chatting to other prisoners and the man told him he had had a good day.

37. On 19 April, the man attended the ACCT support group at day care where he appeared relaxed and shared his thoughts with others. He talked later to an officer about his love of gardening and his fish pond, and seemed in good spirits. At 11.00pm, he spoke at length to the Operational Support Grade (OSG) who was on duty during the night. The man told the OSG that the other prisoners shouting to each other and ringing their cell bells were disturbing him. He felt mentally exhausted and that "his whole life had been shit". He told her that he felt more able to cope in prison, but that if there was a bar across the room and he had a rope he would not hesitate to kill himself. The next morning he told the OSG that he had slept well and felt "so-so".

38. At 9.10pm on 21 April, the OSG saw the man sitting on his bed and rocking backwards and forwards. She asked if he wanted to talk but he said he did not. The OSG contacted the Night Orderly Officer who advised her to raise the frequency of her observations to once every half hour at irregular intervals. At 10.25pm, the Night Orderly Officer unlocked the man to talk to him. The man said he did not want to talk and wanted to give up his job as a cleaner. The Night Orderly Officer said that he was concerned about his behaviour. He decided to remove the man's razor blades and increase the observations to every 15 minutes. The Night Orderly Officer told the man that staff were available if he wanted to talk.

39. The next morning at 9.00am, a member of staff (signature unclear) spoke at length to the man who talked in detail about the abuse he had suffered as a child. The man said he was mentally exhausted and tired of living. He would kill himself if he had the opportunity. He said he did not want to take any medication because he did "not want that stuff in my body". The man said he liked his job as a cleaner and had respect for the wing staff who were "very helpful and compassionate". After talking to the man, the member of staff spoke to healthcare staff and the mental health team. He was informed that the man had refused to see the psychiatrist. At 10.00am, a member of the MHT came to see the man. He said he did not want an appointment with the psychiatrist, and did not want to talk about his problems, but agreed he would come out of his cell and do some work. The member of MHT referred the man for an assessment by the RMN2 (Registered Mental Nurse).

40. The man remained on 15 minute observations during 22 April. At 3.00pm, the RMN2 visited him. The nurse reported that the man was feeling low and was disturbed by memories of his past. The man said he had no hope for the future but denied any intention to harm himself. He wanted to be left alone to deal with the situation on his own. He said he preferred to be in prison because he had nothing to return to in the community. The nurse said that the man should be observed hourly during the day and every half hour during the night and patrol state. The man should be allowed to talk to staff when he wanted. He

was not allowed sharp objects in possession and was to remain on his ACCT plan. The nurse later made an entry to this effect on the man's IMR and added that he should receive further support from the MHT.

41. At some point during 22 April, the man wrote a letter to the daughter of his nominated next of kin. In his letter the man asked that no one should visit him any more because:

> "I'm so fed up and lonely and really low. The thoughts and pain I'm feeling inside are gradually taking hold of me and it's a fight I can't win. I'm sorry for being so negative but the fight inside me has been going on for years and now I'm losing it at last. I've not got the mental strength no more to keep on fighting. My life is and has been shit and now my life is getting worse (mentally)."

42. Later the same day, the OSG drew this letter to the attention of the Security Department and a Security Information Report (SIR) was completed.

43. At 9.00am on 23 April, the man told an officer that he was being pressured by other prisoners for "burn" [tobacco]. He said it was the beginning of his trial soon and he thought psychiatric reports were about to be completed. The man said he thought he was being bullied and threatened because he was on a downward spiral and had been seen by medical staff. He later refused his lunch but spent the afternoon buffing the 1s landing and interacted well with the staff. Later he played table football with the other prisoners and seemed to be enjoying himself.

44. On 24 April, the man appeared to be in better spirits and applied for enhanced status under the Incentives and Earned Privileges Scheme (IEPS – a scheme whereby prisoners have the opportunity to earn extra privileges through good behaviour). The next day he learned that he had been given enhanced status and was described as "very enthusiastic".

45. On 26 April, the man told staff that his mood had dropped again. He felt "screwed mentally" and could not work out why his moods seemed to change so abruptly. At 2.15pm, he attended an ACCT review with the duty SO and a Sister from the Chaplaincy. The SO recorded that he was very low and did not want to speak or make eye contact. He did not go to the day care support group during the afternoon but cleaned the landing instead.

46. On 28 April, the duty SO said she thought the man was in better spirits that morning. At 9.45pm, he was described as being low and not very talkative. A member of staff (signature illegible) wrote in his ACCT record that he thought the man might be being bullied.

47. On 30 April, the man spent the day painting the landing and playing cards with another prisoner. He had a long chat with the landing officer in the morning about life in general. He did not go to the creative writing group but said he would go on 14 May after the Bank Holiday. At 9.00pm, he was seen sitting in his cell staring at his window bars. When asked if he was okay he just

shrugged. According to the landing officer, the next morning the man seemed quite down when his cell was unlocked. The officer said he gave him some time to "sort himself out" and he spent the morning painting the 1s. The man told the officer that he was "like that" most mornings but was fine once he had "got going". Later on 1 May, the man told another officer that he was a bit concerned about his upcoming court case. During the evening he appeared to be much more positive and watched football on television.

48. On 2 and 3 May, the man remained in relatively good spirits. He continued to work as a painter on the wing and advised the landing officer on treatment for his numb arm. He showed another officer some poetry he had written. He did not attend the day care support group but seemed happy after having a shower in the evening.

49. On 2 May, the man wrote to his nominated next of kin, the mother of one of his friends. He apologised for not turning up when she had last visited him. He said that it was too distressing to see everyone leaving at the end of visits and he had "been up and down with my depression". He told her that he had been put on the enhanced level of IEPS and asked her to send him some games for a PlayStation or Game Cube. He hoped she would write to him again.

50. At 1.20am on 4 May, the man had a long conversation with the night OSG. The man told him that he did not want to be released from prison as he had nothing to go back to. The OSG said that, although he appeared to be quite upbeat, the things he was talking about were quite negative. The man told the OSG that he liked being in prison because the staff gave him more respect than anyone had ever done outside. He was considering changing his plea to guilty to ensure a longer sentence.

51. The duty SO told my investigator she was on duty all day on 4 May. She remembered seeing him painting a cell on the 1s landing during the morning and thinking he seemed in a good mood. The man came to see her just before lunch and, as he was about to go back to his cell, he touched her on the back and said "Goodbye darlin'." She replied with words to the effect of: "Go on, you cheeky devil."

52. At 12.25pm, an officer wrote on the man's ACCT that he had spent the morning painting cells and appeared to be in a good mood.

53. At approximately 2.05pm, the second landing officer began a roll check of the prisoners on C2 landing. The officer looked into the man's cell and saw him with a bed sheet round his neck attached to the top of the window. The man's knees were on the floor of the cell and there was blood on the wall and the windowsill.

THE PRISON'S RESPONSE TO THE MAN'S DEATH

54. The second landing officer told the investigation he called to the second wing officer who was on the landing with him. When the second wing officer arrived at the man's cell, the second landing officer unlocked the door. The landing officer shouted for assistance from other staff and went into the cell. He supported the man's body while the second wing officer undid the sheet. The third wing officer entered the cell and the three officers laid the man on the bed. The landing officer said they decided not to put the man on the floor because it looked as though it was covered in urine. The landing officer checked for a neck pulse but could not find one. The duty SO and two officers arrived and took over. The second landing officer said the duty SO left to get the First Aid box and he was told to leave the cell and went to the SO's office on C1 landing.

55. The second wing officer said he was also conducting a roll check of prisoners on C2 landing when he responded to a call from the second landing officer for help. He entered the man's cell and saw him hanging from the window. He saw blood and smelt urine on the floor. He said he and the second landing officers tried to take the weight of the man's body. The third wing officer came into the cell and this allowed the second wing officer to try to undo the sheet while the third wing officer and the second landing officer took the man's weight. (Officers in Chelmsford carry personal issue cut down tools but the sheet had been twisted round and was too thick to be cut.) The second wing officer said they put the man on the bed and he tried to tip the man's head back to keep his airway open. Both he and the second landing officer tried to find a pulse in the man's neck but without success. The second landing officer described the man as grey in colour with dark blue lips. He said the man felt cold. When other staff arrived, the second wing officer was told to leave the cell and go to the staff room.

56. The third wing officer said he was taking a prisoner to a cell on C3 landing when he heard calls for staff assistance. He ran to the man's cell and found the second landing officer and the second wing officer trying to release the man from the sheet. He helped them do this and then left the cell to shut the observation hatches on the other cells on the wing.

57. The duty SO said that mass movement (the period when prisoners are let out of their cells to go to work and education classes) had just finished at about 2.00pm when she heard a shout for assistance from one of the landings upstairs. She initially went to the 3s landing but then realised that the emergency was on the 2s landing. It was at this point that she thought something might have happened to the man. She arrived at his cell to find 3 officers inside. The officers told her that the man did not have a pulse and she went down to the office to collect the emergency response kit. At the same time she notified the control room that there was an emergency. The duty SO returned to the cell and unwrapped a Resusci-Aid (a breathing mask with a non-return valve for performing rescue breaths in cardio-pulmonary resuscitation). She said she performed one breath but was unable to carry on as she had caused stale air from the man's body to be expelled. Officer A took

over and Officer B began chest compressions. The duty SO left the cell as healthcare staff arrived.

58. Officer A said she followed the duty SO upstairs to C2 landing and entered the cell with her as the officers were putting the man on his bed. She confirmed that the SO went to get the emergency response kit and did one breath using a Resusci-Aid. Officer A took over when the SO was unable to continue. She continued to breathe into the man with Officer B doing chest compressions until the emergency nurse arrived. Officer A said that the nurse told them to put the man on the floor. Officer A resumed mouth to mouth resuscitation and the nurse did chest compressions. A prison doctor arrived and pronounced the man dead at approximately 2.21pm.

59. The nurse on the scene was the emergency response nurse on 4 May. She was in the substance misuse office on E wing when she heard a call on the radio for her to go to C2 landing immediately. She told my investigator she received another call immediately afterwards telling her that the emergency was a code 1 (a code 1 in Chelmsford indicates that someone is unconscious or bleeding). The nurse did not have any emergency equipment with her when she arrived on C wing and asked for the emergency bag and defibrillator when she got there. She said she saw the man lying on the bed with two officers attempting CPR. She noticed a strong smell of faeces and urine. She asked the officers to place the man on the floor because it is preferable to do CPR on a hard surface. The nurse said the man was very difficult to manipulate and she could not feel a pulse. Her first impression was that he was dead. The nurse did four cycles of CPR with Officer A. The prison doctor on duty and the RMN arrived and the man was given oxygen from an Ambu-bag. The defibrillator was then attached and gave a reading of no cardiac output. The prison doctor told her to stop CPR and pronounced the man dead.

60. The emergency nurse thought that, had the defibrillator and oxygen been available when she first arrived at the man's cell, it would not have made any difference to the outcome. Her opinion was that the man was already dead. My investigator asked her whether she thought it would be feasible for someone to be made responsible for collecting the emergency bag as soon as a code 1 was called. She said she did not think there were sufficient staff available for this to be practical.

61. The prison doctor told the investigation he arrived at the man's cell with the RMN. He saw the emergency nurse doing chest compressions and Officer A doing mouth to mouth resuscitation. The doctor said the man was very cyanosed (a blue colouring of the skin, indicating a lack of oxygen in the blood) and unresponsive. He said the emergency nurse did three cycles of chest compressions and then he took over and did three cycles. The doctor said the man was given oxygen via an Ambu-bag and the defibrillator was attached but gave a reading of no pulse. The doctor said he told staff to stop trying to resuscitate the man and pronounced life extinct at 2.21pm. The first response ambulance paramedic arrived shortly afterwards. The paramedic decided to cancel the ambulance but the crew arrived as they were speaking. The

ambulance crew did not attend the man because death had already been pronounced.

62. Officer C started a log outside the man's cell at 2.10pm. He recorded which staff had already entered the man's cell and those who did so subsequently. The officer's log shows that, when he started recording events, the second landing officer, the second wing officer, Officer A and the duty SO were already in the cell. The log records the emergency nurse arriving at 2.13pm and the prison doctor and the RMN arriving at 2.16pm. At 2.35pm, Officer D took over as log keeper. In addition to these two logs, a log was kept between 2.35pm and 4.57pm in the Command Suite. An incident log was also completed in the control room. The control room log shows the emergency call being received from C wing at 2.07pm.

63. The logs show that the Principal Officer (PO) was asked at 2.38pm to complete reviews of all prisoners on open ACCT forms. At 2.47pm, the Governor asked for notices to staff and prisoners to be prepared. At 2.51pm, the PO was asked to contact the man's next of kin. At 3.01pm, the Governor approved the notices of the man's death and distribution was set for when the police arrived. At 3.02pm, members of the staff welfare team saw the officers who were first into the man's cell. At 3.15pm, Listeners (prisoners trained by Samaritans to provide confidential emotional support to fellow prisoners in distress) were sent to C wing. Also within the first hour of the man's death, the prison had contacted the police, the Coroner, the Prison Service's National Operations Unit, the Area Manager, the Independent Monitoring Board and the chaplaincy.

64. The PO and the Head of Residence drove to break the news to the man's next of kin in the late afternoon of 4 May. They visited her a few days later with the man's property. The nominated next of kin told my office that she had also received a letter of condolence from the Governor but this had upset her greatly because there were several errors in it. When she told the PO about this, she later received a letter of apology and two bouquets of flowers. The prison offered the family financial assistance towards the man's funeral and members of staff attended.

ISSUES CONSIDERED DURING THE INVESTIGATION

The prison's response to the man's death

65. It is evident from contemporaneous accounts that the man was already dead when the second landing officer found him. Despite this, staff made a serious and sustained attempt to revive him. I have great sympathy for the duty SO who knew the man well and found herself unable to continue mouth to mouth resuscitation after her initial breath had caused stale air from the man's body to be expelled. I consider that Officer A in particular deserves credit for continuing to give the man mouth to mouth resuscitation for over ten minutes. The Governor will wish to consider if the actions of Officer A and those of other staff deserve formal recognition.

66. At the time of the man's death each wing had an emergency response kit that was kept in the wing office and contained CPR face masks and resuscitation aids. Specialist equipment including oxygen and a defibrillator was kept in the healthcare centre and in B wing medical room just off the centre (wings A-D are in the old Victorian radial pattern leading out from a circular centre). Officers did not carry masks on their belts. When wing staff responded to the second landing officer's calls for help they were not aware of the nature of the problem or that they needed to bring the emergency response kit. The duty SO collected the kit after first running to the cell. It was only when she returned with it that CPR began.

67. My investigators walked the route between E wing and C wing and between B wing medical room and C2 landing. They estimated that it would have taken the duty SO no longer than two minutes to run to the 2s landing from the office, return to the office to get the emergency response kit and run back to the man's cell to begin CPR. This is consistent with the log timings that show that the emergency call was made at 2.07pm, and that the SO and Officer A were in the man's cell when Officer C began the log at 2.10pm.

68. I consider that the short delay between discovery of the man and CPR being started did not have an effect on the man's chances of survival. However, in cases of hanging, timing is crucial and even such small delays could make the difference between life and death. The latest guidance from the Resuscitation Council is that chest-compression only CPR may be as effective as performing rescue breaths and chest-compressions together. This means that it is not necessary to wait for a mask before beginning CPR. In all cases of attending attempted hangings, it is important that staff begin chest compressions immediately.

I recommend that the Governor of Chelmsford issues a notice to staff informing them of the latest Resuscitation Council guidance. The notice should include the information that chest compressions should be started immediately someone is found not breathing and that it is not necessary to wait for emergency equipment such as masks before CPR is started. In addition, the Prison Service's Safer Custody Group may wish

to consider if advice to that effect should be shared with all establishments.

69. None of the discipline staff who responded to the second landing officer's call for assistance told my investigators they had received recent CPR or First Aid training. However, they all said they felt quite confident that they could perform chest compressions and mouth to mouth resuscitation if required in an emergency. I accept that it is not realistic to expect prisons to keep all of their staff up to date with CPR training in case they are required to respond to an emergency. Nevertheless, I note that HM Chief Inspector's report of July 2007 shows that updated resuscitation training was due for most staff. It would be prudent for the Governor to reassure himself that an appropriate percentage of staff are up to date with this training.

70. The emergency response nurse arrived at the man's cell without bringing equipment from the healthcare centre or the B wing medical room. She was aware that the emergency was a code 1, which meant that someone was unconscious or bleeding. On arrival at the man's cell, the nurse asked for the defibrillator and oxygen to be brought. The equipment was collected from the B wing medical room. The nurse told my investigators that she did not think it was practical or possible to give another member of staff the role of bringing the emergency equipment from the healthcare centre or B wing when a code 1 is called.

71. The control room log shows that at 2.07pm a call was put out over the radio for all healthcare staff to attend C2 landing with their emergency equipment. At 2.08pm, a call was made for the defibrillator and oxygen to be brought to C2. My investigators estimated that it would have taken the emergency nurse about three minutes to get from E to C wing. It takes less than a minute to get from C2 landing to B wing medical room and back to C2. Officer's C log shows that the nurse arrived on C2 at 2.13pm. At 2.16pm, the prison doctor and the RMN arrived. It is not absolutely clear from the staff incident reports, but at this point either the RMN left immediately to get the defibrillator and oxygen from B wing or it was brought by the emergency nurse (who had been told by healthcare officers that it was needed). In either case, it appears that some eight minutes after the call for the defibrillator and oxygen had been put over the radio, and some three minutes after the emergency nurse had arrived at the man's cell, the equipment had not arrived. Again I think it unlikely that this delay was significant in the man's case, but it could be so on a future occasion.

I recommend that Chelmsford's death in custody contingency plans should be amended to give the control room the responsibility of allocating a specific member of staff the responsibility of collecting the defibrillator and oxygen and taking it to the scene of all code 1 emergencies.

72. Overall, I believe Chelmsford's response to the man's death was efficient, organised and timely. The family liaison was sensitive and the news of the man's death was delivered in person. I have not seen the original letter of

condolence sent to the man's next of kin but, once it became obvious that offence had been caused by errors in it, steps were taken to remedy the situation. I have been pleased to learn that the next of kin felt the liaison had been of a high standard, and to record that in this report. The next of kin was also very complimentary about the staff on the wing and in the Visits Centre at Chelmsford. Both staff and prisoners told my investigators that the memorial service for the man was well attended and very moving. The Governor and Area Manager may wish to share the man's next of kin's views with staff.

The assessment and management of the man's risk

73. From the moment he arrived at Chelmsford, the man told staff he would kill himself. He comes across as a man who suffered from overwhelming grief from his childhood and the break up of his marriage. The man had been depressed for a number of years and had made two previous attempts to kill himself. He had no contact with his family and said on a number of occasions that he felt he had nothing to live for. The man repeated his wish to kill himself throughout his time in Chelmsford. His mood fluctuated greatly, but an underlying sense of hopelessness appears to have remained.

74. The man's risk was identified on arrival at Chelmsford and he was placed on constant observation during his first couple of days in custody. An ACCT document was opened immediately. A trained ACCT assessor assessed him within 24 hours. The man was referred to the MHT but declined to see them throughout his period on E wing. He moved to C wing on 19 February 2007. The ACCT form remained open until his death.

75. When he arrived on C wing, the man was very quiet and unwilling to talk. The duty SO described to my investigators how he used to "shuffle about the landing with his head down". The SO said that the man became her "project". All ACCT reviews on C wing are scheduled to take place on Thursday afternoons so that non-wing staff from other disciplines can attend more regularly. The man consistently refused the opportunities offered to him to engage with mental health staff and attend the day care support group and creative writing group. He refused to talk to the chaplaincy and did not speak to Listeners. Because of this, and because he found it difficult to talk about his feelings, the duty SO often moved his ACCT reviews to other days so that she had more time to talk to him. Of the six reviews the man had on C wing, three were on a Thursday, one was on a Friday and two were on a Saturday. Only one review was attended by a member of staff other than wing staff – on 26 April when the Sister from the Chaplaincy attended. Significantly, the man is recorded as not wanting to talk during this review.

76. It is apparent from the man's ACCT form, and from interviews with staff, that he gradually formed good relationships with them and was able to talk more about his thoughts and feelings. There are several entries on the man's ACCT demonstrating that staff took time to talk to him and think of ways to help him cope with his problems. He was given books, CDs and puzzle books to occupy his mind while he was in his cell. He was also given a job painting and cleaning the wing and this appears to have significantly improved his mood and

his self-esteem. He attained enhanced status on IEPS. There are also several entries where the man reportedly thanked staff for their care and compassion.

77. Quality written entries and multi-disciplinary reviews are at the heart of the ACCT process. It is important for staff to write frequent and detailed entries so that continuity of care can be maintained. An accurate record of a prisoner's mood, their reaction to events and the identification of trigger points are essential to keeping safe a prisoner who is vulnerable to self-harm or suicide. The entries on the man's ACCT record were not always of the required frequency and standard. It is often difficult to identify staff from the signatures as names are rarely written in capitals underneath. For the reasons explained above, his reviews were not multi-disciplinary and sometimes consisted of only the man and one officer.

78. Nevertheless, in managing prisoners deemed to be at risk of self-harm or suicide, the quality of care is more important than the quality of form filling. The pressures of a busy wing in an overcrowded prison with staff shortages mean that it is not always easy to write detailed entries and organise multi-disciplinary reviews. However, staff must try, wherever possible, to hold such reviews and write the required number of entries. The man's ACCT record shows regular management checks and reminders to staff about the quality and frequency of entries.

79. The key aims of the ACCT process are to build relationships with people who are at risk of self-harm and suicide, to listen to them, identify their needs and to offer individualised care. Support plans must recognise the importance of keeping the prisoner at risk engaged. Places in the prison workshops are at a premium in Chelmsford but wing staff provided the man with activity inside and outside his cell. I consider that in the man's case staff on C wing fulfilled the aims of the ACCT process and deserve credit for the way they managed him. The man's next of kin told my senior family liaison officer that, if she was worried about the man after visiting or talking to him, she would tell wing staff or call them and always felt she was listened to. Again, the Governor may wish to pass on to his staff my views and those of the man's next of kin.

The man's clinical care

80. As noted earlier, a medical practitioner from Mid-Essex Primary Care Trust (PCT) undertook a review of the man's clinical care while in Chelmsford. The clinical reviewer makes some comments about record keeping and the integration of mental health notes with the Inmate Medical Record. When my investigator was first provided with the man's prison and medical records, the records of his contact with the MHT and the record of the assessment carried out by the staff nurse were not included. I endorse the clinical review recommendations and draw particular attention to her comments about integrating medical and MHT records.

81. On 31 January, the prison doctor, assessed the man. The prison doctor wrote in the man's IMR:

> "Not keen to discuss his problems – constantly avoided it. Would not attempt to engage. Agreed he was manipulating because it 'suited' him. Mood and conversation content totally appropriate."

The clinical reviewer says in her review:

> "The GP's initial assessment of patient identifies the patient as uncooperative but there is no evidence of a pro-active approach to support a prisoner who has underlying, long term mental health issues."

I share her concern. It is not apparent that the man saw the prison doctor except on this one occasion. I should add that any belief that self-harm and suicidal feelings are manipulative and attention seeking may prevent the offering of appropriate care and support.

82. On 1 February, the man was referred to the MHT after his ACCT assessment interview. The same day, a forensic psychiatrist spoke to a GP in the man's home practice and discussed the man's notes with him. The psychiatrist did not interview the man or assess him. A later appointment must have been made for the man to be assessed by the psychiatrist because on 16 February it was recorded in his IMR that he refused to attend. After this, the psychiatrist concluded there was "little point" in continuing to try to see him.

83. Because of the passage of time, and the fact that the clinical reviewer did not ask the prison doctor or the psychiatrist to explain their respective views and decisions, I make no further comments or recommendations. The PCT will receive a copy of this report and may wish to satisfy themselves of the reasoning.

84. On 17 February, the man told an officer that he did not want to be involved in the group work offered at the day care support group for prisoners on ACCT forms. On 26 February, he was low and an officer wrote in his ACCT record that he would pass on staff concerns to a CPN. There is no record to indicate this happened. On 28 March, the man went to the day care support group for the first time. He was reported to have been quiet and unwilling to talk but agreed to a MHT assessment. The date of this assessment appears to have been 11 April but this was cancelled because the man was in court that day. (My own view is that two weeks is a long time to wait for an assessment.) The assessment eventually took place on 17 April and a support plan for the man to attend the day care support group and the creative writing class was put in place. The man chose to attend the support group in day care on only one occasion (on 19 April).

85. The man became very distressed again on 22 April. He was assessed by the RMN2 and offered the opportunity to speak to the psychiatrist. The man said he did not want to talk to the psychiatrist or speak about his problems. He said he preferred to remain on the wing to clean. The RMN2 recommended that the man should receive further support from the MHT. It is not obvious whether any support was offered outside of the support plan written by the staff nurse.

86. When the man arrived at Chelmsford it appears he was extremely unwilling to speak to anyone. He did not participate in all his early ACCT reviews and showed little inclination to engage with staff. I do not think this is unusual behaviour for someone who is depressed and coming to terms with being in prison. The very prisoners who are most vulnerable may be those who are most unwilling to talk about their feelings. I am concerned that it was determined just over two weeks after he had arrived that there was "little point" in the MHT trying to see him. I accept that on two later occasions the man declined the opportunity to speak to the MHT. I also accept that, because the man's ACCT reviews often took place on a Saturday (something which, on other grounds, I have commended), there was decreased opportunity for multi-disciplinary involvement in his overall management. Nevertheless, between 17 February and 28 March this very depressed and suicidal man does not appear to have been spoken to by any member of the healthcare team or MHT.

I recommend that the PCT reviews the role of the Mental Health Team in HMP Chelmsford. The review should consider putting in place a 'safety net' for those prisoners who refuse to engage with the MHT but remain on open ACCT forms.

Allegations made by another prisoner

87. On 11 May 2007, a prisoner completed a Prison Service complaint form in which he alleged that the man had killed himself after "relentless bullying" by staff. An officer from the Safer Custody Team undertook a local investigation. Prisoner A told the officer that the man had come to his cell on several occasions and complained that he was not being given medication for his depression. He also said that another prisoner, prisoner B, had information about the man's death.

88. On 15 May, my lead investigator interviewed the prisoner who had made the allegations. The prisoner told my investigator that the man had been bullied by staff. However, he was unable to give specific examples of the form this bullying had taken and the frequency with which it had occurred. Eventually, the prisoner said that the landing officer had "wound the man up" and made comments about his offence. The prisoner said that prisoner B would be able to confirm his allegations. My investigators spoke to prisoner B when they returned to the prison to interview staff. Prisoner B told them that the man had a good relationship with all staff on the wing and had not had a problem with any of them. The allegations were put to the landing officer during interview on 25 July 2007. The officer denied making any comments to the man about his offence even as "banter".

89. On 22 April, the man refused medication for his depression on the grounds that he "did not want that stuff in my body". He was consistent in his unwillingness to talk about his problems and there is no evidence that he ever asked for medication while in Chelmsford. It is clear from the man's ACCT record and from interviewing the landing officer that he had a very good relationship with the man, and that the man trusted and respected him. I conclude that the allegations made by the prisoner are untrue.

CONCLUSION

90. The man was a very damaged and depressed man who felt hopeless about his future. The management of people like him provides an enormous challenge for the Prison Service. The Service's guide to managers on caring for prisoner's at risk says:

> "Preventing suicide involves listening to the person at risk, engaging them in planning ways of reducing their problems, helping them to build up their own sources of support and thus helping them to choose life.
>
> "Watching and stopping can be important but it only works in the short term."

91. Staff on C wing listened to the man, engaged him and tried to help him to choose life. Unfortunately, he made another choice.

RECOMMENDATIONS AND GOOD PRACTICE

1. **I recommend that the Governor of Chelmsford issues a notice to staff informing them of the latest Resuscitation Council guidance. The notice should include the information that chest compressions should be started immediately someone is found not breathing and that it is not necessary to wait for emergency equipment such as masks before CPR is started. In addition, the Prison Service's Safer Custody Group may wish to consider if advice to that effect should be shared with all establishments.**

   The prison accepted this recommendation at draft report stage and responded:
   "A Governors Information Notice has been prepared and circulated to staff. The notice contains a flow chart which sets out actions to be taken following a discovery of an apparent suicide by hanging and contains up to date Resuscitation Council guidelines. It also makes it clear CPR should be started regardless of the availability of emergency equipment.

   The decision to circulate this information to all establishments will be taken in consultation with Offender Health."

2. **I recommend that Chelmsford's death in custody contingency plans should be amended to give the control room the responsibility of allocating a specific member of staff the responsibility of collecting the defibrillator and oxygen and taking it to the scene of all code 1 emergencies.**

   The Prison accepted this recommendation at draft stage and responded:
   "As an alternative we intend to locate a Defibrillator and Oxygen in the Wing Manager's Office for all 7 Residential Wings. This will ensure that staff have immediate access to life saving equipment on site. This action will be complete when all Nurses are fully trained."

3. **I recommend that the PCT reviews the role of the Mental Health Team in HMP Chelmsford. The review should consider putting in place a 'safety net' for those prisoners who refuse to engage with the MHT but remain on open ACCT forms.**

   This recommendation was accepted at draft stage and the PCT said they had completed a review.

Good practice:

- **The support group for prisoners on ACCT forms is good practice.**

- **Creating a job for the man painting on the wing to get him out of his cell and interacting with staff and prisoners was good practice.**

- **Moving the man's ACCT reviews to a day when he could be given the time he needed to talk was good practice.**